

Tackling Inequalities: Moving theory to action

**A final report on Health
Inequalities Awareness Workshops
for the health sector**

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Executive Summary

This report discusses a health inequalities awareness-training programme for the health sector run in 2002/2003. It outlines the development and implementation of the programme and reports on findings from the work. Inequalities in health are pronounced in New Zealand and increasing at least up until 1999 when the latest data is available. This training programme is part of the Ministry of Health's role in meeting the Government's overall commitment to reducing inequalities in health, education, employment and housing, and is consistent with efforts in other countries.

The programme was developed in an innovative partnership between academics at the Wellington School of Medicine and Health Sciences and the Ministry of Health Inequalities Team. It was based on a needs assessment of senior staff in the Ministry of Health and District Health Boards (DHBs) which indicated strong support for awareness training. Eight workshops were held: one for DHB Māori managers, two for Ministry of Health staff and five for groups of DHBs.

The purpose of the workshops, *Tackling Inequalities: Moving theory to action*, was 'to increase the knowledge and skills of DHB and Ministry of Health staff to act on, and advocate for, eliminating inequalities in health in Aotearoa/New Zealand'. They were practical, evidence-based and action-oriented. Consistent with the international and national literature, the workshops took a social approach to the causes of inequalities in health, focusing on the unequal distribution of the determinants of health. Critical factors in this unequal distribution appear to be socioeconomic position and social exclusion, including racism, sexism and disablism. The training programme used ethnic inequalities as a case study and focused on racism to explore issues of social exclusion. Institutional theory was used to provide a framework for participants to consider how to tackle inequalities in the institutions in which they work. Central to the workshop process was the introduction of the Ministry of Health's Intervention Framework to Improve Health and Reduce Inequalities. It was used together with a Health Equity Assessment Tool (HEAT) to determine and analyse interventions for their impact on equity.

In the workshops participants identified many obstacles to tackling inequalities in health, such as a perceived lack of leadership, the limited capacity of the workforce, the need to change contracting and monitoring processes to support this work, and limited intersectoral collaboration between the Ministry of Health and other sectors. Participants did, however, identify many supports that they required, such as good-quality information, strengthening relationships between key players within and outside the sector, appropriate accountability and monitoring mechanisms, and political and sector-wide leadership on this issue. Participants also identified opportunities, including the chance to develop models appropriate for New Zealand for tackling inequalities.

Approximately 160 people participated in the workshops. In post-workshop evaluations participants indicated overwhelmingly that they valued the workshops. Teleconference follow-up sessions were held some months after the workshops to provide support to participants. While attendance at these follow-up sessions was low (24), some spoke for the wider group of workshop participants from their workplace. Follow-up sessions indicated that workshop tools were being used successfully, participants had been able to spread the messages of the workshop to colleagues, and progress had been made on action plans developed at the workshops.

The report concludes that this series of awareness-raising workshops has been a limited, but valuable, part of the process of moving the New Zealand health sector towards the development of a comprehensive co-ordinated policy to tackle inequalities in health. By commissioning this series of workshops, combining the academic expertise of the Wellington School of Medicine and Health Sciences with the policy and sector experience of the Ministry of Health, the Ministry has demonstrated a visionary commitment to tackling inequalities in health. The training team knows of no other country where such a partnership has linked with health care providers on this critical issue. There is considerable international interest in this process and its outcomes.

The development of innovative policy initiatives requires careful support in the implementation stage. There is a real danger that the expectations and hopes raised in this programme will not be met without financial and management resources to support innovation in the development, implementation and evaluation of efforts to tackle inequalities in health. Explicit institutional, professional and economic incentives need to be in place if organisations are to seriously address these issues. The training team sees sector leadership and the training of all those who work in the health sector as critical to the success of efforts to tackle inequalities. Effective equity-focused contracting and contract monitoring by the Ministry of Health and DHBs are also vital, as are research and information on inequalities in health and effective interventions to address them.

As Te Rōpū Rangahau Hauora a Eru Pōmare state, ‘the prevention of social inequalities in health requires substantial attention, determination, creativity and the efforts of many’. Currently, the health sector is better placed than it has been for many years to act. The ongoing challenge is to ensure that an equity approach is institutionalised throughout the health sector – that it becomes business as usual. There are a number of ways this can be achieved. The workshop action plans provide many possibilities for action, some of which are already in place.

The way forward

The way forward is to acknowledge the strength of the partnership between the Wellington School of Medicine and Health Sciences and the Ministry of Health, build on the success of the health inequalities awareness-raising workshops, and signal that the Ministry of Health is committed to continuing to work to reduce health inequalities.

The following actions were derived from the awareness-raising workshops and incorporate feedback from the workshop participants, the Wellington School of Medicine and Health Sciences and the Ministry of Health. They are currently being developed or implemented across the Ministry of Health.

Recommended actions derived from the workshops

Sector leadership

It is recommended that:

1. the Ministry of Health briefs the Minister of Health on the success of the health inequalities awareness-training programme

2. the Ministry of Health continues to demonstrate, through its Statement of Intent, how it intends to move over the medium term towards achieving reduced health inequalities
3. the Director-General of Health and the Ministry's Senior Management Team continue to signal the critical importance of an inequalities approach for the entire health sector in all key sector documents
4. the Ministry of Health incorporates an inequalities perspective in all aspects of its work programmes
5. the Ministry of Health establishes links with other government agencies that impact on inequalities in health
6. institutional, professional and economic levers are utilised to encourage progress in tackling inequalities
7. senior management teams of DHBs signal the critical importance of an inequalities approach in all work by the DHBs and their providers.

Training

It is recommended that:

8. a monograph of the training programme is developed for use in future training
9. funding is made available for the development of audiovisual resources to support this training
10. the training programme is extended to ensure that senior staff of the DHBs, Ministry of Health staff and boards of DHBs who have not currently had the benefit of training are given the opportunity to participate
11. ways are explored to build an inequalities focus into the curriculum for all initial health training (eg, nursing, medicine, dental therapy)
12. ways are explored to ensure that all staff currently working in the health sector receive in-service training on tackling inequalities
13. specific training is developed and delivered for the Māori health workforce, including Māori providers
14. specific training is developed and delivered for the Pacific health workforce, including Pacific providers.

Effective contracting and contract monitoring by the Ministry of Health and DHBs

It is recommended that:

15. contracting and monitoring frameworks that focus on tackling inequalities are developed, implemented and evaluated, with particular emphasis on the ability of mainstream services to reduce inequalities
16. the inequalities framework and the HEAT tool are included as part of these contracting and monitoring frameworks
17. ongoing support to, and performance review of, staff responsible for contracting and monitoring within the Ministry of Health and DHBs are provided with regard to the implementation of these frameworks.

Awareness raising

It is recommended that:

18. a national conference is sponsored to highlight the issue of inequalities in health, publicise the evidence, and build on the commitment, and that it includes overseas guests such as James Nazroo and Hilary Graham
19. information is built into a number of conferences, including the next Public Health Association conference.

Research and information

It is recommended that:

20. evaluation of the use of the intervention framework and HEAT tool is funded
21. an inequalities website is developed, with current information from New Zealand and internationally and links to appropriate sites
22. an edited book of case studies of efforts to tackle inequalities in New Zealand is commissioned by the Ministry of Health
23. the outcomes of the workshops are disseminated through the release of the current report and publications in peer-reviewed journals.

Issues for further consideration

The following issues require further discussion with other agencies within the health sector. It is suggested that:

24. the National Health Committee (NHC) continues to provide advice on inequalities in health
25. the Ministry of Health encourages the Health Research Council (HRC) to maintain a focus on funding research in relation to tackling inequalities in health
26. the Ministry of Health encourages the HRC to continue to provide support to researchers working to tackle inequalities in health
27. funding is made available for independent evaluation of mainstream health service provision (to assess its capacity to tackle inequalities in health, and to assess the effectiveness of changes aimed at tackling inequalities in health), and for disseminating the evaluation findings.

Introduction

How well and how long one lives is powerfully shaped by one's place in [social] hierarchies (Graham 2001: 3).

