# Memo

## Equity Impact Assessment - Omicron public health strategy

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| **Date:** | 1 July 2022 |
| **To:** | Dr Ashley Bloomfield, Director-General of Health |
| **Copy to:** | Group Managers, COVID-19 Directorate; <br> John Whaanga, Deputy Director-General, Māori Health |
| **From:** | Karen Jacobs-Grant, Chief Equity Advisor, Outbreak Response, Interim Health New Zealand |
| **For your:** | Information and Decision |

## Purpose of report

1. The purpose of this report is to set out the Equity Impact Assessment (EIA) that was undertaken by the Ministry of Health (the Ministry) on the three-phase Omicron public health strategy in the early stages of its implementation. It includes a summary of the EIA's findings and the actions taken by the Ministry to address these findings, along with Ministry learnings.

## Background and context

### Development of the Omicron public health strategy and commissioning of the EIA

*A three-phase Omicron public health strategy was developed at pace to respond to modelled demand*

2. On 26 November 2021, whilst New Zealand was in the late stages of its Delta response, the World Health Organization declared Omicron a variant of concern. After undertaking a preliminary Public Health Risk Assessment (PHRA) on 6 December 2021 and a more fulsome PHRA on 16 December 2021, the Ministry quickly began developing a strategy to respond to Omicron.

3. The Ministry's Omicron strategy up to mid-January 2022 was to keep Omicron at the border and detect and rapidly respond to any Omicron cases in the community, while continuously reviewing and strengthening public health measures. This strategy relied on much the same infrastructure, systems and processes as already established for previous variants.

4. The Ministry recognised that once Omicron was seeded in the community, the strategy would need to rapidly shift. Evidence from overseas had shown that the Omicron variant, compared to Delta, was more infectious and that cases would increase rapidly once the variant entered the community, and at rates much higher than seen during the Delta outbreak (which peaked at just over 200 daily cases in New Zealand).

5. Early modelling based on Omicron community spread in Australia suggested that within 19 days of a spread of at least 10 Omicron cases in the community, over 5,000 cases were

expected to occur per day (low scenario being between 1 and 1,000 daily cases, medium scenario being between 1,000 and 5,000 daily cases, and high scenario being over 5,000 daily cases). In response, the Ministry rapidly developed a three-phase Omicron public health strategy to respond to each of the low, medium, and high scenarios.

6.    This strategy was initially presented to Minister Verrall for discussion on 11 January 2022. An updated strategy based on Minister feedback and latest evidence on the Omicron variant was approved by the Director-General of Health in a memorandum on 21 January 2022.

*The Omicron public health strategy came with significant operational changes to our COVID-19 response*

7.    The three-phase strategy came with significant operational changes to testing, case investigation and contact tracing approaches so to manage the expected exponential increase in case numbers, and associated demands this would place on the system. A summary of changes included:

- a shift to utilising supervised and unsupervised Rapid Antigen Testing (RAT)

- the development of a case self-registration portal for positive RAT results

- prioritisation of phone-based case investigations for those who met the defined risk criteria (based on age and ethnicity)

- a phased discontinuation of the publication of locations of interest and push notifications via the NZ COVID Tracer App

- an end to routine testing of close contacts and investigation and contact tracing of border cases

- stepwise changes in the testing and isolation requirements for cases, household contacts and close contacts.

8.    The operational changes required, presented a shift in strategy to highly digitalised processes with increased responsibility on individuals, whānau and communities to manage their own health and safety.

9.    With these changes, the Ministry acknowledged that welfare provision would need to scale up significantly and with agility to support cases and contacts in self isolation; the Ministry supported the Ministry of Social Development (MSD) to lead this welfare response.

10.   Prioritised populations were to be provided additional support through the newly established Care in the Community Hubs, delivering personalised health and social services at the local level to those most in need, under the Care in the Community programme.

*An Equity Impact Assessment on the developing strategy was commissioned*

11.   In acknowledging that proposed changes to the Omicron public health strategy would impact priority populations, it was identified that an EIA was necessary to identify potential inequities, and opportunities and solutions for mitigating these inequities in the development of the strategy and its implementation.

12.   On 14 January 2022, the then Deputy Chief Executive, COVID-19 Health System Response, Bridget White commissioned an EIA on the Omicron public health strategy to be undertaken.

*COVID-19 impacts on health equity for priority populations*

13. The Ministry defines equity as:

    'In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes.'

