

MONITORING SOCIAL WELL-BEING TO SUPPORT POLICIES ON THE SOCIAL DETERMINANTS OF HEALTH: THE CASE OF NEW ZEALAND'S "SOCIAL REPORTS/TE PŪRONGO ORANGA TANGATA"

Social Determinants of Health Discussion Paper 3

DEBATES, POLICY & PRACTICE, **CASE STUDIES**

MONITORING SOCIAL
WELL-BEING TO SUPPORT
POLICIES ON THE SOCIAL
DETERMINANTS OF
HEALTH:
THE CASE OF NEW
ZEALAND'S "SOCIAL
REPORTS/ TE PŪRONGO
ORANGA TANGATA"

The Series:

The Discussion Paper Series on Social Determinants of Health provides a forum for sharing knowledge on how to tackle the social determinants of health to improve health equity. Papers explore themes related to questions of strategy, governance, tools, and capacity building. They aim to review country experiences with an eye to understanding practice, innovations, and encouraging frank debate on the connections between health and the broader policy environment. Papers are all peer-reviewed.

Background:

The idea of this paper and the case study it describes was generated in discussions between WHO and Don Matheson who represented New Zealand on the country stream of work of the Commission on Social Determinants of Health (CSDH). The country stream of work aimed at galvanizing political will for tackling the social determinants of health and supporting knowledge sharing across countries on how to implement the social determinants agenda. The principal investigator was Frank Pega, who also developed the first draft of the paper. The paper was written by Frank Pega, Nicole Valentine and Don Matheson.

This paper provides a historical overview of how New Zealand's social indicators reports came to be generated, describing the contextual issues related to the use of the report for monitoring social progress. It attempts to make a first assessment of the policy impact of the social indicators reports.

Acknowledgments:

The authors want to thank Orielle Solar (WHO Geneva), Teresa Wall (Ministry of Health, New Zealand), Martin Tobias (Ministry of Health, New Zealand) and Kumanan Rasanathan (WHO Geneva) for their comments on the paper and the key informant survey prepared to document the case study. Particular thanks are extended to five key-informants from the New Zealand Ministries of Health and Social Development and to 24 respondents who participated in a survey. Frank Pega was supported by a BRCS Travel Award and an International Travel Award from the Royal Society of New Zealand (Ref: ITF08-01) to work earlier drafts of this paper. He developed and finalized this paper under contract to the Department of Ethics, Equity, Trade and Human Rights at WHO.

Suggested Citation:

Pega F, Valentine N, Matheson D. Monitoring Social Well-being: the case of New Zealand's Social Reports / Te Pūrongo Oranga Tangata. Social Determinants of Health Discussion Paper 3 (Case Studies).

WHO Library Cataloguing-in- Publication Data

Monitoring social well-being to support policies on the social determinants of health: the case of New Zealand's "social reports/ te pūrongo oranga tangata".

(Discussion Paper Series on Social Determinants of Health, 3)

1.Socioeconomic factors. 2.Health care rationing. 3.Health services accessibility. 4.Patient advocacy. 5.Health policy. 6.New Zealand. I.World Health Organization.

ISBN 978 92 4 150086 9

(NLM classification: WA 525)

© World Health Organization 2010

All rights reserved. Publications of the World Health Organization can be obtained from WHO Press, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel.: +41 22 791 3264; fax: +41 22 791 4857; e-mail: bookorders@who.int). Requests for permission to reproduce or translate WHO publications – whether for sale or for noncommercial distribution – should be addressed to WHO Press, at the above address (fax: +41 22 791 4806; e-mail: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Printed by the WHO Document Production Services, Geneva, Switzerland.

Contents

EXECUTIVE SUMMARY	2
1. INTRODUCTION	5
2. BACKGROUND	7
2.1 The Social Indicator Movement	7
2.2 Right to health monitoring and indicators	8
3. METHODOLOGY	10
4. FINDINGS	12
4.1 New Zealand's Social Reports [http://www.socialreport.msdc.govt.nz/]	12
4.2 The political history of the Social Reports	13
4.2.1 Building momentum	13
4.2.2 Establishing the Social Reports	14
4.2.3 Refining the Social Reports	17
4.3 An assessment of the Social Reports' policy impact	19
4.3.1 Currency in government	20
4.3.2 Currency "beyond government"	23
5. INNOVATIVE FEATURES OF THE SOCIAL REPORTS	26
5.1 Assuring civil society participation, transparency and accessibility	26
5.2 Monitoring the SDH	27
5.3 Monitoring social equity in the Social Reports	28
5.4 Using social reporting to foster inter-sectoral action	32
5.5 Broadening understandings of health and health determinants	32
5.6 Highlighting strengths and using language that is responsive to policy opportunity	33
5.7 Developing social indicators in societies with indigenous populations	33
5.8 Securing on-going, regular, "neutral" social reporting	35
6. KEY LESSONS LEARNT	36
LIST OF ABBREVIATIONS	41
REFERENCES	42
ANNEXES	49
Annex 1: Selected national social reporting schemes	49
Annex 2: Selected supranational and international social reporting schemes	51
Annex 3: E-mail survey	52
Annex 4: Social outcomes domains, desired outcomes and social indicators	54
FIGURES	
Figure 1: Pyramidal framework covering outcomes indicators for the Social Reports' Health domain as proposed to the Ministry of Social Development by the advisory group assembled by the Ministry of Health	16
Figure 2: Diagrammatic comparison of selected indicators of Social Well-being for Pacific Peoples, relative to New Zealand Europeans, 2004-2006	30
Figure 3: Summary of findings from the Health domain, 2007 Social Report	30