This report discusses a health inequalities awareness-training programme for the health sector run in 2002/2003. The report outlines the needs assessment conducted to assess the training needs of senior health sector staff, describes the workshops, and discusses key aspects of the workshop content. The key findings from the workshops are outlined, including obstacles to tackling inequalities in health and the supports required by the sector to overcome the obstacles. Outlines of the action plans developed by workshop participants to strengthen the capacity of their organisations to tackle inequalities in health are presented and reviewed. A summary of workshop evaluations, including recommendations for further action, is provided. Follow-up sessions were offered to all participants, and the findings from these sessions are discussed. The report concludes with an acknowledgement of the value of health inequalities awareness training and makes recommendations about future initiatives to strengthen the capacity of the health sector to tackle inequalities in health.

The Ministry of Health contracted the Public Health Consultancy and Te Rōpū Rangahau Hauora a Eru Pōmare at the Wellington School of Medicine and Health Sciences to work with the Ministry of Health Inequalities Team to design and deliver a series of inequalities awareness training workshops. They were designed for senior staff in the Ministry and District Health Boards (DHBs) and board members of DHBs.

Inequalities in health and in the determinants of health are pronounced in New Zealand and increasing, at least up until 1999 (Howden-Chapman and Tobias 2000, Ajwani et al 2003). Commitment to 'reduce inequalities in health, education, employment and housing' (Ministry of Health 2002: 10) is one of the six key Government goals to guide public sector policy and performance. The Minister of Health has identified 'reducing inequalities in health outcomes' and 'meeting obligations under the Treaty of Waitangi' as two of the five objectives for the health sector (Ministry of Health 2002: 16). The over-arching New Zealand Health Strategy sets the platform for the Government's action on health. The Strategy acknowledges the need to address health inequalities as 'a major priority requiring ongoing commitment across the sector' (Minister of Health 2000: 4). The awareness-raising initiative discussed in this report was identified as an important step in meeting the Government's objective to reduce inequalities, and is consistent with efforts in other countries such as Australia and the United Kingdom.

The contract consisted of two parts:

- a needs assessment with key staff at the Ministry of Health and District Health Boards (Ministry of Health et al 2002)
- the design and delivery of the training workshops.

Needs Assessment

The purpose of the needs assessment was to assess the training needs of senior DHB staff and board members and Ministry of Health staff in relation to their awareness of the nature and impact of inequalities in health and interventions to address these. The methods used for the assessment were a review of recent key Ministry and DHB documents, a series of interviews and focus groups with staff from across the Ministry, and semi-structured telephone interviews with senior staff of 20 of the 21 DHBs. The DHB staff interviewed were chief executive officers (or, where they were not available, funding and planning managers), 18 senior Māori managers and two Pacific managers.

The needs assessment identified strong support for training in awareness of health inequalities in both the Ministry and DHBs. The objective to address inequalities in health is very visible in key Ministry documents, and staff acknowledged the importance of this objective, arguing that it needs to be ‘internalised into all the work that is undertaken in the Ministry of Health’. Staff indicated the need for approval from the Ministry executive team to encourage participation. There was also a level of cynicism about whether ‘anything can be done’ to address inequalities and a sense among some staff of being overwhelmed by what they perceive to be the size of the challenge.

Several DHBs listed inequalities as a key driver, or top criterion for decision-making. The researchers were frequently referred to the DHBs’ health needs analyses and strategic and annual plans as evidence of their need to work in this area and of their commitment to the issue. The challenge for the DHBs appears to be translating this commitment into action.

In terms of workshop content, a wide range of training needs was identified, from the theoretical to the practical. There was a call for fundamental knowledge about inequalities in health, including information on the different theoretical positions and their strengths and weaknesses. However, some staff argued that they have had the debate about the need to tackle inequalities and want to focus on strengthening their practice. There was a clear call for input and discussion of effective interventions to address inequalities in health and for ways to measure effectiveness. Highlighting appropriate tools to use in assessing inequalities in health, determining effective interventions and measuring progress were also identified as valuable.

The Pacific interviews were not completed in time to be included in the needs assessment report but did inform the workshop planning and implementation. In addition to supporting the key findings of the needs assessment as a whole, the Pacific managers emphasised the importance of the role of appropriate primary health care in addressing Pacific health inequalities. They also emphasised the importance of governance structures where communities are appropriately and meaningfully represented. Institutional racism was identified as a critical factor by one manager and the other spoke of the need to change decision-makers’ mind sets.

A key focus for the training identified in the needs assessment was tackling ethnic inequalities, a critical issue for the entire health sector. The need to strengthen the capacity of Māori staff within the Ministry, and Māori managers within DHBs, in order to achieve this was clearly expressed. This was also identified for Pacific staff and managers, particularly in the seven DHBs where the Pacific population is significant.

As a result of the needs assessment, it was concluded that the workshops needed to:

- be practical
- be evidence-based and action-oriented
- foreground Māori and Pacific health
- facilitate discussion among participants so that they could debate the issues and share their experiences.

In terms of logistics, it was clear that DHB workshops should be run locally, and that DHB Māori managers would be best served, in the first instance, by a separate workshop. It should be noted that some of the smaller DHBs warned that they would have difficulty in releasing staff. All respondents were keen to have senior management participate in the workshops. As one respondent said, the awareness needs to 'start at the top'. Some Ministry informants suggested that everybody in the Ministry should attend the workshops. Priority groups appeared to be staff managing the funding and contracting relationships with DHBs, and senior managers and analysts from each directorate.

The Workshops

The workshops were developed by the Wellington School of Medicine and Health Sciences team in partnership with the Ministry of Health Inequalities Team, based on the findings from the needs assessment. Eight workshops were held from September 2002 until May 2003.

Date	Workshop	Location
September 2002	DHB Māori managers' hui	Hongoeka Marae, Wellington
September 2002	First Ministry of Health workshop	Wellington
October 2002	DHB workshop for Nelson/Marlborough, West Coast and Canterbury DHBs	Nelson
November 2002	DHB workshop for Southland and Otago DHBs	Dunedin
November 2002	DHB workshop for Capital and Coast, Hutt, Wairarapa, Palmerston North and Wanganui DHBs	Wellington
March 2003	Second Ministry of Health workshop	Wellington
April 2003	DBH workshop for Northland, Auckland, Waitemata, Counties–Manukau and Waikato DHBs	Auckland
May 2003	DHB workshop for Lakes, Tairāwhiti, Taranaki and Bay of Plenty	Rotorua

Local Ministry staff also attended DHB workshops, as did members of the Ministry executive team.

Aims of the workshops

The workshops were titled *Tackling Inequalities: Moving theory to action*, and their specific purpose was 'to increase the knowledge and skills of District Health Board and Ministry of Health staff to act on, and advocate for, eliminating inequalities in health in Aotearoa/New Zealand'. The learning outcomes were identified as follows.

After completing the workshop, participants should be better able to:

- appreciate that tackling inequalities in health is a challenge being picked up by health agencies internationally and how it will contribute to population health
- analyse evidence of inequalities in health in Aotearoa / New Zealand
- understand a range of theoretical explanations for, and the multiple causes of, inequalities in health in Aotearoa / New Zealand
- critically analyse the role of historical and contemporary policies and programmes in producing and maintaining or eliminating inequalities in health in Aotearoa / New Zealand and internationally
- understand the need to prioritise tackling inequalities between Māori and non-Māori
- identify strategies to tackle inequalities in health through the work of the Ministry of Health

- identify the obstacles to progress and the supports needed to address them
- advocate for tackling inequalities in health
- identify some key tools to use (frameworks, diagnostic tools and intervention tools)
- appreciate the need to apply an 'equity lens' and intervention framework to all the work they do
- apply strategies to tackle inequalities in health in their work.

Workshop content

The workshops began with a presentation of the international evidence on social and economic inequalities in health. Information on inequalities in health in Aotearoa / New Zealand was then discussed. Different theoretical positions for the causes of inequalities in health were identified, including social and biological causes (Krieger 2001). There was then discussion about how inequalities in health in Aotearoa / New Zealand occur. Interventions to reduce these inequalities and a case study were presented. Participants also did an intervention planning exercise.

Day two began with reflection on the learning from the previous day. Participants critiqued the intervention planning exercise they had done previously. Evidence on the need for monitoring and evaluation of effectiveness was presented, followed by a discussion of Pacific health inequalities. A group discussion of obstacles to progress and ways forward was followed by an opportunity for participants to share with each other their efforts to tackle inequalities in health. This exercise also provided the opportunity for participants to critique their own work.