14. Health inequities arise from and are maintained by the unequal distribution of the determinants of health such as income, employment, housing availability and conditions, access to appropriate health care and provision of social support. This unequal distribution occurs through privileging some people or groups over others because of socially constructed factors such as ethnicity, class, gender, or ableism.

15. The intersectional impact of several constructed factors being present in the life of a person, whānau or community often result in poorer health outcomes. For example, a person who identifies as Māori, Pacific Peoples, disabled or is experiencing mental health distress and/or addiction often has poorer health outcomes than non-Māori non-Pacific due to this intersectional effect. The COVID-19 pandemic has exacerbated these existing inequities and intersectional barriers for people already under-served by the health system.

*The Omicron public health strategy needed to be developed at pace, leaving little time to complete an EIA before the strategy was implemented*

16. The first case of community transmission of the Omicron variant was identified on 18 January 2022. In order to respond at pace, particularly to deliver on one of the strategy's main objectives to minimise harm to vulnerable communities, the Ministry rapidly finalised its strategy and it was publicly announced on 26 January 2022.

17. Although the Ministry had intended for the EIA to inform the development of the strategy, officials had very limited time to develop the strategy itself, as well as conduct the EIA in a robust and meaningful way before it was required to stand up the new strategy.

18. In acknowledging that the strategy would evolve over time, and that learnings and feedback from communities was important to this evolution, the Ministry saw the opportunity to pivot the EIA from assessing the developing strategy to one that informed decision making in real time through the early stages of its implementation.

**Equity Impact Assessment on the Omicron public health strategy undertaken by the Ministry**

*The Ministry undertook a series of hui to inform the equity impact assessment*

19. The EIA was led by the COVID-19 Equity team with significant input form the Mental Health and Addiction Directorate, Māori Health Directorate, Pacific Health team, Science and Insights group as well as the wider COVID-19 directorate. It was conducted over a three-week period between 20 January and 24 February 2022.

20. To inform the assessment, a series of hui was undertaken with a wide range of groups working directly with and supporting priority populations in the ongoing COVID-19 response. Groups included community stakeholders, Tiriti o Waitangi partners, Pacific health leaders, clinicians, District Health Board (DHB) kaimahi, Māori nurses, and lived experience groups including disabled people and their carers', individuals with experience of mental health distress and/or addiction, their whānau, and support workers. A full list of those engaged with is provided in **Appendix 1**.

21. The purpose of the hui was to identify equity impacts across key areas of phase two and three of the strategy (where the bulk of the operational changes would kick in) and identify possible actions and opportunities to mitigating these impacts.

22. To guide the hui, assumptions on how the Omicron outbreak was likely to track were presented, along with identified priority populations, and detailed information on the strategy and its operations across testing, case investigation and contact tracing, isolation and quarantine, and Care in the Community. Our Te Tiriti o Waitangi obligations and key aspects of the COVID-19 Māori Protection Plan (set up to guide health and disability system actions for Māori through the COVID-19 response) were also presented.

*Feedback from the hui covered equity issues relating to the wider COVID-19 response*

23. While the approach to the EIA was intended to focus only on equity impacts of the Omicron public health strategy, the actual assessment undertaken captured feedback on equity issues covering the broader COVID-19 response. This was largely due to the strategy being developed and implemented at pace and therefore not allowing officials time to engage in detailed discussions with communities. Further, those engaged with were concerned with and eager to articulate immediate issues regarding their ongoing response to the Delta outbreak while facing significant workforce pressures, funding uncertainties, and newly established Care in the Community Hubs.

*There were limitations in the Ministry's ability to use the EIA to inform decision making during early implementation of the strategy*

24. The Ministry acknowledges that, despite the intent of the EIA and Ministry's best efforts, there were limitations in its ability to use the EIA to inform decision-making on the response during its early implementation. This is discussed in more detail at the end of this report under 'Ministry learnings', along with identified areas for Ministry improvement informed by the EIA.

## Equity Impact Assessment: feedback and actions

25. The feedback from the hui has been consolidated and summarised under the following key themes:

    i. *delivery and access of health and welfare support*

    ii. *funding to support a pro-equity approach*

    iii. *supporting and sustaining the workforce*

    iv. *providing tailored and accessible communications*

    v. *improving access to, and capturing of, data to inform the response*

    vi. *ensuring well integrated partnerships at the local level to meet the needs of communities.*

26. Each of these themes are set out in this report below, supported by a selection of quotes captured during the hui. Each theme is accompanied by a summarised priority mitigation action informed by various recommendations captured from the hui.

