



# **SUMMARY REPORT**

## **Health Equity Assessment:**

**Child & Adolescent Physical Therapy Team  
Service for Children  
aged 3 to 5 years**

**Report Prepared by the Public Health Unit  
Taranaki District Health Board  
June, 2020**



# BACKGROUND

The purpose of this Health Equity Assessment (HEA) was to apply a health equity lens to the service delivered by the Child and Adolescent Physical Therapy Team (CAPTT) of the Taranaki District Health Board (Taranaki DHB) to children aged 3 to 5 years.

The findings of this report are based on the analysis of data captured by the service, and findings from a HEA workshop held with the CAPTT on 21 November, 2019.

## PROMOTING EQUITY IN HEALTH

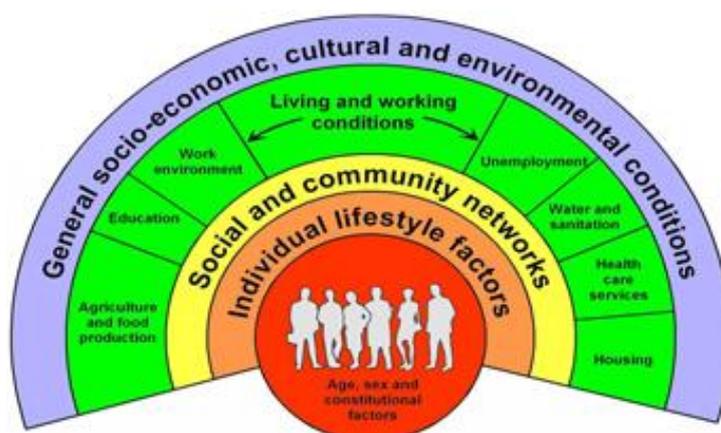
Health inequities are avoidable, unnecessary and unjust differences in the health of groups of people (Whitehead, 1992). They result from the unequal distribution of the determinants of health, including employment, income, housing, education and health care (Graham, 2001).

Health equity is the absence of systematic disparities in health between groups with different levels of underlying social advantage and disadvantage (Braveman and Gruskin, 2003). The Ministry of Health (2019) defines health 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.*

The health care sector is a vital determinant of health in itself and a key resource in improving health in an equitable manner (Baum et al, 2009). As a sector, health has a responsibility to recognise and reverse its propensity to generate health inequities. To do this, the sector must consider the wider socio-economic, cultural and environmental conditions in which consumers of health services live and work and the impact of these on consumers ability to engage in available health services (Figure 1).

**Figure One – The main determinants of health (Dahlgren and Whitehead, 1991).**



## **HEALTH EQUITY ASSESSMENT TOOL**

Taranaki DHB is committed to creating a fairer society where everyone has the opportunity for good health and where our health system meets the needs and aspirations of Māori. Eliminating differences in health outcomes which are unnecessary, avoidable, unfair and unjust is a core theme of our work.

Reducing health inequities is greatly assisted by tools that enable the assessment of interventions, such as policies, programmes and services. Such tools examine the potential of these interventions to contribute to reducing health inequalities. From an assessment, informed decisions can be made about how to build and strengthen policies, programmes and services.

Taranaki DHB identifies the Ministry of Health's Health Equity Assessment Tool (HEAT) as its preferred methodology for undertaking health equity assessment.

HEAT (Signal et. Al., 2008) consists of a set of 10 questions that enable assessment of policy, programme or service interventions for their current or future impact on health inequalities. The questions cover four stages of policy, programme or service development:

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

## **HEALTH EQUITY ASSESSMENT**

The objective of this HEA was to apply a health equity lens to the service delivered by the Child and Adolescent Physical Therapy Team (CAPTT) of the Taranaki District Health Board (Taranaki DHB), specifically to children aged 3 to 5 years.

The project aimed to:

1. Gain an understanding of the existing inequities in service delivery by the CAPTT to children aged 3 to 5 years in Taranaki
2. Identify opportunities for the CAPTT to review service provision to reduce inequities for service users aged 3 to 5 years in Taranaki

The HEA was facilitated by Taranaki Public Health Unit (Taranaki PHU). Taranaki PHU provides support to enable Taranaki DHB services to integrate the use of HEAT into service planning, development and evaluation.

## **SCOPE**

It should be noted that this report does not attempt to offer a full exploration of the service provided by the CAPTT but, instead, provides a summary of the findings of the HEA process applied to the service delivered by the CAPTT, specifically to children aged 3 to 5 years.