Executive summary

Since the “Social Indicator Movement” was pioneered in the mid 1960s, national social reports have become established tools for the monitoring of social well-being outcomes in many countries. In line with their mandate, international organizations, including the United Nations system, have contributed to these efforts with the publication of international social reports. They have also provided encouragement, technical and conceptual support for Member States to establish national social reporting schemes and set internationally ratified standards and norms around definitions and measurement of social outcomes. Intersecting these previous achievements in the area of social monitoring and the quest for health equity, the recent work of the United Nations Special Rapporteur on the “right to health” promoted a right-based approach to the monitoring of the realization of the right to health, implying that health indicators need to include the determinants or conditions for health, as outlined in the General Comment. In sum, this national and international work has generated a comprehensive body of theoretical and practical knowledge on social indicators.

Investigating the case of New Zealand’s “Social Reports/ te pūrongo oranga tangata”, the core aim of this discussion paper is to contribute to answering the research question of how monitoring social well-being supports a policy agenda aimed at addressing the social determinants of health to improve health equity. Hence, this study contributes to the WHO goal for improving the dissemination of knowledge to support action on the broader determinants of population health and health equity (which we term “the social determinants of health”) - both within and outside the health and government sectors. It builds on the work of the WHO Secretariat in supporting the global Commission on Social Determinants of Health and is a contribution by New Zealand, as a country partner, to the body of knowledge on institutions and mechanisms for supporting implementation of the social determinants of health agenda in countries.

The paper provides a historical overview of how New Zealand’s social indicators reports came to be generated, describing some of the contextual issues related to the use of the report for monitoring social progress, and attempts to make a first assessment of their policy impact. Methodologically, the paper draws on the social reports themselves, as well as diverse secondary academic texts and white papers of relevance. In addition, the paper draws on structured key-informant interviews, which were undertaken with five senior policy staff from the Ministries of Health and Social Development and results of an e-mail survey of 24 key informants, mostly civil society representatives from a range of different economic sectors.

In New Zealand, a nation with a history of strong social welfare policy, the establishment of social reports was preceded by a short and jagged pre-history of national interest in and action on social reporting dating to the early 1970s. These early endeavors were interrupted by governments focusing singularly on national free-market economic policy reforms which were implemented in the 1980s and 1990s, eventually leading to a standstill of the national social indicator work. However, motivated by a change of government in 1999, New Zealand’s emphasis shifted from a sole focus on economic growth as a measure of progress to include the achievement of social progress, as marked by social indicators. As part of this general policy re-orientation the New Zealand government also enacted a broad cross-government initiative aimed at “Closing the Gaps” (later terminology changed to

“Reducing Inequalities”) between the indigenous Māori and ethnic minority Pacific peoples on the one hand and non-Māori, non-Pacific New Zealanders on the other in terms of economic and social outcomes. In this era, achievement of equal rights and a more equitable society again became central benchmarks of policy. Changes of Administrative changes, such as the formation of the New Zealand Ministry of Social Development, accompanied these political navigations. The establishment of the series of *New Zealand Social Reports/ te pūrongo oranga tangata* (the “Social Reports”), the first report of which was launched in 2001 by the Ministry of Social Development, was embedded in these policy and administrative changes. Conceptually grounded in findings from two national Royal Commissions of Inquiry into Social Security and Social Policy, the reports detail, over time and often in comparison with OECD reference populations, social well-being organized in ten social outcomes domains, including a health domain. Following its first release, the reporting underwent a two-year phase of development, which was marked by careful evaluation (i.e. nation-wide public and stakeholder consultations) and major conceptual and technical improvements. This resulted in governmental commitment to on-going, annual publication of the reports. Since 2003, while retaining the overall conceptual framework, the annual reports have been refined and up-dated, for instance through the further upgrading of social indicator measures and by using new data sources, when those become available. There have been attempts to put some legislative or compulsory reporting into formal government accountability systems around these indicators, but these efforts have been unsuccessful.