27. Under each theme and associated action is a 'Ministry response' that provides a summary of key actions we have taken that address that theme. It is worth noting that these actions cover only a selection of Ministry actions. A more fulsome list of actions the Ministry has taken to

improve its response, particularly with regards to equity, can be found in the recently published table on Ministry actions that respond to the prioritised recommendations from the independent *Dovetail Delta Response Rapid Review* into the August 2021 Delta outbreak (https://www.health.govt.nz/publication/delta-response-rapid-review).

### i. Delivery and access of health and welfare support

*Delivery of health and welfare supports to priority-populations*

28. Appropriate levels of health and welfare support for under-served populations and how these would be delivered to keep them safe was a concern raised through the hui.

29. Many raised concerns that the self-management model of the Omicron strategy would not work for people already disconnected from mainstream services or who may not have the capacity or resources to look after themselves or reach out for help.

30. There was significant concern that low-income households, people living in inadequate housing (such as over-crowded, emergency, or transitional housing), socially isolated people, people with lived experience of mental health distress and/or addition, as well as disabled people would not receive timely welfare and medical supports.

31. It was highlighted in the hui that for many people, particularly those with lived experience of mental distress and addiction, isolation exacerbated distress experienced as well as disrupted usual supports.

    'People with lived experience of mental distress and addiction are very concerned about the safety and ongoing health and support needs of their communities if required to self-isolate.'

    'Wellbeing for all household needs is required in care packages to support the levels of mental distress that is occurring. For example, physical exercise guidance, activities for children, access to counselling, crisis and mental health support and practical materials to support the wairua and hinengaro of the whānau.'

32. Many raised the importance of ensuring that priority cases were triaged by someone who was culturally appropriate and who understood their circumstances and needs.

    'It is essential that priority whānau are triaged by a person who is whanaunga and will understand their circumstances and needs. This is essential to support ongoing communication and safety.'

33. Ensuring disabled people had access to tailored support during isolation was a concern raised. As well as the prioritisation of basic needs for self-isolation and continuity of care, supporting disabled populations to access treatments such as the newly approved anti-viral medicines and the 5-11 year and booster vaccine roll-outs was of high concern.

    'Disabled people who have extreme anxiety around vaccines need more support...Booking home vaccinations is key for this group and delays in access to this service are occurring.'

    *Access to PPE to community providers and testing for at-risk communities*

34. Concerns were raised regarding timely access to Personal Protective Equipment (PPE) for small community providers. There were also concerns raised regarding priority population access to oral anti-viral medications and testing that was readily available and free of charge. The approach to ensuring this access was also raised, including through mobile services.

> **1. Summarised priority mitigation action identified in the hui: health and welfare support**
>
> Appropriate and timely health and welfare support delivered to under-served communities for the duration of their isolation, tailored to their needs, along with free testing and supports to access this testing where needed. A focus also on ensuring adequate supplies of PPE is delivered to all community providers in a timely manner.

**Ministry response**

*The Ministry has undertaken significant work to ensure priority populations have access to the support they need*

Care in the Community programme including Care Coordination Hubs

35. The Care in the Community programme was established in November 2021 and its Care Coordination Hubs were newly stood up when the EIA was undertaken. The Care in the Community response brings together the Ministry, MSD (who lead the welfare response), and the Ministry of Business Innovation and Employment (as the provider of alternative isolation accommodations services) to provide integrated care and support with equity embedded at its core. The delivery of services is coordinated at the local level through 53 Care Coordination Hubs, including iwi and Pacific led Hubs, which are set up across New Zealand to provide locally led, tailored responses to meet the needs of communities.

Prioritising priority populations in case investigation and supporting Māori and Pacific service delivery

36. The National Case Investigation Service, delivered by Reach Aotearoa, was stood up to support the investigation of cases in November 2021. Calling capacity was prioritised to priority populations with a focus on culture and language matches where possible. These calls focus on 'walking' individuals through the self-investigation and close contacts identification forms and connecting people into relevant health and care support systems under the Care in the Community pathway. The Māori Regional Coordination Hub (MRCH) and Pacific Regional Coordination Hub (PaRCH) was established in late January 2022 in partnership with the NHRCC to receive and manage all Māori and Pacific COVID-19 cases in Tāmaki Makaurau. MRCH and PaRCH provide a unique opportunity for Māori and Pacific peoples with COVID-19 to be supported and engaged with through a by-Māori for-Māori and by-Pacific peoples for-Pacific peoples model.

