NEW ZEALAND COLLEGE OF PUBLIC HEALTH MEDICINE

1. Partner to achieve health equity

Entrenched systematic health disparities persist in Aotearoa New Zealand. These are driven by differences in the social determinants of health, access to care and the timeliness and quality of care received. Racism is increasingly recognised as a key driver of inequity. Individual clinical practice, institutional biases, and health system barriers also contribute. The failure to redress this health inequity, and with urgency, breaches the Crown's Tiriti o Waitangi obligations to Māori. Achieving health equity will improve the health of New Zealanders and benefit individuals, whānau, communities, the economy and wider society. Equity needs special attention in service planning and implementation, so that services and systems achieve equity in outcomes.

Prioritise the needs of the most disadvantaged, and shape approaches that are effective in achieving equity. Where universal actions are required, the intensity of these actions must be proportionate to the level of disadvantage, so that those most in need receive the most benefit. Nonetheless, focusing only on those most in need will only address a small part of the problem. Monitor and analyse health data and equity outcomes by subgroup, to identify unwarranted variation, and evaluate your actions. Do not add to inequity, be alert to it and work in partnership to eliminate it.

For Māori in particular, achieving equity will require Treaty partnerships, as well as partnering and power sharing with community groups, and intersectoral and whole-of-government approaches that align with Tiriti o Waitangi principles. Lead and advocate for equitable access to high-value care delivered in culturally competent and safe ways. Commit to improving living conditions and eliminating inequities of the social determinants of health, including power and resource imbalances.

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2. Allocate health resources systematically, cost-effectively, equitably, sustainably, and responsibly

Health resources are finite. Allocating them needs good evidence, prioritising and optimising the greatest health gains for the greatest unmet need, equitably and sustainably, taking account of environmental impacts and the time and cost resources available.

An evidence-informed approach to allocating resources means using multicriteria decision-making, with each criterion informed by the best available evidence. Include in the criteria:

a) *Health need: the magnitude and distribution of disease burden (premature death, morbidity/disability and suffering)*

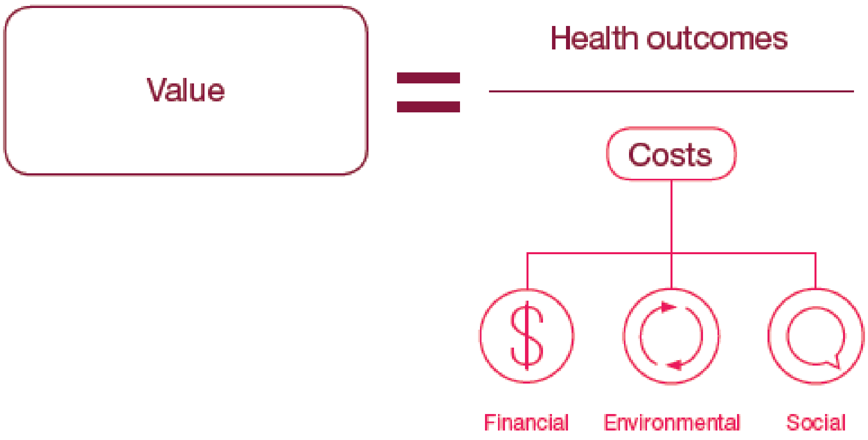
b) *Health gains: the effectiveness of the intervention, and the magnitude and distribution of gains in health and wellbeing*

c) *Affordability including sustainability: economic evaluation of cost-effectiveness, costs and savings in the short-term and long-term, and thus measuring how affordable, fiscally durable and environmentally sustainable the intervention*

d) *Impact on health inequities: using an equity lens such as the Health Equity Assessment Tool (HEAT)*

e) *Feasibility and acceptability: take account of society's values and expectations, and feasibility of implementation.*

Sustainably means doing more with less, and not doing or using too much. Sustainable health improvement meets the essential health needs of the present (especially the world's poor) without compromising future generations' abilities to meet their own needs. This approach accepts limits, protects the environmental determinants of health and reduces healthcare spending, so freeing opportunities elsewhere and in future.



adapted from Academy of Royal Medical Colleges, 2014

Allocating resources equitably means accounting for the significant historical and contemporary underfunding of health care for Māori.

The process of prioritisation is as important as the outcome. Criteria can often conflict with each other, eg. the most equitable option may not be the most cost-effective. The relative balance of these criteria is crucial. Engage with stakeholders when developing the criteria, make sure the decision-making process is robust and explicit, and that decisions (and reasons for them) are publicly accessible and defensible. Partner to achieve equity in health outcomes, do not add to inequity, and be alert to inequity and work in partnership to eliminate it.