In terms of policy impact, the Social Reports have gained some level of prominence in central and local government. For sectoral public agencies, the Social Reports appear to constitute a valuable policy tool to foster intersectoral thinking and joint action on the social determinants across sectors. Senior health officials from the Ministry of Health unanimously agreed that the institution of routine social reports and the content of these reports have assisted in both raising awareness and stimulating action to address the social determinants of health to improve health equity, both within and outside the health sector. However, government agencies concerned with national policies related to economic development and the Treasury made negligible use of the national social reporting, which significantly limited the report’s impact. Amongst civil society actors, the Social Reports have gained a good level of currency, especially amongst health advocacy agencies, health service providers, Māori organizations, academic audiences and the media. However, the Social Reports have not influenced the business sector.

Some key lessons have arisen from the New Zealand experience of social reporting with respect to addressing the social determinants of health and health equity. Firstly, social reports can be successfully used for monitoring social determinants of health and social (including health) equity. To measure within-country equity, social reports ought to present data disaggregated along the “social determinants of health inequity”, whereas in order to account for between-country equity, national level social reports need to include cross-countries comparisons of equity. Social reports need to be published over time, preferably periodically, to assure time-series of social outcomes are available for equity trend analyses. It needs to be ensured that an on-going focus on findings with respect to equity, which have arisen from social reporting, is maintained.

Secondly, social reports can catalyse policy action on the social determinants of health, within and outside the health sector, in government and beyond. They can generate some political will, and action, with respect to addressing the social determinants of health to achieve health equity. Social reports can be used to validate and strengthen a health-sector approach focused on addressing the social determinants, and can enhance intersectoral coordination in support of determinants-based policy-action. For policy actors from civil society that are concerned with health equity, social reports present a good advocacy tool by providing official, authoritative, government-sourced data on health (and social) equity. Social reports can meaningfully be used as a platform to raise awareness of the health outcomes of disadvantaged populations of specific policy interest (i.e. indigenous people). Social reporting extends the health-sector focus on health and well-being to the intersectoral notion of social well-being. Such reporting can also assist in generating national agreement on standard social indicators for national and international benchmarking.

Thirdly, social reports have the potential to inform the evaluation and design of public policy and intervention. They can be used to assess the medium and long-term impact of policy initiatives to reduce social and health inequity. Preferably, social reports explicitly link to policy action and clearly demonstrate the interconnectedness between their individual outcomes domains.

Finally, social reports need to be developed with a number of core process, conceptual and technical considerations in mind. If the public, especially diverse disproportionately burdened populations, have the chance to actively participate in the conceptual development of social reports, and if the reports are transparent with respect to changes made and easily available free of charge, an emphasis on equity in social reports is likely to be strengthened and public debate and up-take of the reports' findings increased. If possible, social reports should be based on positive, as opposed to deficit-based, concepts to enhance up-take, especially from civil society. To be able to guide action towards addressing between-country inequities, country-level social reporting ought to be aligned with international social reporting, i.e. by using internationally standardized social indicators. Only when social reports link their health outcomes findings to accurate research into the cause/effect relationship between social determinants of health, policy actions and health outcomes, conclusions can be drawn with respect to causality. Countries with indigenous populations appear to have the collective need for a distinct set of social indicators that, developed by indigenous people, have the ability to document trends in indigenous people's social (including health) outcomes. It seems advisable to anchor a responsibility to publish social reports in national legislation.

1 Introduction

It has become a widely accepted fact that health and well-being cannot be addressed from within the health sector alone. In other words, a multiplicity of social factors influences the health outcomes of populations. A synthesis of existing theoretical models (Solar & Irwin, 2010) has shown that what we term the “social determinants of health”, hereafter SDH, can be divided up into three distinct blocks: The “socioeconomic and political context” (labor market; education system; social policies; and culture, religion and human rights), describing the “causes of the causes”; the “social determinants of health inequities” (socioeconomic position and social class as expressed through an individual’s or social group’s income, education, occupation, gender and ethnicity); and, finally, the “intermediary factors” (the material circumstances, psychosocial factors, and behavioral and biological factors, as well as the health system and its impact on the distribution of sickness, disability and other consequences like impoverishment from catastrophic expenditures). Social cohesion and social capital act across the two later blocks of determinants to mitigate some of the effects of social stratification or intermediary factors. The SDH influence the distribution of health along the socioeconomic spectrum, causing health inequities, and, as decomposition analysis has evidenced, for many health outcomes the SDH contribute more to health inequities than the entire health system (Hosseinpoor et al., 2006; WHO, 2006, 2007a).

As a consequence, national governments and international health agencies are increasingly becoming aware that no matter whether the goal is to enhance overall health outcomes or to achieve greater health equity, sectors outside the health arena need to be influenced. For health policy-makers this means thinking and working between and across sectors as well as considering the

impact of social factors in the way they design and run their health services and programs. Historic strategies to address the SDH through intersectoral action have been documented (Solar & Irwin, 2006), but there is a need for further international exchange of experiences and sharing of learnings with respect to policy tools, including related institutions, facilitating intersectoral action on the SDH. In the policy context of trying to impact on the determinants of health, it is obvious that monitoring performs a critical function. Across sectors, it can be used to support accountability of different actors who may not form part of the same line ministry or sector impacting on health.