Investment has been made and services established targeted at under-served communities

37. The Ministry has invested $22 million to support Pacific health providers to respond to Omicron. This investment has supported sustaining service capacity and provider response activities such as maintaining a focus on vaccinations, delivering multiple additional pop-up testing sites, providing wrap-around health and social support, providing mental health support and delivering much needed business as usual services, particularly for Pacific families with complex needs.

38. In September 2021, the Ministry established a $4 million transport fund to support disabled people to access vaccination services and supported the standing up of a disability-focused phone and text service through Whakarongorau Aotearoa staffed by people with lived

experience and whānau whaikaha (whānau of disabled people). Through this line disabled people and their whānau can access advice on vaccinations, mask exemptions, and support if they or their family test positive for COVID-19. Soon this service will be extended further to offer support to disabled people who have urgent missed cares (eg if their carer has COVID-19 and is unable to provide care) – people will be able to call this number to discuss their missed cares and get some assistance if the situation is considered urgent.

39. In late 2021, the Ministry supported Care Coordination Hubs to work with local Māori health providers to ensure whānau had access to rapid antigen tests (RATs). This led to the establishment of the national 'Māori providers distribution channel' where providers across New Zealand receive RATs from a central distribution point to distribute to whānau and organisations in their community.

## ii.  Funding to support a pro-equity approach

40. Concerns were raised about the allocation of enough funding to provide wrap-around services and a 'manaaki first' approach to at-risk communities in a sustainable way, particularly to Māori and community-based providers.

    'Automated welfare outside main providers is required to enable access into the system. Non-health providers need to be able to access the manaaki first pathway of funding and welfare provision.'

    'Communities and providers are preparing but need resources that are ongoing and adequate to enable sustained service provision. Direct funding and ability to provide end-to-end services appears to be a barrier for this preparation.'

41. Targeted resource allocation, flexible funding models, and bulk or frontloading funding to providers to help them to prepare, were common solutions raised that could enable a pro-equity approach to be actioned. For vulnerable individuals and their whānau, the provision of 'no questions asked' income and supports without the need to prove eligibility or register into a government system was a common recommendation.

    'Automating welfare support in a medium and high-risk community would help mitigate disproportionate impacts on low socioeconomic, marginalised communities and areas of high housing deprivation.'

> **2. Summarised priority mitigation action identified in the hui: funding**
>
> Enable flexible funding models that provide direct funding to Māori and community-based providers to support communities with 'no questions asked' support.

### Ministry response

*The Ministry is investing significantly in Māori and Pacific models of care*

42. Through Budget 2022, the Ministry is providing significant, ongoing investment in Māori and Pacific models of care, as well as developing better engagement pathways for communities and whānau to design and influence health services. This investment includes:

- $30 million over four years for the Māori Provider Development Scheme and $49.9 million for the Pacific Provider Development Fund, to support Māori and Pacific providers to adapt and transition their models of care into the new health system and new locality approach

- $8.8 million over four years to develop a consumer and whānau voice framework that will allow the health system to continuously ensure consumers and whānau contribute to the design, delivery, and evaluation of health services

- $168 million over four years for Hauora Māori commissioning, which will fund a range of initiatives to improve primary and community care for Māori and enable a Māori-led approach to population health and prevention that targets the wider determinants of health and wellbeing.

### iii.    Supporting and sustaining the workforce

immediate workforce re-deployment, training, and support

43.    Concerns were raised over workforce shortages and workloads and that additional resourcing and support was needed in order for providers' responses to remain sustainable- providers were responding to significant COVID-19 workloads on top of business-as-usual work all while managing fatigue and burn-out from over two years of a dedicated response.

Many raised the need for immediate workforce re-deployment, training, support and back-up for specialised health and disability care (e.g. care for disabled people, people with addictions, people under the Mental Health Act 1992, dementia care, community hospice and cancer care services). Also raised, was the need to prioritise increased support to health care workers that identified from priority populations and that were trusted sources of information and care for their community.

'Prioritisation of cultural and specialised workforces (such as mental health and addiction, disability, gang whānau) for supervision and workplace support is required due to additional work-loads and complexity of adapting to COVID-19 regulations'.

'Nurses and other health workers who identify from prioritised communities are a trusted source of information, awhi, manaaki and clinical care. Their expertise, skills and knowledge need to be prioritised, utilised, and protected as a precious resource rather than an expendable labour unit.'

44.    Recommendations were made to increase the workforce through fast-tracking the authorisation of non-regulated staff to support the regulated workforce as well as reconfiguring workforces to enable increased support for manaaki first services.

'Non-regulated workforces need to be grown and invested in and encouraged. They have been already trained as vaccinators and swabbers.'