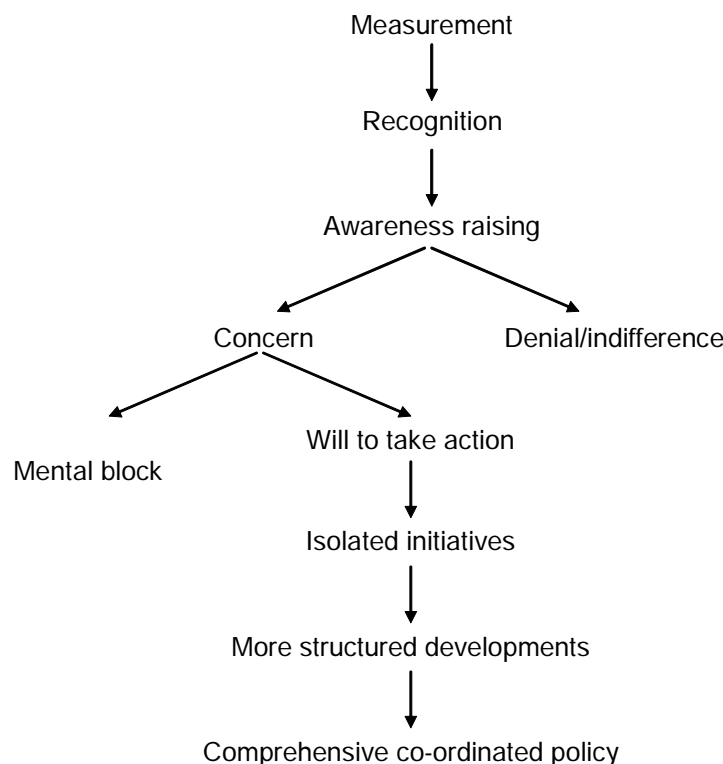
Participants then worked in their DHB/Ministry groups to consider ways to strengthen the capacity of their organisation to tackle inequalities in health. These findings were reported back to the whole group. Time was then given for personal reflection. This gave participants the opportunity to think about their learning and consider what they could personally do to tackle inequalities through their work. The workshops concluded with a workshop summary, discussion and workshop evaluation.

The workshops used a mix of methods, including PowerPoint presentations, case studies, story telling, individual and group exercises, and workshop discussion. Material was presented to the participants, but they were also given the opportunity to reflect on this material and apply it to their own work. As the series of workshops progressed, the content was modified in response to feedback from participants and the experience of the training team. The agenda for the final workshop is included in Appendix 1.

Whitehead has described the stages of readiness of organisations for action on inequalities in health in an Action Spectrum on Inequalities in Health (see Figure 1) (Whitehead 1998). This spectrum is a useful representation of the process of change the workshop leaders were trying to move the participants through. Whitehead argues that countries can move along this spectrum, from a situation of measuring health inequalities to recognition of disparities and an awareness of health determinants and consequences. Once the awareness of inequalities in health has been raised, they can either be concerned about them, or deny them or be indifferent to them. If there is concern, countries may develop a will to take action and move through a process from isolated initiatives to more structured developments, to a comprehensive co-ordinated policy. As part of the workshop evaluation, the workshop participants were asked to

rate themselves on the spectrum at the beginning and again at the end of the workshop. In doing so, the training team applied Whitehead's model to individuals and found it a useful extension of her work. The findings are discussed later in this report.

Figure 1: Action spectrum on inequalities in health



Source: Whitehead 1998

A key focus of the workshops was to explain the need for an 'equity lens' (Signal 2002). This concept refers to a metaphorical pair of glasses that ensures people ask 'Who will benefit?' It can be used prospectively to assess planned work, or it can be used to critically analyse current services in order to assess 'Who benefits from this service?' Without assessing the impact of business as usual on existing inequalities, health services run the risk of perpetuating, or increasing, existing health inequalities.

The workshops took a social approach to the causes of inequalities in health. This is consistent with a shift in the international literature from biological explanations for health inequalities to stronger evidence for social factors (Krieger 2001). The training programme was based on the evidence that it is the unequal distribution of the determinants of health – such as income, education, housing and employment – that causes and maintains inequalities in health (Graham 2001). While there are many explanations for this unequal distribution, critical factors appear to be socioeconomic position and social exclusion,¹ including racism, sexism and disablism. Karlsen and Nazroo, in a rethinking of the causes of the inequalities in health, conclude that 'ethnicity as structure (both in terms of racialisation and class experience), rather than ethnicity as identity, is strongly associated with health for ethnic minority people living in Britain' (Karlsen and Nazroo 2000: 55).

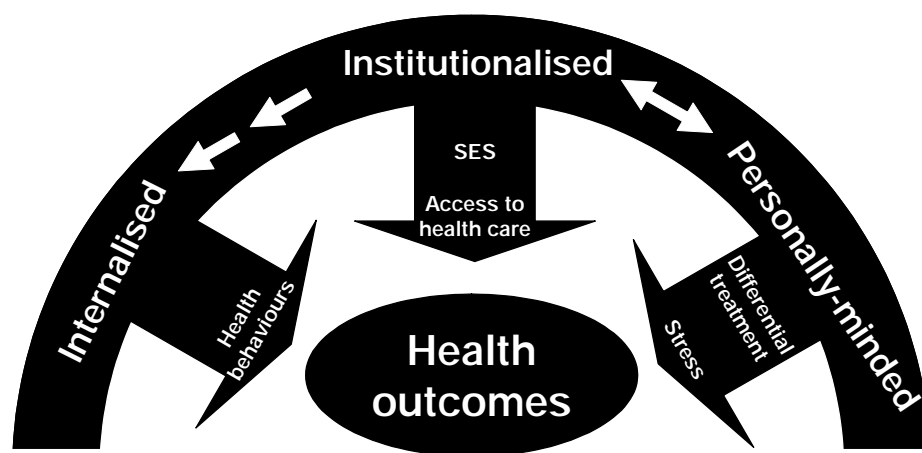
¹ Social exclusion is defined as 'the process by which individuals are denied the opportunities to participate in the activities normally expected of members of that society' (Raphael 2001: 29).

This training programme foregrounded ethnic inequalities in health. In doing so, inequalities for Māori and Pacific people provided a case study to demonstrate how all inequalities occur, how they can be addressed and how progress in tackling them can be monitored and evaluated. This is consistent with a Treaty of Waitangi approach.

Foregrounding ethnic inequalities led to a focus on racism to explore issues of social exclusion. In doing so the training team used the work of Camara Jones (Jones 1999, 2000). Jones argues that ‘it is important to be able to examine the potential effects of racism in causing race-associated differences in health outcomes’ (Jones 2000: 1212). Jones has developed a framework for understanding racism on three levels – institutionalised, personally mediated and internalised – and has applied it to health (see Figure 2). She argues that ‘this framework is useful for raising new hypotheses about the basis of race-associated differences in health outcomes, as well as for designing effective interventions to eliminate those differences’ (Jones 2000: 1212). Jones defines institutionalised racism as

... differential access to the goods, services, and opportunities of society by race. ... it is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalised racism is often evident as inaction in the face of need (Jones 2000: 1212).

Figure 2: The impacts of racism on health



In order to understand how the institutions of the health sector create and maintain inequalities in health, institutional theory was utilised (March and Olsen 1984). This has been developed in political science and economics, and its proponents argue that ‘institutions matter’; that institutions structure the development and implementation of policy and therefore the programmes and services that follow. The approach focuses on such aspects of institutions as their dominant ideas, their organisational structures, and the processes and rules by which they operate. It provided a framework for participants to focus on the institutions within which they work and to tackle the ways these institutions operate to create and maintain inequalities.

As part of the project, the team developed a tool to help in assessing the health equity of health interventions. The Health Equity Assessment Tool (HEAT) (Ministry of Health et al 2002, see Appendix 2) is adapted from part of a health inequalities impact assessment tool developed in Wales (Bro Taf Authority 2000). It has been modified to take a Treaty approach, to focus on who is advantaged and to explore how inequalities have occurred and therefore how they can be addressed. The HEAT consists of a simple set of questions which challenge the user to

think more broadly about the equity impacts of health issues and responses. The initial simplicity hides the need for information and research to assist in answering the questions. The tool is best used by a group of people who reflect the range of views of the community being worked with. The questions in the tool were worked through over the two days of the workshop, demonstrating to participants its use in tackling health inequalities.