The human rights literature refers to the monitoring function at the national level as including the following mechanisms: (1) administrative, policy, political mechanisms; (2) judicial mechanisms; and (3) national human rights institutions (see the OHCHR/WHO document on “The Right to Health” available online PDF [52p.] at: <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf>). This paper focuses on a somewhat narrower public health and epidemiological definition of “monitoring” by discussing the tracking of quantitative trends and relationships between social and health variables.

The routine analysis of health inequities (monitoring in its narrower sense) has been well-explored on a conceptual level (i.e. Braveman, 2003, 2006; Gakidou, Murray & Frenk, 2000; Sen, 2001) and methodologically (Braveman, 2006; Gakidou, Murray & Frenk, 2000; Harper & Lynch, 2006; Keppel et al., 2005; Manor, Matthews, & Power, 1997; Sen, 2001; Wagstaff, Paci, & van Doorslaer, 1991; Wolfson, & Rowe, 2001). Health equity monitoring enjoys popularity and has become a well-established policy tool in a number of countries. The monitoring of SDH, while still

an emerging approach, is attracting increasing national and international attention. For example, the Basket of Health Inequality Indicators¹ produced by the London Health Observatory covers a significant number of measures on social and economic determinants of health that are available down to local authority-level and also relevant at the local level, both for monitoring and for taking actions. To provide a second example, the Netherlands are introducing a multi-level surveillance system for monitoring health inequalities, targeting with their set of indicators those topics aligned with specific governmental policy objectives (see Case study 16 in Kelly et al., 2007).

The “Social Indicators Movement” has arisen, in some senses, in parallel to efforts for health equity monitoring. It convenes a diverse group of actors that more often have statistical or social welfare backgrounds than “health” backgrounds.

At the international level, the Millennium Development Goals (MDGs) bring together health and social development considerations and provide a tracking system for the “average” levels of several social and health variables. Such an approach of following a number of development indicators at the global level is a major step

forward. However, changes need to be made to add an equity dimension to this important international monitoring instrument, as it is currently possible to achieve the MDGs but make equity worse. At WHO itself the WHO Advisory Committee on Health Statistics and Monitoring (2006) has recommended equity monitoring. This renews efforts towards the institutionalizing of an operational health equity surveillance system from the late 1990s (i.e. Braveman, 1998). Further to this, the *Report of the Commission on Social Determinants of Health* recommends monitoring of SDH both by WHO and the United Nations (UN) system as a whole. After all, countries and the international community can only know about with certainty, and act upon, equity trends, if these are systematically reported.

This paper aims to contribute to the existing scholarship on both social indicators and health equity monitoring through a focus on “how” social reporting it is done in one country. It explores how a tool for reporting on social well-being (“social reporting”) can support a policy agenda aimed at addressing the social determinants of health to improve health equity by conducting a case study of the *New Zealand Social Reports/ te pūrongo oranga tangata* (hereafter the “Social Reports”).

¹ See <http://www.lho.org.uk/>

2 Background

Social reporting has become an established academic and public policy discipline, enjoying a long tradition both nationally and in international settings (e.g. OECD, European Barometer). To contextualize our New Zealand case study, a brief overview of national and international contributions to the "Social Indicator Movement" and recent efforts to establish a system of right to health monitoring and indicators needs to be given.

2.1 The Social Indicator Movement

Mancur Olson has in his well-known definition called a social indicator 'a statistic of direct normative interest which facilitates concise, comprehensive and balanced judgements about the condition of major aspects of a society'. He goes on to say

"It is in all cases a direct measure of welfare and is subject to the interpretation that if it changes in the 'right' direction, while other things remain equal, things have gotten better, or people are 'better off.'"

US Department of Health, Education and Welfare (1968), p97.

Since its birth in the United States of the mid-1960s, for instance with Bauer's (1966) milestone publication *Social Indicators*, and its boom period

in the 1970s, the "Social Indicators Movement" sparked, and maintained up to today, world-wide interest in the public monitoring of social outcomes (Zapf, 2000). A great number of countries have since published national level social reports (see Annex 1 for a list of selected national social reports). Such reporting regimes are often spearheaded by a government's statistics department and vary in structure, depending on the respective administrative needs they serve. To provide examples, the German government has funded an external research agency, the German Social Science Infrastructure Service (GESIS), to develop the science-based German System of Social Indicators¹, which covers 14 social outcomes domains with almost 400 indicators and over 3000 time series since its initiation at the beginning of the 1950s. Another well-documented example is the emergence of the *South Africa Social Indicators* series produced by the Center for Social and Developmental Studies biannually between 1983 and 1998 (Møller, 1997) and Statistics South Africa's utilization of social indicators to report on international goals of development (Udjo, Orkin, & Simelane, 2000).