'Reconfiguring existing contracted services and workforces such as Health Coaches, Health Improvement Practitioners and Access and Choice mental health providers to provide a manaaki first service and support the non-government organisation sector.'

Continuity of care of high-needs individuals where their carer is impacted by COVID-19

45.    Many of those that we engaged with, voiced their concerns regarding continuity of care for high-needs individuals if their carers were required to self-isolate. These concerns were

particularly focused on disabled populations, people living in group homes, or those who lived alone.

'When someone who has 24/7 carers has to go into self-isolation, this means that the caregivers must also be isolated with them and consequently, their families. How will this person get food if their whole support system is also isolated?'

<u>Burden on Māori and community-providers to deliver a manaaki first response</u>

46. Many raised concerns that the welfare response was relying on a significant, unpaid volunteer workforce. Concerns were also raised about workforce fatigue and the burden on Māori and other community-based providers to provide a manaaki first response that delivered to their communities.

'Work-load and burden of manaaki first is being placed on community providers who are at high risk of burn-out or ill health developing from stress.'

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**3. Summarised priority mitigation action identified in the hui: workforce**

Increase workforce capacity and support particularly to cultural and specialised workforces and enable the non-regulated workforce to support with the COVID-19 response including vaccinations and testing.

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## Ministry response

*The Ministry is undertaking work to increase, support and sustain our workforce, particularly our Māori and Pacific health workforce.*

47. In the first quarter of 2022, the Ministry began planning for the future of the health workforce based on what it had learned from the Delta response and preparation for Omicron. An Omicron Workforce Plan has been developed based off the Ministry's Health Workforce Strategic Framework that was developed prior to COVID-19. The Omicron Workforce Plan has a range of initiatives over the short and long term, including those focused on developing a more culturally diverse workforce.

48. Through Budget 2022, the Ministry has secured $76 million over four years (and a further contingency of up to $31 million) for the workforce training and development needed to underpin critical reform initiatives and support the delivery of services through locality networks. This includes funding to grow and develop the hauora Māori and Pacific workforces, and to provide training for Certified Patient Care Technician workforces that may not have previously worked in primary and community healthcare settings.

49. The Ministry worked with Te Puni Kōkiri to obtain $39.6m funding for Māori and Pacific health providers (distributed by the Ministry) and $6.2m Care in the Community funding as one-off grants to Māori and Pacific health providers to support workforce resilience initiatives.

50. An initiative to enable students from Māori and Pacific schools of nursing to be trained as vaccinators is underway, acknowledging the value these students bring to their communities.

## iv.  Providing tailored and accessible communications

51. Many raised the need for tailored information regarding isolation requirements, how to access support, and medical guidance that was designed for easy translation, and accessible

for disability related needs and able to be customised for specific audiences such as youth, the disabled community, those with mental health issues, or the elderly.

52. A lack of suitable communication products was perceived as a significant barrier to empowering and enabling communities to keep themselves safe.

53. Many raised the need for layered communications to be provided through different mediums other than digital or web-based applications to ensure reach to those without access to digital solutions.

'The lack of tailored communications is alienating people from the response. Potentially the most at risk of COVID-19 are the least likely to know what to do or to engage with the system.'

'Digital solutions and website-based information campaigns in English are not appropriate for large sections of society and continue to be used as the default and main form of the COVID-19 response. There are little choice or options available for people who are unable or unwilling to access digital solutions and information.'

54. Many raised the need for localised, community-specific messaging led by Māori for Māori to ensure Māori communities were delivered messaging that was engaging, and culturally appropriate.

'We need communications to effectively tell people that they will be able to support themselves in this context. These communications must be Māori-led, communicated in a culturally-appropriate way.'

55. Along with this, misinformation and disinformation were raised as issues that were making it difficult for frontline workers to gain trust and support people effectively.

56. There were also issues raised about the need for appropriate and targeted communications to the providers themselves.

'Providers are preparing and are aware of the need for rapid communications to their hāpori/communities. Delays with Ministry of Health templates and guidance is preventing this due to the need to provide consistent and accurate advice.'

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**4. Summarised priority mitigation action identified in the hui: communications**

Provide clear, easily understood communications around self-isolation in different mediums that is tailored to Māori and other priority populations, and that is accessible to our disabled populations.

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## Ministry response

*The Ministry has undertaken work to improve our COVID-19 communications to under-served communities*

57. As part of the $22 million investment to support the Pacific response to Omicron (refer to paragraph 33), a portion of this funding is enabling Pacific health providers deliver Pacific communication and engagement activities. This includes the recommunication of

culturally appropriate key health messages to encourage compliance with public health guidance (e.g. vaccination and testing) and the various health supports available.