Central to the workshop process was the introduction of the Ministry of Health's Intervention Framework to Improve Health and Reduce Inequalities (Ministry of Health 2002) (see Appendix 3). This framework argues for a comprehensive approach to intervention at the following four levels of society.

1. *Structural* – tackling the root causes of health inequalities (ie, the social, economic, cultural and historical factors that fundamentally determine health).
2. *Intermediary pathways* – targeting material, psychosocial and behavioural factors that mediate the impact of structural factors on health.
3. *Health and disability services* – undertaking specific actions within health and disability services.
4. *Impact* – minimising the impact of disability and illness on socioeconomic position.

The training process indicated the value of the framework, which helps people to understand the need for a comprehensive approach and challenges the health sector to consider its role in the structural and intermediary pathways that cause inequalities in health. It also focuses the health sector on its own role in contributing to, and maintaining, health inequalities, and its ability to contribute to minimising the impact of disability and illness on socioeconomic position. The complexity of the framework does mean that it takes time to comprehend and integrate the concepts. The focus on improving health and reducing inequalities means that potentially interventions to improve health at each of the four levels may not always also reduce inequalities. For this reason, using the HEAT tool together with the framework was trialed in the workshops, with some success.

This section of the report has outlined the workshop content. Key findings from the training programme are now explored.

Key Findings: Obstacles, Supports and Opportunities

Obstacles to progress in tackling inequalities in health, supports needed and opportunities that present themselves were discussed in the needs assessment, in the workshops themselves, and in the teleconference workshop follow-ups. Consistent themes were identified across all three settings and are discussed below.

Obstacles

Leadership

A commonly identified issue at the workshops was the lack of leadership at governance and management levels (the lack of senior management presence at the workshops was identified as evidence of the problem). Participants were clear that leadership is required to ensure that tackling inequalities stays on the agenda when there are competing priorities.

Politics

Several political issues were identified as obstacles, including:

- professional capture
- strong vested interests at all levels
- such immovables as the three-year political cycle (mentioned by several of the groups)
- the stresses in the sector caused by constant restructuring – one group stated that restructuring had created a ‘risk averse’ environment.

Knowledge

Participants emphasised the need for a common knowledge base across the sector, stating that information and understanding of the data were needed. The lack of opportunity for health workers to reflect on inequalities and develop strategic and long-term thinking was also identified. This included the lack of a forum for sharing ideas. The workshops clearly provided a starting point for all of these issues, but participants were concerned at the variable workshop attendance and about what kind of follow-up would be available. They also identified the need to shift the information and awareness into the community and into other sectors.

Commitment

The lack of commitment of the sector to tackling inequalities was also identified as an issue. Participants questioned how important inequalities really are on the health agenda. Others questioned who ‘owns’ inequalities – both within and outside the health system. One participant discussed the difficulty of the sector making the ‘cultural change’ required; another spoke of the dominant focus on hospitals rather than the determinants of health; a third spoke of the blocks to the consciousness of people of the importance of ethnic inequalities.

The challenging nature of the work

An obstacle identified by a number of participants was the challenging nature of the work. As one participant stated, ‘people get scared by the broadness and all-encompassing nature of the issue. They need to appreciate the big picture and yet still see where individual pieces of work address inequalities’. Another discussed the pressure the sector as a whole is under, noting that ‘work on inequalities ought to be seen as something that can make the sector’s work easier. People need to see this work as a contribution to business as normal – to normalise this work rather than see it as a new strategy’. A third participant discussed their concern with naming social exclusion processes such as racism and ‘being called fanatics’.

Process issues

A number of process issues were identified as obstacles, including:

- inflexible contracting systems
- the constant crisis management required in the health sector
- the pressure to focus on the short-term, which limits a long-term focus on changing the way the health sector operates
- the need for strategic and policy support to be linked at higher levels
- annual plans not being signed off until half-way through the year, which means that changes cannot be made
- issues with regard to a mainstream services approach that ‘one size fits all’
- smaller DHBs not benefiting from the economies of scale larger DHBs can generate.

Structural obstacles

Structural obstacles were also identified. For example, when the Māori manager is not in the DHB senior management team their capacity to influence decision-making can be significantly reduced. Institutional inertia was also identified as an obstacle, as were the work silos within the Ministry.

Working with communities of need

Participants noted that working with communities of need can be challenging, especially when those who are being targeted don’t buy into the service or the service is not designed in a way that reaches the people.

Intersectoral issues

The lack of collaboration/communication between the Ministry of Health and other sectors was seen as an obstacle to progress.

Workforce capacity

Another frequently mentioned obstacle was the limited capacity of the workforce to work in this area. Issues included workloads, lack of confidence and lack of co-operation.

Funding

Funding was a frequently mentioned obstacle. Issues included:

- DHB deficits
- short-term funding cycles
- the lack of funding for innovation
- the current balance of funding allocation between personal and public health
- very little money to move to primary health organisations (eg, to fund the development of strategic plans, retrain workforce, etc)
- prioritisation formulas not emphasising reducing inequalities
- the population-based funding formula.

Measurement and monitoring

Issues identified in relation to measurement and monitoring included the difficulties around choosing appropriate measures, limited ways of measuring success, too much focus on short-term impacts, the tendency to over-monitor new, small initiatives while under-monitoring mainstream services, and difficulties identifying data relevant at the local level. Concerns were also expressed at the difficulty identifying service inequalities until ethnicity data is collected thoroughly.

Supports

Participants identified many supports needed to overcome the obstacles to reducing health inequalities.

Leadership

Leadership, both political and at all levels across the health sector, was frequently identified as an important support.

Information

Good information was considered important. This was identified in a number of ways, including:

- effective ethnicity recording
- access to existing information (eg, the health variations website in the United Kingdom)
- sharing among DHBs
- a forum for sharing to minimise isolation and duplication
- networking
- dissemination of information.

Relationships

Participants identified developing and strengthening relationships, both within and outside the health sector, such as:

- between the Ministry and DHBs, particularly in respect to contracting
- with primary health organisations
- with iwi, Māori development organisations and other Māori organisations
- with public health units
- with other central government agencies (eg, Te Puni Kōkiri and the Ministry of Pacific Island Affairs)
- with national organisations
- with academic institutions
- with communities
- internationally.

Funding

The ability to access funding from other sectors for action on determinants of health. The extra funding PHOs will have to reduce inequalities and their clinical performance indicators.

Resources

Resources participants identified as supporting the work include the strategy documents developed at both the Ministry and DHB level; existing energy, ideas and initiatives; and, especially, people. In particular, Māori staff and their community links were acknowledged as key supports.

A strong workforce focused on tackling inequalities

An increased workforce, well trained in addressing inequalities in health, was frequently discussed.

Accountability and monitoring mechanisms

A number of participants mentioned the need for appropriate accountability and monitoring mechanisms to be in place.

Opportunities

Workshop participants identified a range of opportunities that could be utilised to progress the work of tackling inequalities. The current climate was seen as offering opportunities for innovation and the chance to develop a New Zealand model for reducing inequalities.

Specifically, the participants identified the opportunity to:

- provide leadership on this issue
- build a culture that sees reducing inequalities as important and embed it in work programmes
- revise contracts and measure performance on tackling inequalities
- include inequalities reduction in the prioritisation exercise
- involve Māori at all levels of DHBs, especially in the executive team
- build on the expertise within our DHBs, including the expertise of the Māori and Pacific staff
- present the workshop ideas elsewhere in the system
- highlight successes.

Opportunities for collaboration were frequently mentioned, including:

- developing good relationships with communities
- discussion with providers about how they can make a difference
- intersectoral action
- collaboration between DHBs.

The development of primary health organisations was identified as a new opportunity, and it was suggested that the accreditation of hospital services provides an opportunity to reflect on the effectiveness of hospital services in tackling inequalities.

Action Plans Developed by Participants

As part of the workshop, each Ministry working group and DHB developed an action plan outlining ways to strengthen their capacity to tackle inequalities in health. In developing these plans, participants explored ways to institutionalise an inequalities focus in their organisations. They were encouraged to do so based on institutional theory, as discussed above (March and Olsen 1984). Participants considered:

- how to institutionalise the ideas about inequalities in health into their organisations
- how to reorganise the way their organisation is structured
- the processes, or ways of working, used in the operation of their organisation
- the rules or legal requirements and formal policies governing their organisation.

Detailed action plans were developed. These are recorded in the workshop minutes. The Ministry Inequalities Team may wish to review these plans for further action that could be taken across the sector. Key aspects of the plans are discussed below.