International organisations and supranational administrations have made a three-fold contribution to the "Social Indicator Movement": Firstly, they have prepared international social reports that monitor social outcomes across their various Member States (see Annex 2 for a list of selected international social reports). For example, the Organisation for Economic Cooperation and Development (OECD) has played a crucial role in recent times by reviving its *Society at a Glance: OECD Social Indicators* publication series (a follow-on from its *Living Conditions in OECD Countries* report published

¹ See http://www.gesis.org/en/social_monitoring/social_indicators/Data/System/index.htm

only once in 1986) since 2001 (OECD, 2001; 2002; 2005; 2006), based on the heavily influential conceptual “OECD Programme of Work on Social Indicators” (OECD, 1982). Secondly, as will be demonstrated below with reference to the work of the UN agencies, international organizations have taken an international coordination role with the major goals being to encourage Member States to develop social reporting regimes at the national level and to offer an on-going technical guidance and support function. Finally, realizing the importance of working towards internationally comparable reporting, international organizations have enhanced the “Social Indicator Movement” significantly on a conceptual and technical level; they have set internationally ratified standards and norms around definitions and measurement of social outcomes domains and social indicators, for instance by compiling social indicator lists.

Within the UN system, social indicator work was often driven by the United Nations Statistics Division (UNSD) and, according to Menozzi (2003) and colleagues (Banda & Menozzi, 2003), has developed in various distinct, yet interrelated phases. The first phase was marked by the publication of a groundbreaking 1954 twin report titled *International definition and measurement of standards and levels of living* (UN, 1954a, b) and, eventually, an interim guide (UN, 1961) which identified specific social indicators aligned under twelve distinct components of social outcomes. The major achievement of this early work was that it advocated a ‘component approach’ (UN, 1954a: 18) to social outcomes, hierarchically ranking the various proposed statistical indicators and, in turn, identifying a selected set of indicators of primary conceptual importance (Menozzi, 2003). In a second phase, inspired by the perceived desirability of establishing a closer link between social and economic statistics, the United Nations Social and Economic Council (ECOSOC) advanced the field by proposing an integrated “System of Social and Demographic Statistics” (UN, 1970). This work, lead by Noble-prize laureate Sir Richard Stone, laid the foundation for the proposal of the UN’ 1975 “Framework for Social Statistics”, which marked the beginning of the third phase of the “Social Indicator Movement” within international organizations and mounted in the publication of preliminary guidelines (1978) and a handbook (1989) on social indicators. This work was driven by the need to develop a more dynamic and flexible approach to social reporting (hence the terminological shift from the more dogmatic “system” to “framework”) which better suited the

needs of all Members States. As another reaction, conceptual framing for social indicators servicing the needs of low- and middle-income countries was provided in 1979 (UN, 1979). A phase of in-house debate about the relationship between social indicators and the overall framework that they were embedded in followed. The core contention was ‘whether indicators should be viewed as outputs of the overall system or whether they should be developed in relation to specific policy needs.’ (Menozzi, 2003: 9) and the Statistical Commission came to the conclusion that ‘a pragmatic approach, oriented towards user needs should have priority, but that co-ordination and improvement of the underlying data should proceed in parallel, and that a detailed overall system was clearly impractical.’ (Menozzi, 2003: 10). As a response, several lists of social indicators have been compiled since, amongst the most prominent of which are principal indicator lists such as the Minimum National Social Data Set (UN, 1996) and the MDGs (UN, 2001). Harmonization and rationalisation of development indicators (including social indicators) across international organizations and across countries has played a major role in recent times (UN, 2000; 2001; 2002), also in the context of the MDGs (UN, 2003). Today, the UNSD remains to report on a range of principal social indicators through its “Social Indicator Programme”², guided by a report summarizing the statistical implications of major UN conferences, especially the World Summit for Social Development (1996).

2.2 Right to health monitoring and indicators

One additional stream of work of the UN provides further context for this case study, namely current efforts to establish a system of right to health indicators. A right to health approach is strongly linked to, and complements, the notion of health equity. Like a social determinants of health approach, it reframes health discourse towards the health of populations as influenced by ‘the social characteristics within which living takes place’ (Tarlov, 1996: 72), as opposed to a narrow focusing on the health of individuals and the individualizing notion of “lifestyle factors”, and emphasizes governments responsibility for the health of all of their citizens, particularly though for disadvantaged individuals and populations. The former Special Rapporteur of the United

² See <http://unstats.un.org/unsd/demographic/products/socind/>

Nations Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health ["the right to health"], Mr Paul Hunt (2004: 58), has stated that 'in addition to the classic human rights methodologies, we need new skills and techniques if we are to engage effectively in policy-making. For example, we need indicators, benchmarks and impact assessments that address the right to health.' For him, right to health indicators can fulfil two central purposes: First, to assist governments in the monitoring of their progressive realization of the international right to health; and second, to act as an accountability measure for governments in relation to their implementation of the right to health (UN, 2006).