58. Work has been, and continues to be, undertaken to improve communications for disabled people including:

- an online one-stop COVID-19 information hub for disabled people was launched on the Unite Against COVID-19 (UAC) website in April 2022. The Ministry is working with other government agencies to regularly review and update the webpage to ensure information is current and available in alternate formats and in a range of languages

- work to ensure that resources and communications on vaccinations are available in easy read, New Zealand Sign Language, large print and Braille.

### v. Improving access to, and capturing of data to inform the response

59. Providers raised an urgent need for access to localised and relevant data so they could meet individual needs and anticipate the needs of their communities. This included information sharing about positive cases, ethnicity, hospitalisations, access to Managed Isolation and Quarantine, gaps in vaccination, as well as cases that identified as disabled people or had pre-existing health conditions, so providers knew who to prioritise with immediate support.

60. Identifying needs for communities, articulating gaps in service delivery and utilising local knowledge and intelligence effectively were all raised in the context of data sharing solutions. Data sharing was often positioned as a way to engender meaningful reciprocal partnerships and as an opportunity to build on this for the health reforms and transition to new systems of working.

'There is a lack of understanding of the high-needs populations out there, the quantity of people we're talking about, and how they'll be impacted in the case of an outbreak.'

'Pathways for data capture and information sharing of essential social information is unclear and is required for funding and planning (e.g. red flags on high and complex Māori and Pacific cases).'

'Ability to check that people are getting the clinical care they need for COVID and non-COVID, needs to be built into monitoring.'

61. Providers raised the need for intersectional data capturing priority populations within priority populations to support prioritised and targeted responses as well as support resource allocation and planning.

'Ministry data is missing refugees, migrants, low-income, homeless, immune-compromised, over 65's, pregnant people, as well as vulnerable populations within vulnerable populations.'

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**5. Summarised priority mitigation action identified in the hui: data**

Enable providers to access timely health data on priority populations to support their response through improved data capture specific to underserved communities, as well as pro-active information sharing.

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### Ministry response

*The Ministry continues to improve information sharing and community providers' access to health data to inform their response, although we acknowledge further improvements need to be made*

62. Updates to the information captured via the online contact tracing form and the phone-based case investigation means the Ministry now collects more data on a person's health and disability status and any associated needs. This data is collected and utilised to ensure appropriate referrals for support can take place where required.

63. The Ministry is updating its surveillance strategy to focus more on Māori and other priority populations and the intersectional risks to their health from COVID-19. The soon to be released updated Surveillance strategy addresses these objectives in-more depth to emphasise Māori, priority populations and intersectional risks to health from COVID-19.

64. From February 2022, the Ministry has been producing Māori and Pacific COVID-19 data weekly reports to a distribution list of 140+ people inside and outside the Ministry. These reports cover data on vaccination rates of disabled people and people with lived experience of mental distress or addiction. The Ministry has included a public version for community providers since early April 2022.

65. The Ministry uses national and regional data to assess whether vaccinations are being rolled out equitably. This data informs strategies to increase vaccine uptake, with successful strategies shared between organisations and groups such as Te Puni Kōkiri, DHBs, iwi and Māori organisations.

66. The Ministry acknowledges there is much more work to be done to improve our capturing and analysing of, as well as reporting on priority populations in our COVID-19 response. This future work is addressed further at the end of this report under 'Ministry learnings'.

## vi. Ensuring well integrated partnerships at the local level to meet the needs of communities

67. Supporting the emerging community partnerships and practices being established for Omicron were also signalled as an important legacy of COVID-19 that could be leveraged to strengthen co-governance arrangements.

68. Maōri providers, iwi, hāpu and local communities and providers were leading the way with meeting their regional health needs. Many informants raised the desire to continue to work in this joined up way and build on this work.

69. The focus of Care in the Community on 'manaaki first' and leaning on collective community strength and resilience was voiced as an opportunity for a change in focus of healthcare delivery as a way to support the upcoming health reforms.

'Omicron is an opportunity to shift to a stronger whānau and hāpori centred approach in line with the health reforms.'

> **6. Summarised priority mitigation action identified in the hui: local-level partnerships**
>
> Support emerging community partnerships by ensuring Care Coordination Hubs integrate community providers, iwi, and non-government organisations to deliver a joined up, manaaki first response.