Ministry of Health participants' plans

Ways to institutionalise ideas about inequalities in health

- Have the *Statement of Intent* flag outcomes regarding inequalities issues instead of taking the 'average view'.
- Build an equity lens into the strategic planning template, service specifications and contracts.
- Review the prioritisation tool and resolve the inherent conflict between improving health and reducing inequalities.
- Use Māori models of health in policy-making.
- Organise training in tackling inequalities for policy analysts.

Structural changes to assist in tackling inequalities

- Create a Māori advisory group in mental health policy-making.
- Institute shared leadership with Māori in policy-making.

Process changes to assist in tackling inequalities

- Ensure a strategic and systematic approach to intersectoral work putting effort where health can make the biggest gain in addressing inequalities (Te Puni Kōkiri, Pacific Island Affairs, Housing, Ministry of Social Development, Education, Treasury).
- Encourage Māori involvement throughout the policy process.
- Encourage Pacific involvement throughout the policy process.
- Measure how effective we are at improving Māori health.
- Do more work on funding inequalities action at a local level.

- Look at ways to use existing DHB reporting requirements to inform inequalities work (ie, not just another indicator).
- Apply pressure to DHBs to ensure data is captured, and ensure consistent data sets to enable a comparison. Measure change and identify improvements.
- Benchmark DHBs' performance and feed this into best practice guidelines, etc.
- Audit ethnicity recording in DHBs to ensure consistent recording using standardised questions.

Rules to assist in tackling inequalities

- Embed the HEAT tool in the policy framework.
- Build an equity requirement into business-planning processes.
- Encourage accurate ethnicity recording.

DHB participants' plans

Ways to institutionalise ideas about inequalities in health

- Identify inequalities 'champions' within the DHB.
- Present workshop material to the DHB board and senior management.
- Ensure all staff are aware of inequalities issues.
- Develop inequality workshops for providers.
- Provide Treaty training.
- Establish a key ideas group of DHB senior management, professional groups and primary health organisations to progress this work.
- Include health inequalities debate in intersectoral forums.

Process changes to assist in tackling inequalities

- Encourage integral and ongoing community involvement.
- Engage with isolated communities.
- Apply an equity lens to the planning process.
- Update the needs assessment template to include a strong focus on inequalities in health.
- Ensure all DHB patients are receiving their full benefit entitlements.
- Identify areas outside the health sector where DHBs can advocate (eg, housing).

Structural changes to assist in tackling inequalities

- Establish a memorandum of understanding with tangata whenua.
- Strengthen relationships with iwi.
- Increase Māori representation on the board, executive and among staff.
- Increase Pacific representation on the board, executive and among staff.
- Employ resource people at all levels to address inequalities in health.
- Analyse obstacles to accessing services.

- Establish a health inequalities working group within the DHB.
- Ensure representation from Māori, Pacific and low socioeconomic communities on key advisory groups.
- Build capacity within Māori communities (eg, mentoring, investment strategy).
- Fund and support ‘by Māori for Māori’ and ‘by Pacific for Pacific’ services.

Rules to assist in tackling inequalities

- Use the HEAT tool in all decision-making.
- Develop inequalities key performance indicators (KPIs).
- Ensure accurate ethnicity recording.

Participants' Evaluation of the Workshops

All participants (approximately 160 in total) were asked to participate in workshop evaluations. For the Māori DHB managers' hui, evaluation took the form of oral feedback at the poroporoaki (closing ceremony). The feedback was very positive, with a number of participants providing additional affirmative feedback in the following weeks. Many of the Māori managers subsequently attended the DHB workshops or sent representatives. There has been both formal and informal ongoing support to these participants throughout the project, including presentations by Papaarangi Reid at Tumu Whakarae and the Public Health Association Conference, a grand round presentation at Hutt DHB, and advice over the phone.

For the seven DHB and Ministry workshops a written evaluation was undertaken (see Appendix 4). The contract requirement that 85% of participants find the workshop 'at least satisfactory' was easily met. All workshops were rated valuable, very valuable or extremely valuable by at least 90% of participants. In two workshops all participants found the workshop either valuable or extremely valuable.

When participants were asked to identify the main messages of the workshop they answered in line with the learning objectives, although not all of the key messages were identified by everyone. Many participants had taken on board both the personal messages of action and responsibility, and the messages relating to the importance of structures and institutions in understanding and challenging inequalities.

When asked about change in their position on the Action Spectrum on Inequalities in Health (see Figure 1) over the duration of the workshop, all but two participants rated themselves as willing to take action. Some had moved to at least a focus on isolated initiatives, with many moving to structured developments and comprehensive co-ordinated policy. Ministry participants started further back on the action spectrum than DHB participants, and while most moved at least one step, fewer of them moved to more structured initiatives and comprehensive programmes.

Feedback on the strengths and weaknesses of the workshops largely confirmed that the workshop design was appropriate. The range of presenters and quality of presentation were identified as strengths at every workshop. Participants valued the opportunity for time out to discuss issues with colleagues. The workbook was considered a valuable resource by many. Overwhelmingly, participants liked the balance of workshops and presentations, but frequently people expressed the desire for more time in the exercises and discussion (without indicating what should be omitted). Staff from DHBs who sent a number of participants were more likely to be highly positive about the workshop. As one participant stated, 'a number of members from our DHB attended which means we have a team'.

Ministry participants valued the opportunity for partnership between policy and research provided by the workshop, and requested continuing support and feedback from their own workshop and the workshops with DHBs. Several participants emphasised the value of having the range of presenters, often naming different presentations they had found powerful.

The most frequently expressed improvement suggested by DHB participants was to make sure their board, CEOs and managers attended. As one participant noted, 'ensure that future forums include not only the converted *but* also the *don't wanna knows!* DHB Boards – Senior Managers – other stakeholders'. Ministry participants agreed with this. They raised, in both verbal and written feedback, the need for senior management at the Ministry to show their support for the issue. Staff requested that they do this both by attending the workshops and providing strong leadership within the Ministry to tackling inequalities across the organisation. Another significant improvement recommended was the use of developed case study examples.

Participants clearly expressed a wish to stay in touch and to have some forum to continue the discussion of how to tackle inequalities in health. Other suggestions included:

- evidence to back up action, including updates of initiatives
- assistance with monitoring and evaluation
- assistance with training in DHBS, including a summarised version of presentations
- presenting the workshop information to senior staff and boards
- developing an inequalities website
- the training team being available for advice
- reviewing progress in 2003/2004.

Follow-up Sessions

Follow-up sessions were recommended in the needs assessment, and at the workshops the participants requested a forum to continue the discussion. As a result, all workshop participants were invited to attend a two-hour follow-up session. The Ministry participants were invited to attend a face-to-face session, while the DHB participants were invited to participate via teleconference. A separate teleconference was held for each of the workshops, except for the Māori managers' hui. Because the intention was that the Māori managers would participate in the mainstream DHB workshops, and many of them did, they were given the opportunity to participate in these follow-up sessions. The sessions were held from May to July 2003, some months after the relevant workshop. Unfortunately, attendance at these sessions was low (24 participants in all), despite participants receiving notice in good time and reminder notices being sent. However, some participants acted as spokespeople for the wider group from their workplace who attended the workshop.

Those who did attend reported that they found the follow-up sessions useful. It was also valuable for the training team to hear how the tools and resources presented in the workshops had been used and to learn of the progress being made.

Participants reported that attending the workshops had had a positive effect on their work. They had made progress on their action plans, although most did not achieve all they had planned. Actions taken included training colleagues, workshops with providers, and use of the HEAT tool and the inequalities framework in planning and contracting. The HEAT tool is being used for the purchase of services in more than one DHB and has been built into the planning template for some services at Nelson/Marlborough, Canterbury and Wanganui DHBs. Participants reported being pleased with the results.

The inequalities framework was used in one DHB to audit existing services to see where action to reduce inequalities needed to be strengthened. Ministry staff described using the framework for brainstorming and developing a new action plan, and reported that using the framework helped them to 'think outside of the box' and ensured a more comprehensive and focused plan.

Participants reported on progress on improving ethnicity recording. Some DHBs had a clear plan and confidence that they were moving forward. Others expressed reservations as to whether the process was in place or about the level of commitment to it in their DHB. Participants reported taking on the message that this is a mainstream issue, and that the message must reach all levels of their DHB.