## **EXISTING INEQUITIES IN SERVICE DELIVERY BY THE CAPTT TO CHILDREN AGED 3 TO 5 YEARS IN TARANAKI**

### **Access for children living outside of New Plymouth District**

The key factor driving inequities in the service is access for children living outside of New Plymouth District. While staff are able to visit children in their homes for many of the services required throughout Taranaki, there are some services that are only delivered at the Child and Adolescent Centre on the Taranaki Base Hospital campus in New Plymouth.

Families/whānau are required to travel to New Plymouth to access these services, placing a greater burden of time (round trip of two or more hours if from South Taranaki District) and cost.

Māori whānau who use the services of CAPTT are more likely to live outside of New Plymouth District, so carry a larger burden of travel, than Non Māori.

The data indicates that there is a higher proportion of children (3 to 5 years of age) accessing the services of CAPTT who live in South Taranaki (compared to the proportion of children aged 3 to 5 years in the population) than in other district council areas in Taranaki. South Taranaki is an area of high need for the services of CAPTT.

It is clear from the findings of both the data and workshop that while children who live outside of New Plymouth District have similar needs for services as those who live in the city, they do not receive the same level of service or ease of access.

### **Location and work hours of staff**

The current location and hours of work of staff further exacerbates this inequity. All staff are based at the Child and Adolescent Centre in New Plymouth, and the majority work part-time hours. When travel time and work hours of staff are considered, this reduces the number of children they can visit outside of New Plymouth District, especially in South Taranaki.

### **Gender**

The data showed that more males used the services than females. This, however, is not an inequity but a gender inequality due to the condition/diagnosis, i.e. autism is approximately four times more common in males than females.

## **Service responsiveness to the cultural needs of tamariki Māori and their whānau**

While the service is well accessed by tamariki Māori (at the rate that is seen in the population for this age group), the workforce currently lacks Māori staff. Staff expressed interest in increasing their use of reo Māori when working with tamariki Māori and their whānau.

## **OPPORTUNITIES FOR THE CAPTT TO REVIEW SERVICE PROVISION TO REDUCE INEQUITIES**

The key strategy to reduce inequities in the CAPTT service is to increase the level of service based in Hawera.

The current staffing structure, i.e. all staff based in New Plymouth and working part-time, makes this difficult and requires review. It is noted that even though the service delivers to 5-year-olds (who are at school), there is currently minimal staffing available to offer after school appointments. Any revision of current resources should consider the CAPTT service ability to offer after school appointments to families/whānau to minimise disruption to schooling.

Lack of age-appropriate equipment for children aged 3-5 years, and space (including for storage of equipment) in Hawera also presents challenges to the CAPTT service. Suggestions of reaching out to collaborate with community organisations (such as Autism Connex and CCS Disability) may result in solutions to issues relating to the funding, provision and storage of equipment. Having additional support staff to set up, clean and put away equipment is another possible consideration.

Currently the CAPTT service does not automatically send out text reminders to parents/caregivers for appointments, with staff sending these out personally as required. Staff felt that it would be of more benefit having additional administrative time to send out text reminders (rather than administrative assistance) to help strengthen the relationships they have with families/whānau.

Working closer with Te Pā Harakeke (Māori Health team) would further support building relationships with tamariki Māori and their whānau.

The workshop participants made a number of suggestions for ways the external supports, such as funding for vehicle modifications, housing and for specialised equipment (e.g. beds, including moving beds) could better meet the needs of families with disabled children. While out of the scope of the assessment, there exists an opportunity to advocate to Taranaki DHB and the Ministry of Health regarding current funding and processes to better support families/whānau with disabled children.

## RECOMMENDATIONS

Based on the findings of this HEA, and in consultation with the CAPTT, the following recommendations are made.

1. Explore opportunities to engage in learning Te Reo Māori for the team.
2. Explore opportunities to work collaboratively with the Pou Hapai, Te Pā Harakeke in South Taranaki and/or CCS Disability Worker in South Taranaki to provide cultural support for Māori patients and whānau in their appointments with therapists.
3. Review existing staffing to offer increased service in South Taranaki and increased flexibility in appointment times e.g. after school times.
4. Discuss options to create a treatment/assessment space and storage of equipment with Hawera Hospital management.
5. Team to review work models and processes to increase efficiency, writing up notes, collecting patient statistics, send out text reminders and use of IT.
6. Explore opportunities and requirements to run a full therapy session/telehealth on Zoom.

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