### Ministry response

*The Ministry is currently delivering the locally-led Care in the Community programme to care for people and their whānau isolating at home with COVID-19.*

70. 53 established Care Coordination Hubs connect health and local support, share information, and enable regional leaders to operate in a way that had not done so previously. A variety of models have been set up including iwi-based hubs where Iwi Māori are taking the lead. The Hubs have also partnered with the sector, bringing together iwi, PHUs, Primary Care, MSD and DHBs to coordinate and collaborate on delivering health and welfare support to those in need.

## Ministry learnings from the Equity Impact Assessment

*The Ministry had some success in disseminating feedback from the EIA at the time it was captured to inform its decision-making, but improvements can be made*

71. To have the EIA inform the early stages of the implementation of the strategy, best efforts were made to rapidly disseminate feedback from the hui to relevant teams within the Ministry. Feedback was provided as it was captured, to teams including Testing and Supply, Contact Tracing, Science and Insights, and Care in the Community. This feedback informed advice on isolation and quarantine requirements, funding to communities to support mental health workforce capacity, and changes that enabled providers to access distribution channels for PPE and RATs through their existing Ministry contracts.

72. While the feedback captured at the time did influence some decision-making, the Ministry acknowledges that there were limitations to the extent to which this happened due to the pace at which the strategy was being implemented. It also acknowledges that stronger internal feedback pathways would have made this dissemination of feedback easier and more influential. Improvements need to be made to internal communication pathways between business units, policy and subject matter experts and advisors to better facilitate this.

*Ministry equity advisory groups are supporting improved feedback loops and engagement on equity issues, but direct communication channels are needed between communities and senior decision-makers*

73. The Ministry's COVID-19 Equity Oversight Group (EOG), which was set up in early 2021 and has membership from across the Ministry, meets weekly to provide a forum for equity advice and intelligence regarding COVID-19 workstreams. The EOG has been improving its structure and processes to support stronger communication and feedback channels across the Ministry on equity issues. The COVID-19 policy group and adjacent teams have become increasingly aware of this group as an equity resource; the EOG has subsequently been utilised for policy

work, strategies and operational programmes including the Variants of Concern Strategy, the COVID-19 workforce educational pathway and the disability outbreak advisory.

74. The Ministry also engages in fortnightly hui with its lived experience group Te Kōtuku e Rere who play an important part in designing and developing approaches that connect with rural Māori, Pacific, mental health and addiction and disabled populations.

75. However, underserved communities and providers working on the front-line voiced their desire through the EIA to connect directly with those high up in the Ministry making decisions affecting equity as opposed to what they understood to be the 'middle man'. This speaks to the need for clearer communication pathways whereby those on the ground feel they have a direct mechanism for informing decision-making.

76. In the months following the EIA, the Ministry stood up solutions and approaches (including those captured in our responses above) that aligned with the advice and guidance we received from communities and providers. The Ministry acknowledges that communities know what needs to be done, and that early engagement with them to inform direct decision-making is critical to ensuring we are implementing the best solutions as early as possible.

77. The Ministry recognises the importance of community voices as a rapid pipeline to equity in practice and acknowledges that having decision-makers connected to these forums directly in future emergency planning is a way to fast-track pro-equity decision-making. With the move to locality-based health care, this learning appears important to emphasise as an urgent and key operational task. Enabling direct community interaction with the planning and design of how Health New Zealand, the Public Health Agency and Māori Health Authority will carry out kaitiakitanga for locality-based re-structuring, is likely to assist in equity-focused policy and operational decision-making.

*A shared equity analytical framework with improved data can improve our equity response*

78. The Ministry identifies the need for a consistent and practice-oriented shared equity analytical framework for COVID-19 across the directorate to make it easier for multiple workstreams to work in-sync with each other towards the same outcomes. A clear definition of priority populations, baseline metrics and data reporting across the response will also support this. Developing an equity-in-practice framework with clear expectations, including Te Tiriti o Waitangi responsibilities, that is applicable across policy, operations, expert advisory and administrative functions appears essential core work that will support the health reforms and transition to working with equity at the forefront of all work.

*There is an opportunity to consolidate insights from the EIA and other feedback on the Ministry's COVID-19 response to inform the future of our COVID-19 strategy (and other outbreak strategies) that is integrated across our new health entities*

79. The EIA is one of several sources of information available (or soon to be available) relating to feedback on the Ministry's COVID-19 response and recommendations for future improvements, particularly regarding a pro-equity response. These include the *Dovetail Delta Response Rapid Review* that was recently published as well as a research report focused on communities' experiences of COVID-19 (conducted by Te Rau Ora) which is due to be released early July.