Participants reported using the resources provided in the workbook extensively. One commented on the added credibility of the material because the Ministry provided it; another described it as important material for helping to motivate people.

Not surprisingly, more impact was seen where there were more attendees. Where only one or two people attended from a DHB, it had affected *their* work rather than impacting more widely, though several participants had made significant efforts to pass on the information to colleagues. Often where a group of colleagues attended they had continued to debate and develop the ideas discussed in the workshop. They also spoke of the support colleagues gave them when they wanted to progress the inequalities agenda in their workplace.

Although the follow-up sample is limited, it appears likely that there has been more impact in public health than in other areas of the sector. This may be because public health staff are already thinking in population health terms.

In summary, participants in the follow-up sessions discussed the ways in which they had used the tools, spread the message, and used the resources provided in the course book. They reported good progress on their action plans, and were able to use the models provided to think and act their way around obstacles encountered in implementing strategies to reduce health inequalities.

Conclusion and Recommendations

Overwhelmingly, participants acknowledged the value of the workshops in raising their awareness of the importance of tackling inequalities and of ways to achieve this.

However, the training team had a number of concerns. The training needs analysis interviews identified support from CEOs and senior management of DHBs, but there was some difficulty in attracting all of the senior management teams of every DHB. Members of the Ministry senior management team did attend the workshops, but very few managers at the next level attended. It is of concern that without the support of senior management, the enthusiasm of those staff who attended might be lost, and they could become pessimistic about the difficulty of doing this work.

The number of participants at many workshops was less than the number invited. This raises the possibility that the issue of tackling inequalities is not viewed as seriously within DHBs as the Ministry Inequalities Team expected, or that other competing objectives were given a higher priority. It may also be that finding time to attend a two-day workshop is very difficult for senior staff (particularly from the smaller DHBs), especially when it is held at another DHB. The attendance of the Māori managers suggests that they are highly committed to tackling inequalities. The fact that only a few other senior staff supported them may indicate that the DHBs view tackling inequalities as a Māori issue, not an issue for the entire organisation.

While it was pleasing to see that nearly all participants made a shift in their willingness to take action on inequalities in health, more needs to be done to support everyone to move to a position of being willing, and able, to take a comprehensive co-ordinated policy approach. There is an ongoing challenge to focus and maintain the health sector's gaze on the social and systemic causes of inequalities in health rather than on individual and biological causes. There is also a challenge to understand, and address, the tension between improving health on the one hand and tackling inequalities in health on the other. Further training opportunities have been, and must continue to be, sought. It is critical to deliver the message that tackling inequalities is a challenge for the entire health sector.

The immediate outcomes sought for the workshops were that:

- evaluations sheets show the workshop was informative and useful
- action plans are prepared
- participants know where to go for more information.

The training team succeeded in achieving these outcomes. The workshop evaluations were extremely positive. All participants were involved in preparing action plans which, according to the follow-up sessions, were acted on (at least in part) in many organisations, and the workbooks informed participants about where to go for more information.

This series of awareness-raising workshops has been a limited but valuable part of the process of moving the New Zealand health sector towards developing a comprehensive, co-ordinated policy to tackle inequalities in health. The participants identified many obstacles to progress, such as a perceived lack of leadership, the limited capacity of the workforce, the need to change contracting and monitoring processes to support this work, and limited intersectoral collaboration between the Ministry of Health and other sectors. Participants did, however, identify many supports they required, such as good-quality information, strengthening relationships between key players within and outside the sector, appropriate accountability and monitoring mechanisms, and political and sector-wide leadership on this issue. There are also opportunities to capitalise on, including the chance to develop New Zealand-specific models for tackling inequalities.

In conclusion, by commissioning this series of workshops, combining the academic expertise of the Wellington School of Medicine and Health Sciences with the policy and sector experience of the Ministry of Health, the Ministry has demonstrated a visionary commitment to tackling inequalities in health. The training team knows of no other country where such a partnership has linked with health care providers on this critical issue. There is considerable international interest in this process and its outcomes.

The development of innovative policy initiatives requires careful support in the implementation stage. There is a real danger that the expectations and hopes raised in this programme will not be met without financial and management resources to support innovation in the development, implementation and evaluation of efforts to tackle inequalities in health. Explicit institutional, professional and economic incentives need to be in place if organisations are to seriously address these issues. The training team sees sector leadership and the training of all those who work in the health sector as critical to the success of efforts to tackle inequalities. Effective equity-focused contracting and contract monitoring by the Ministry and DHBs are also vital, as are research and information on inequalities in health and effective interventions to address them.

As Te Rōpū Rangahau Hauora a Eru Pōmare state, ‘the prevention of social inequalities in health requires substantial attention, determination, creativity and the efforts of many’. Currently, the health sector is better placed than it has been for many years to act. The ongoing challenge is to ensure that an equity approach is institutionalised throughout the health sector; that it becomes business as usual. There are a number of ways this could be, or could continue to be, achieved. The workshop action plans provide many possibilities for action, some of which are already in place.

Recommended actions derived from the workshops

Sector leadership

It is recommended that:

1. the Ministry of Health briefs the Minister of Health on the success of the health inequalities awareness-training programme
2. the Ministry of Health continues to demonstrate, through its Statement of Intent, how it intends to move over the medium term towards achieving reduced health inequalities
3. the Director-General of Health and the Ministry's Senior Management Team continue to signal the critical importance of an inequalities approach for the entire health sector in all key sector documents
4. the Ministry of Health incorporates an inequalities perspective in all aspects of its work programmes
5. the Ministry of Health establishes links with other government agencies that impact on inequalities in health
6. institutional, professional and economic levers are utilised to encourage progress in tackling inequalities
7. senior management teams of DHBs signal the critical importance of an inequalities approach in all work by the DHBs and their providers.

Training

It is recommended that:

8. a monograph of the training programme is developed for use in future training
9. funding is made available for the development of audiovisual resources to support this training
10. the training programme is extended to ensure that senior staff of the DHBs, Ministry of Health staff and boards of DHBs who have not currently had the benefit of training are given the opportunity to participate
11. ways are explored to build an inequalities focus into the curriculum for all initial health training (eg, nursing, medicine, dental therapy)
12. ways are explored to ensure that all staff currently working in the health sector receive in-service training on tackling inequalities
13. specific training is developed and delivered for the Māori health workforce, including Māori providers
14. specific training is developed and delivered for the Pacific health workforce, including Pacific providers.

Effective contracting and contract monitoring by the Ministry of Health and DHBs

It is recommended that:

15. contracting and monitoring frameworks that focus on tackling inequalities are developed, implemented and evaluated, with particular emphasis on the ability of mainstream services to reduce inequalities
16. the inequalities framework and the HEAT tool are included as part of these contracting and monitoring frameworks
17. ongoing support to, and performance review of, staff responsible for contracting and monitoring within the Ministry of Health and DHBs are provided with regard to the implementation of these frameworks.

Awareness raising

It is recommended that:

18. a national conference is sponsored to highlight the issue of inequalities in health, publicise the evidence, and build on the commitment, and that it includes overseas guests such as James Nazroo and Hilary Graham
19. information is built into a number of conferences, including the next Public Health Association conference.

Research and information

It is recommended that:

20. evaluation of the use of the intervention framework and HEAT tool is funded
21. an inequalities website is developed, with current information from New Zealand and internationally and links to appropriate sites
22. an edited book of case studies of efforts to tackle inequalities in New Zealand is commissioned by the Ministry of Health
23. the outcomes of the workshops are disseminated through the release of the current report and publications in peer-reviewed journals.

Issues for further consideration

The following issues require further discussion with other agencies within the health sector. It is suggested that:

24. the National Health Committee (NHC) continues to provide advice on inequalities in health
25. the Ministry of Health encourages the Health Research Council (HRC) to maintain a focus on funding research in relation to tackling inequalities in health
26. the Ministry of Health encourages the HRC to continue to provide support to researchers working to tackle inequalities in health
27. funding is made available for independent evaluation of mainstream health service provision (to assess its capacity to tackle inequalities in health, and to assess the effectiveness of changes aimed at tackling inequalities in health), and for disseminating the evaluation findings.