The former Special Rapporteur in his term from 2003-2008 advocated and conceptually progressed a system of right to health indicators, arguing in his first interim report to the UN General Assembly that 'what tends to distinguish a right to health indicator from a health indicator is less its substance than (i) its explicit derivation from specific right to health norms; and (ii) the purpose to which it is put, namely right to health monitoring with a view to holding duty-bearers to account.' (UN, 2003: 6). He adds that a system of right to health indicators 'should not only reflect specific right to health norms, but also related human rights provisions, including non-discrimination and equality', emphasizing repeatedly the particular importance of social disaggregation of the indicators in relation to as many of the internationally prohibited grounds of discrimination as possible as a means to reveal, whether or not marginalized individuals and communities are exposed to de facto discrimination (UN, 2006: 7).

In his last enterprise, aimed at developing a manageable set of right to health indicators to assist governments to monitor the implementation of their national, and international, obligation with respect to the right to health, the former Special Rapporteur focused attention on structural-³,

process-⁴ and outcome indicators⁵ (UN, 2006) (the classic framework made popular in health by Donabedian, 1980). Initially he thought of identifying a list of robust rights to health indicators that would then be benchmarked and outcomes monitored along the set targets as a way of identifying whether governments have fulfilled their international obligations with respect to the realization of the right to health (UN, 2003). However, concluding findings from his global consultation, the former Special Rapporteur shifted thinking in his 2006 report, then arguing for a human rights-based approach⁶ to health indicators. According to the former Special Rapporteur,

"A human rights-based approach to health indicators is not a radical departure from existing indicator methodologies. Rather, it uses many commonly used health indicators, adapts them so far as necessary (e.g. by requiring disaggregation), and adds some new indicators to monitor issues (e.g. participation and accountability) that otherwise tend to be neglected. In short, a human rights-based approach to health indicators reinforces, enhances and supplements commonly used indicators."

UN (2006), p8

³ 'Structural indicators address whether or not key structures and mechanisms that are necessary for, or conducive to, the realization of the right to health, are in place. They are often (but not always) framed as a question generating a yes/no answer. For example, they may address: the ratification of international treaties that include the right to health; the adoption of national laws and policies that expressly promote and protect the right to health; or the existence of basic institutional mechanisms that facilitate the realization of the right to health, including regulatory agencies.' (United Nations, 2006: 15)

⁴ 'Process indicators measure programmes, activities and interventions. They measure, as it were, governments' effort. For example, the following are process indicators: the proportion of births attended by skilled health personnel; the number of facilities per 500,000 population providing basic obstetric care; the percentage of pregnant women counselled and tested for HIV; the percentage of people provided with health information on maternal and newborn care, family planning services and sexually transmitted infections; the number of training programmes and public campaigns on sexual and reproductive health rights organized by a national human rights institution in the last five years. Such process indicators can help to predict health outcomes.' (United Nations, 2006: 15)

⁵ 'Outcome indicators measure the impact of programmes, activities and interventions on health status and related issues. Outcome indicators include maternal mortality, child mortality, HIV prevalence rates, and the percentage of women who know about contraceptive methods.' (United Nations, 2006: 15)

⁶ The Special Rapporteur explains: 'Very briefly, in general terms a human rights-based approach requires that special attention be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these – and other features of a human rights-based approach – is to empower disadvantaged individuals and communities.' (United Nations, 2006: 7)

3 Methodology

Drawing on the case of New Zealand, this study aims to investigate the overarching research question of how monitoring social well-being can support a policy agenda aimed at addressing the social determinants of health to improve health equity.

TO ANSWER THIS QUESTION, THE CASE STUDY AIMS AT FOUR KEY OBJECTIVES:

- To document the pre-history, establishment and refinement of the *Social Reports* with a particular emphasis on the associated political climates and motivations and, as part of this historical analysis, to explore the Social Report's embedding in broader policy initiative addressing the SDH. Findings of this aspect of the analysis are reported in the section titled *The political history of the Social Reports*.
- To evaluate the *Social Report's* impact on public policy by assessing the reports' currency in government, especially the public health policy sector, and their acceptability as progress markers in broader society. Findings from this aspect of the analysis are reported in the section titled *An assessment of the Social Reports' policy impact*.
- To describe innovative process, content and technical features of New Zealand's social reporting scheme, with an emphasis on exploring their contribution to supporting policies concerned with addressing the SDH. Findings from this aspect of the analysis are reported in the section titled *Innovative features of the Social Reports*.
- To synthesize the findings by describing *Key lessons learnt*.