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3. Use absolute risk ahead of relative risk when assessing and communicating risks, harms and benefits

Successful evidence-based practice and shared decision-making between health professionals and the public depends on effective communication about risks, harms and benefits. Health information framed in terms of relative risk is frequently misunderstood and is potentially deceptive. A specific relative risk reduction, such as 50%, may represent markedly different absolute risk reductions depending on the baseline risk. Health professionals, as well as the public, tend to over-estimate the effectiveness of an intervention when results are expressed in relative terms, because such results are naïve to the baseline risk. Absolute risk reduction and numbers-needed-to-treat are more direct measures of the relevance of an effect than relative risk reduction and are less likely to influence medical and public decision-making to inappropriately adopt an intervention. Relative risk has its place, but an absolute risk approach achieves a better balance between prevention and avoiding unnecessary intervention.

Express absolute risk reductions in numbers and as natural frequencies, ahead of relative risk reductions, eg. as "[number] A out of 1000 people will have [outcome] Z with [intervention] X, compared with [number] B out of 1000 people without X [or with an alternative intervention]. Given [number] C people in New Zealand have [disease] D, intervention X will thus reduce the case load by [number] E over 5 years. This is an x% absolute reduction." Use pictures and pictograms, which are effective.

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4. Apply established screening criteria when assessing potential screening programmes

Screening tests asymptomatic individuals for a particular disease or condition, and can reduce future mortality and morbidity by establishing risk of disease or identifying early asymptomatic disease (or a disease precursor) that is amenable to treatment. Screening programmes can improve population health, but can also cause harm and perversely increase health inequities.

Use established screening criteria to make sure that there is robust evidence the programme will provide benefit, achieve equitable outcomes and minimise potential harms. In Aotearoa New Zealand the following criteria are recommended:

1. *The condition is a suitable candidate for screening.*
2. *There is a suitable test.*
3. *There is an effective and accessible treatment or intervention for the condition identified through early detection.*
4. *There is high quality evidence, ideally from randomised controlled trials, that a screening programme is effective in reducing mortality or morbidity.*
5. *The potential benefit from the screening programme should outweigh the potential physical and psychological harm (caused by the test, diagnostic procedures and treatment).*
6. *The health care system will be capable of supporting all necessary elements of the screening pathway, including diagnosis, follow-up and programme evaluation.*
7. *There is consideration of social and ethical issues, including health equity.*
8. *There is consideration of cost-benefit issues.*

Make sure programmes aim to achieve equitable outcomes, have informed choice and equity of access for all the target populations, and are culturally competent and safe. Design screening programmes explicitly for equity – including participation, access, timeliness, and quality of care and outcomes. Have in place measures and monitoring to ensure programmes achieve equity. Do not add to inequity, be alert to it and work in partnership to eliminate it.

Make sure programmes are coordinated, supported by clinical leadership, independently monitored and evaluated, and have continuous quality improvement.

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5. Evaluate programmes at every stage of implementation

Effective programme evaluation is a systematic way to improve and account for public health actions, ensuring effective use of public and community resources. Programme evaluation leads to more logical programme plans, stronger partnerships, integrated information systems and more systematic measurement, outcome and equity achievements, and the detection of programme effects. Evaluations can inform decisions about and guide changes in public health strategies and ensure equitable programme design and implementation.

Plan for adequately-resourced evaluation early in a programme's inception, to support better design, piloting and implementation, as well to assess its benefits, and the dissemination of successful programmes. Have practical, ongoing evaluation strategies and measures developed with all programme stakeholders, that are culturally meaningful and incorporate health equity goals. Evaluation findings should be disseminated appropriately. Evaluate for equity in health outcomes, do not add to inequity, and evaluate for inequity and work in partnership to eliminate it.

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How was this list created?

A set of draft Choosing Wisely recommendations for public health was created and presented at the New Zealand College of Public Health Medicine's College's 2017 Annual Scientific Meeting (ASM), and input was sought from all present. Further work was done following this meeting to refine the recommendations and develop explanatory statements for each recommendation.

The document went through an extensive process of peer review prior to being circulated to all College members for feedback. The final version of the document was recommended by the College Policy Committee and approved by the College Council in August 2018.

The working group was chaired by Ass. Prof. Deborah Read, and included Greg Evans, Fran McGrath RIP, Scott Metcalfe, and Felicity Williamson. Peer reviewers of various sections included Tony Blakely, Rod Jackson, Alex Macmillan, Nisha Nair, Maria Poynter, Nina Scott, Rhys Jones, Papaarangi Reid, Ruth Richards, Ann Richardson, and Tom Robinson. Other College members contributed comments in the member consultation processes.

Minor revisions were made in 2019 (Scott Metcalfe, Fran McGrath RIP, Rhys Jones, Deborah Read, through the College Policy Committee and the College Council).