Appendix 1: Timetable for 'Tackling Inequalities: Moving theory to action'

Day 1

9.00–9.30	Registration and tea/coffee.
9.30–10.30	Welcome, introductions and background.
10.30–11.00	'International evidence on social and economic inequalities in health' – presentation by Philippa Howden-Chapman.
11.00–11.15	Morning tea.
11.15–12.15	'Inequalities in health in Aotearoa/New Zealand' – presentation by Papaarangi Reid.
12.15–12.45	Exercise: map the pathways of inequalities in heart disease. <i>What inequalities exist in this area?</i>
12.45–1.30	Lunch.
1.30–2.00	<i>Who is most advantaged and how?</i> Exercise using heart disease data.
2.00–2.45	<i>How did the inequality occur? What are the mechanisms by which the inequality was created, maintained or increased?</i> Presentations by Vera Keefe Ormsby and Christopher Carroll.
2.45–3.15	'A gardener's tale: understanding the conditions for cultural equality' – presentation by Louise Signal. Discussion: <i>How did this inequality occur? What are the determinants of this inequality?</i>
3.15–3.30	Afternoon tea.
3.30–3.45	'Interventions to reduce health inequalities I' – PowerPoint presentation: Ministry of Health Intervention Framework, by Ruth Richards and Teresa Wall.
3.45–4.10	Interventions to reduce health inequalities II – presentations by Philippa Howden-Chapman and Christopher Carroll.
4.10–4.40	Intervention planning exercise.
4.40–5.10	'The road to Hell is paved with good intentions: stories from dental health' – presentation by Vera Keefe Ormsby.
5.10–5.20	Introduction to tomorrow's exercise – Papaarangi Reid.
5.20–5.30	Questions and final round.
5.30	Social hour.

Day 2

9.00–9.30	Welcome to second day and reflection on day 1.
9.30–10.00	How could the interventions planned yesterday affect health inequalities? <ul style="list-style-type: none">• <i>Who will benefit most?</i>• <i>What might be the unintended consequences?</i>• <i>What will you do to make sure it does reduce/eliminate inequalities?</i>
10.00–10.40	Monitoring and evaluating effectiveness – presentation by Bridget Robson. <i>How will you know if inequalities have been reduced or eliminated?</i>
10.40–11.00	Morning tea.
11.00–11.30	‘Pacific health inequalities’ – presentation by Christopher Carroll.
11.30–12.00	Obstacles to progress and maps to navigate with. Whole group: brainstorm on obstacles to progress, supports needed and opportunities for progress.
12.00–1.00	Current experience of work to tackle inequalities in health. Group work sharing thoughts from preliminary exercise.
1.00–1.30	Lunch.
1.30–2.30	Strengthening our capacity to tackle inequalities in health. Task: work on ways to strengthen our capacity to tackle inequalities in health, and ways to monitor progress.
2.30–3.00	Strengthening our capacity to tackle inequalities in health continued: report back from work groups and discussion in large group.
3.15–3.30	Personal reflection time.
3.30–3.45	Workshop summary, discussion and final round. Formal closing.
3.45–4.00	Evaluation of workshop and afternoon tea.
4.00	Finish.

Appendix 2: A Health Equity Assessment Tool

There is considerable evidence, both internationally and in New Zealand, of significant inequalities in health between socioeconomic groups, ethnic groups, people living in different geographical regions and males and females (Acheson 1998, Howden-Chapman and Tobias 2000). Research indicates that the poorer you are, the worse your health. In colonised countries, such as New Zealand, indigenous people have poorer health than others. Reducing inequalities for Māori is a Treaty of Waitangi obligation and a priority for government. The New Zealand Health Strategy acknowledges the need to address health inequalities as ‘a major priority requiring ongoing commitment across the sector’ (Minister of Health 2000).

Inequalities in health are unfair and unjust. They are also not natural; they are the result of social and economic policy and practices. Therefore, inequalities in health are avoidable (Woodward and Kawachi 2000).

The following set of questions has been developed to assist you to consider how particular inequalities in health have come about, and where the effective intervention points are to tackle them. They should be used in conjunction with the Ministry of Health’s Intervention Framework (Ministry of Health 2002).

1. What health issue is the policy/programme trying to address?
2. What inequalities exist in this health area?
3. Who is most advantaged and how?
4. How did the inequality occur? (What are the mechanisms by which this inequality was created, is maintained or increased?)
5. What are the determinants of this inequality?
6. How will you address the Treaty of Waitangi?
7. Where/how will you intervene to tackle this issue? Use the Ministry of Health Intervention Framework to guide your thinking.
8. How could this intervention affect health inequalities?
9. Who will benefit most?
10. What might the unintended consequences be?
11. What will you do to make sure it does reduce/eliminate inequalities (to manage the consequences)?
12. How will you know if inequalities have been reduced/eliminated?

(Adapted from Bro Taf Authority 2000)

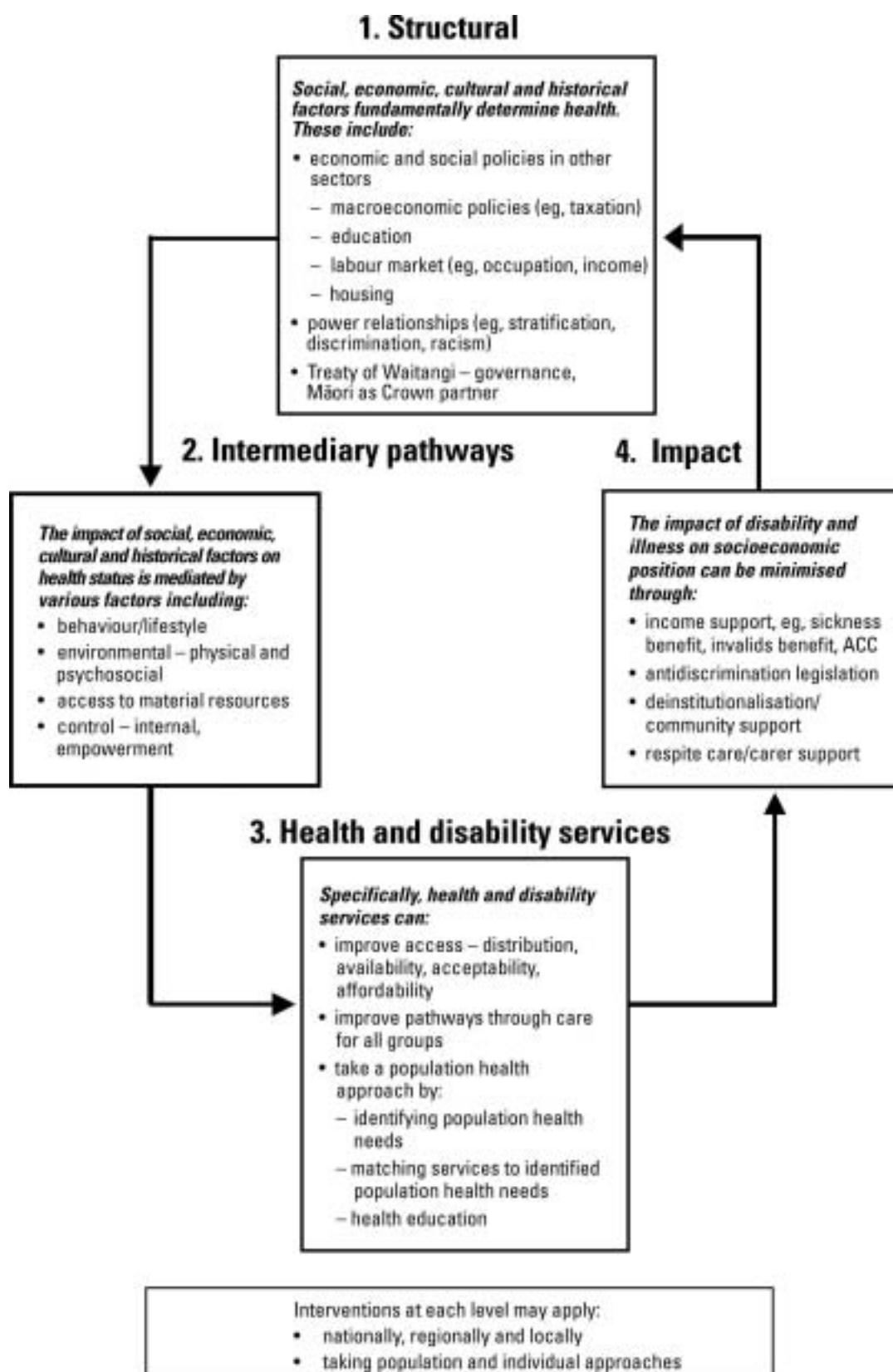
Source: Ministry of Health et al. 2002. (Note that this document has been revised since the workshops).