80. As we begin to revise our current Omicron public health strategy towards managing the future of COVID-19 post-winter, there is an opportunity to consolidate the recommendations

and learnings from this EIA with other relevant information sources to inform a pro-active, fulsome and in-depth assessment of the equity implications of any future strategy; we know that equity must be at the core of any future response and we have the opportunity to build these pro-equity foundations by fully utilising the insights and recommendations gathered so far from communities and providers.

81. As the COVID-19 Equity team, along with other COVID-19 teams under the Ministry's COVID-19 directorate, have now moved to Health New Zealand, we must also leverage opportunities to work in an integrated way across Health New Zealand, the Māori Health Authority and the Ministry of Health to inform any future pro-equity strategy.

## Recommendations

It is recommended that you:

| | | | |
|---|---|---|---|
| 1. | **Note** | An Equity Impact Assessment was undertaken by the Ministry as commissioned by the then Deputy Chief Executive, COVID-19 Health System Response, Bridget White on the development of the three-phase Omicron public health strategy. | Yes/No |
| 2. | **Note** | This report provides a summary of key themes comprising equity issues identified through engagements undertaken as part of the EIA, along with associated prioritised actions and the Ministry's response to these. | Yes/No |
| 3. | **Note** | Feedback from the engagements undertaken as part of the EIA was disseminated to teams within the Ministry at the time it was captured to inform Ministry decision-making. | Yes/No |
| 4. | **Note** | The report sets out the Ministry's key learnings from the EIA, including the opportunity to undertake a proactive, robust and fulsome EIA of any future COVID-19 strategy. | Yes/No |
| 5. | **Note** | A copy of this report will be provided to the groups consulted within the undertaking of the EIA. | Yes/No |
| 6. | **Agree** | To publicly release this report on the Ministry of Health website. | Yes/No |

Signature _____     Date:

Dr Ashley Bloomfield
**Director-General of Health**

**Appendix 1: List or organisations who attended hui**

| Date | Hui | Organisations represented |
|------|-----|---------------------------|
| 19 January 2022 | Ministry of Health PHU Meeting | All 12 PHUs |
| | Te Rūnanga o Aotearoa Poari | 16 Attendees – Māori Nurses |
| | Māori Regional Coordination Hub | 3 Attendees |
| | COVID-19 Equity Oversight Group | 10 attendees |
| 20 January 2022 | Māori Monitoring Group | Written minutes |
| | Ngāti Hine Health – Mahi Tahi | 4 attendees |
| 21 January 2022 | Te Kōtuku e Rere, MoH Lived Experience Group | 6 attendees |
| | Pacific Technical Advisory Group | 8 attendees |
| 26 January 2022 | Mental Health & Addiction Hui-Whakakotahi rōpū-Sector representatives | 18 attendees<br><br>Mental Health Directorate, Asian Family Services, Te Pou, Balance Aotearoa, CAMHS Waitemata DHB, Salvation Army Bridge, Whāraurau Youth Service, Changing Minds, National Needle Exchange, Emerge Aotearoa, Yellow Brick Road, Te Rau Ora |
| | Mental health and Addictions-Lived experience group | 17 attendees (approx) |
| | Leadership group-Mental health and Addictions- Matanga Mauri Ora roopu (MHAD) | 9 attendees (approx) |
| | Te Rūnanga o Aotearoa Poari (2nd hui) | 6 attendees |
| 27 January 2022 | Te Rōpū Waiora (Māori, Pacific and other, disability) | 22 attendees including members of Taikura Trust. |
| 8 February 2022 | Te Arawa Whānau Ora & Te Arawa COVID Hub | 3 attendees |
| | National Hauora Coalition | 8 attendees |
| | CEO, Counties Manukau DHB | Written feedback |

| | Mental Health and Addictions Directorate, Northland District Health Board | Written feedback |
|---|---|---|
| | Te Kōtuku e Rere | Written feedback |
| | Te Upoko o te Ika a Maui | Written feedback |
| | Bhutanese Society of NZ | Written feedback |
| | Pacific group feedback to be provided by Gerardine Clifford-Lidstone and Pacific health team | Written feedback |
| | Te Aho o Te Kahu/Cancer Control Agency | Written feedback |
| 18 February 2022 | Te Arawa Whānau Ora | 6 attendees |
| | Toi Te Ora | 30+ attendees |
| 24 February 2022 | Waiariki Whānau Mentoring (gang outreach) | 3 attendees |