To fulfil these objectives, a range of white papers and secondary, academic texts were collected and analysed: All *Social Reports* were studied in their entirety (content; technical aspects; form); the analysis of the reports informed all four aspects of the study. Secondary academic literature on the *Social Reports*, sourced through a standard university library search and using the Google Scholar databases, informed all aspects of the study. Finally, national white papers and media statements mentioning the New Zealand's *Social Reports* were sourced through the national Te Puna Web Directory; this data was particularly useful with regards to contextualizing the policy impact evaluation of the *Social Reports*, and thereby informing the aspects three and four of the analysis.

In addition, given the lack of previous academic work in this area, key-informant interviews were conducted to assess the currency of New Zealand's *Social Reports* in government (objective three). Semi-structured, face-to-face key-informant interviews of between 45 minutes and 90 minutes duration were conducted in Wellington, New Zealand, with five senior policy-makers from the Ministries of Health (three informants) and Social Development (two informants) between February and April 2008. Interviews were audio-taped and transcribed. Key-informants were selected on the basis of holding central decision-making roles in the establishment and on-going development of the *Social Reports*, and the reports' health domain respectively. For each key-informant an individual question catalogue was designed to cover the respective informant's area of expertise optimally. In this way, the key-informants' institutional knowledge about the political contexts and motivations surrounding the establishment and development of the *Social*

Reports could optimally be sourced, informing various aspects of the case study (especially objectives two and three). However, the main aim of the key-informant interviews was to assess the *Social Reports'* currency in government from the perspectives of the Ministries of Health and Social Development.

To assess how the *Social Reports* are affecting other social actors outside the health and social development arena a brief e-mail survey was developed (see Annex 3). A 9-item questionnaire assessed various dimensions of interest. Two questionnaire versions were sent via e-mail to an overall number of 32 informants in May 2008. The first questionnaire was tailored to the needs of participants from the community, health, social and local/regional government sector (sent to 23 participants); the alternative questionnaire addressed health planners and funders, The Treasury, The Ministry of Economic Development and the business community (sent to nine participants). The sending of the questionnaire was preceded by an e-mail providing introductory information about the purpose of the case study, and the function of the e-mail survey.

Informants were identified on advice of the previously interviewed key-informant policy-makers from the Ministries of Health and Social Development and drawn to represent a cross-section of New Zealand society in terms of the community sector (iwi/tribal authorities; organizations representing urban Māori interests; Pacific Island communities; Asian communities; people living with a disability); the health sector (health service providers; health advocacy agencies; public health researchers); the social services sector (social and welfare service providers; social policy researchers); local government (city - and regional councils); and the economic sector (The Treasury; Ministry of Economic Development; business roundtables; chambers of commerce). All participants held senior roles within their organisations, with the great majority of them acting at the chief executive level. The majority of participants represented national organizations. However, representatives of regional and local organisations were selected with a view on achieving equal geographical spread throughout New Zealand. Twenty-four informants completed the e-mail survey.



4 Findings

4.1 New Zealand's Social Reports [<http://www.socialreport.msd.govt.nz/>]

New Zealand relies on several public instruments for health equity monitoring in the sense of reporting on trends, supported in parallel by the work of academics with an interest in health equity (i.e. the Health Inequalities Research Programme based at the Wellington School of Medicine, Otago University). Centrally, the Ministry of Health has set up an advanced system to monitor health equity outcomes, amongst other means through the New Zealand Health Monitor (NZHM), placing particular emphasis on the disproportionate health burden experienced by the indigenous Māori and minority ethnic Pacific Island populations. The *Decades of Disparities* reports (Blakely et al., 2004; Ministry of Health, 2003; Ministry of Health & University of Otago, 2006), for instance, have fulfilled an important function with respect to monitoring disparities in mortality between these ethnic groups of interest as well as socio-economic stratification of mortality. The *Social Reports* complement this established national monitoring work, adding to their reporting of diverse social, including health, outcomes disparities a measure of a range of other sectors of relevance to health, which reflect several of the key SDH.

The lead agency for New Zealand's social reporting scheme is the Ministry of Social Development¹, one of the country's largest public departments and carrying responsibility for a government vote of over NZ\$16 billion. The service arm of the ministry administers social services to more than one million New Zealanders; the policy arm embodied in the Social Development Policy and

Knowledge Branch carries out the country's social policy development, research, and evaluation, covering the areas of income support, child, youth and family as well as community development.

Since 2001, the Ministry of Social Development has released a series of seven annual reports, the *Social Reports* which assess social well-being and quality of life along ten discrete social outcomes domains, namely *Health; Knowledge & Skills; Paid Work; Economic Standard of Living; Civil & Political Rights; Cultural Identity; Leisure & Recreation; Physical Environment; Safety; and Social Connectedness* (see Annex 4 for a list of the social outcomes domains, their desired outcomes statements and the respective social indicators). The reports now follow a standard format: A *Foreword* from the issuing Minister of Social Development is followed by the *Chief Executive's Preface*. Then follows an *Introduction*, which outlines the purpose of the *Social Reports*, conceptually defines social well-being, comments on the selection of social indicators, reflects on social disaggregation of the presented data, informs on updates to indicators, describes the structure of the report, and informs the reader about future developments of relevance to the report. The next section of the *Social Reports*, which is titled *People*, analyses trends of key demographic measures, i.e. population size and growth, ethnic composition, migration, age and sex structure of the population, and household information. Forming the core of the reports, ten sections (one per social outcomes domain,) follow, reporting on trends as measured through social indicators.