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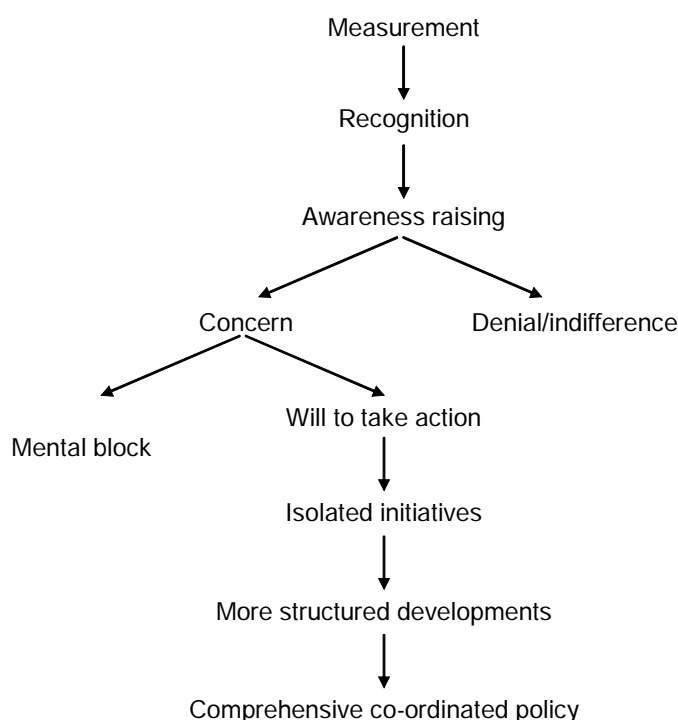
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Appendix 3: Intervention Framework to Improve Health and Reduce Inequalities



Appendix 4: Evaluation of Workshop 'Tackling Inequalities: Moving theory to action'

1. Overall, how valuable do you consider this workshop has been for you?
Not at all valuable 1 2 3 4 5 Extremely valuable
2. What are the main messages you got from the workshop?
3. Consider the following action spectrum on inequalities in health. Where were you on this spectrum before this workshop? Please mark this point with the letter B. Where are you now? Please mark this point with the letter A.



Action spectrum on inequalities in health (Whitehead 1998)

4. The strengths of the workshop were:
5. What could be done to improve the workshop?
6. What support can the training team give you to tackle inequalities in health?
7. Any other comments:

Thank you for providing feedback.

Appendix 5: International Peer Review Report

**Review of Tackling Health Inequalities: Moving theory to action.
A final report on health inequalities awareness workshops for the health sector.**

The final report describes and evaluates a health inequalities training programme for the health sector. The programme was designed and delivered as a partnership. It was designed as a partnership between an academic department (at the Wellington School of Medicine and Health Sciences) and the health inequalities team at the Ministry of Health. It was delivered as a partnership between trainers and participants.

Each stage of design and delivery is carefully detailed, from conception through the programme's development and content to the training in action and programme impact. Additional details of the programme content are available in the (excellent) training materials developed for the workshops.

Innovative elements of the workshop programme

Three elements of the programme are particularly noteworthy and impressive.

- 1. Evidence guided the workshop programme, from initial development to final evaluation, with evidence explicitly defined in terms of both scientific knowledge (from research) and policy know-how (from service planners, managers and practitioners).**

In the UK, the integration of these different forms of expertise is beginning to be recognised as central to building work around health inequalities into the routine business of policy development and delivery.

With respect to *scientific knowledge*, the workshops (course materials, presentations, follow-up activities) drew on cutting-edge research, both nationally and internationally. I am particularly impressed with how the team integrated the range of theoretical perspectives developed to understand spatial, socioeconomic and ethnic inequalities – and represented these in accessible and useful ways.

Policy expertise was built into the workshop programme through a range of mechanisms. For example, the team began with an assessment of training needs among senior health sector managers. The important messages from the assessment process included the need for scientific knowledge, practical examples and policy-development tools, and for the foregrounding of Māori and Pacific health – but against a wider scepticism about whether 'anything could be done' about health inequalities. Looking at the training materials, it is clear that the team took on board these messages. The workshops provided an overview of scientific evidence along with sessions on developing and evaluating interventions, both within and beyond the domains in which the participants worked. As a second example, the workshops provided the opportunity for health sector participants to map in more detail the barriers to and opportunities for developing a strong and consistent policy response to tackling health inequalities. Pages 12 to 16 give a succinct summary of why the know-how of policy practitioners needs to be part of the evidence base of policies to tackle health inequalities. Other examples of how the workshop programme drew on the knowledge of

participants include their action plans (page 16–18) and their evaluations of the workshop programme (page 18–19).

2. The team drew innovatively on established frameworks to guide the development of knowledge and skills among the participants.

Conceptual frameworks are central for understanding: for turning information into knowledge, and techniques into transferable skills. The programme offered participants well-chosen frameworks through which to think through the scientific evidence and their experience of policy and practice.

For example, the programme included Jones' framework for understanding the processes through which racism impacts on health, as part of its wider foregrounding of interventions to tackle ethnic inequalities in health. As a second example, the workshops included a session on the Ministry of Health's Intervention Framework to Improve Health and Reduce Inequalities, linking the intervention levels it identifies to earlier sessions on structural, intermediary and service-related levers on health inequalities.

As a third example, the programme developed and applied the 'action spectrum' which Whitehead developed to map the extent to which national governments were engaging with the challenge of tackling health inequalities. The 'action spectrum' was used as a self-assessment tool for workshop participants to measure their position on the spectrum at the beginning and end of the programme. Movement along the spectrum also provided a measure of the impact of the programme.

3. The team developed new policy tools for the health sector.

Here, the key example perhaps is the Health Equity Assessment Tool. Based on an existing tool, the team refined it in ways which spell out more clearly the reach and stages of the equity assessment – as well as adapting it to the equity imperatives of the Treaty of Waitangi. I would urge the team to write up this example – of how the tool was (re)developed, and how it has been used in practice – for a public health journal. Internationally, the public health community are in urgent need of workable and working models of health inequalities assessment.

Conclusion

My review of the final report, supplemented by the training materials developed for the awareness workshops, is extremely positive. The team are to be congratulated for their work. Specifically:

1. There is clear evidence that the awareness workshops met their core objectives, of increasing the knowledge and skills needed to act on, and advocate for, tackling health inequalities. It is important to note, too, that the workshops did not appear to produce/intensify negative responses – for example, that ‘it is all too complex, nothing can be done and we are all too busy’ – which can be the result of short, in-service programmes. In the process of fulfilling their brief, the team have developed a transferable model of staff development.
2. The programme put into practice the principles of partnership and mutual learning on which it was based. In addition, each component of the workshop programme contains innovative features: the ‘sum of the parts’ is an approach to health inequalities training which is path-breaking, both within New Zealand and internationally.
3. As the authors underline, the workshop programme is only one small element in the larger and longer process of developing a comprehensive policy response to tackling health inequalities. As a contribution to this wider process, the report includes a checklist of recommendations. Grounded in evidence from the workshops, the recommendations target key stages in the policy process: leadership, training and awareness raising, delivery mechanisms, and the enhancement of the evidence base. The team identify a set of recommendations which I would endorse. I would add two other issues which Ministry of Health might wish to consider.
4. ‘Added value’ for the Ministry of Health from its investment in the training programme could come from an international review of investment in health inequalities training in other OECD countries where public health policy is seeking to combine health gain with health equity. Funding for such a review would enable the Ministry of Health to learn from approaches being developed (either by design or default) elsewhere. My knowledge of approaches in other countries is that New Zealand has a product, and a delivery structure, from which other countries can learn.
5. The training programme was targeted at the health sector only, with the workshops making clear that the underlying determinants of health inequalities lie beyond its reach. High levels of knowledge and skills among health sector managers are essential if they are to act as ‘policy champions’ for an intersectoral approach to tackling health inequalities. While an important first stage, the next and bigger challenge is to roll out the programme beyond the health sector: to develop awareness among those leading and managing policy relating to education, employment, taxation and social security, housing, etc.

Hilary Graham
December 2003

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