Each section of the report covering a social outcome domain is preceded by a statement summarizing the respective domain's desired overall social outcome, followed by a definition of the domain's leading concepts. After that, each indicator function is

¹ See www.msd.govt.nz

defined, its relevance is explained, the indicator's current status and trend over time described, and New Zealand outcomes compared internationally with selected OECD countries. If meaningful, and given that the required data is available, outcome measures are presented disaggregated by ethnicity, sex, age, disability status and geographic location. The *Conclusion* synthesizes and integrates findings from the previous sections, reporting changes in social outcomes for New Zealanders over the longer term, sometimes with a thematic focus. The report is completed by a user-friendly tabulated summary of findings which provides snapshot-type comments about the essence of changes in social well-being.

Disaggregation by social stratifiers in the 2006 Social Report

The 2006 report, for instance, drew together data sets from the early 1980s in order to provide a picture of how the social conditions of New Zealanders today compare with conditions before the national neo-liberal economic reforms of the 1980s and 1990s. It also compares New Zealanders' social well-being with that of people living in Australia and in reference to outcomes in the OECD countries and features changes in social outcomes over time by sex and ethnicity (Maori, Pacific peoples, Asian and Other ethnic groups relative to the New Zealand European population). Here, short statements, visually highlighted, give the reader a quick summary impression of changes over time for each social outcomes domain (i.e. when comparing by sex: 'Men generally have better Paid Work outcomes than women, though the gap has narrowed' or 'Although female Health outcomes are generally better, the gap is closing').

4.2 The political history of the Social Reports

The *Social Reports* as they are today have arisen from a confluence of changes in New Zealand's political ideology at the turn of the millennium, associated shifts in the organization of public administration as well as related social science movements in New Zealand and, to some degree, internationally. In order to provide a comprehensive historical overview, we discuss this history in terms of three phases: three building momentum; establishment; and refinement.

4.2.1 Building momentum

Following international trends, the 1970s in New Zealand were a period of striving interest in and public investigation of conceptually defining, as well as measuring, social well-being. The first national milestone that was achieved in this respect was the 1972 report of the Royal Commission on Social Security (also called the "McCarthy Commission"), which comprehensively defined what social well-being meant for New Zealanders. Following on from and adopting the Commission's approach, the Social Development Council, set up in 1971 in the Department of Social Welfare, developed and published in its 1974 report a set of eight social objectives centred on the goal of increased social well-being and quality of life, but founded in the desire for greater equality in opportunities for all.

At the same time, the Council urged the Government to establish a social indicator system to fulfil a social outcomes monitoring function. The Government responded by setting up as part of the national Department of Statistics the Social Indicator Unit in 1976, which developed an interim list of social indicators (Department of Statistics, 1978; updated in 1980) in alignment with the social goals defined by the Social Development Council and social indicator sets developed by the OECD. In collaboration with the National Commission for UNESCO², which provided a link to international social indicator work, the Department of Statistics convened in 1979 the two-day *Workshop on Social Indicators for Development*, aiming to review progress in the construction and application of social indicators. Informed also by findings from an unpublished 1974 report from the Planning Advisory Group on Social Statistics and the Department of Statistics' *Social Trends in New Zealand* document (1977), this effort culminated in the proposal of a collection of key indicators organized in the eight subject domains put forward by the Social Development Council in 1979 (Cant, Hill & Watson). In 1988, the Royal Commission on Social Policy updated definitions of social well-being and re-iterated earlier calls for a thorough national reporting regime.

In parallel to these official movements, geographers inspired by a national surge of interest in "social area analysis" showed an interest in social well-

² This commission acted on behalf of the SDC, the Department of Statistics, the NZ Planning Council, the National Research Advisory Council and other government departments and agencies.

being indicators for rural and urban geographic areas, calling them “territorial indicators” and eventually developing maps and indices of such indicators from Census New Zealand data (Crothers, 2006). A parallel stream of social indicator work was initiated by the Social Monitoring Group of the New Zealand Social Planning Council (1985; 1989) and, after the council’s abolishment in 1992, upheld by Victoria University’s Institute of Social Policy (Davey, 1993; 1998; 2003). Divergent in its approach, this series of social reports titled *Tracking Social Change in New Zealand: From Birth to Death* organized social outcomes along several life-stages, and critical life events respectively (for a detailed review of this reporting regime see Davey, 2000).

After this progress had been achieved up to the 1970s, so argues Corthers (2006), national work regarding social indicators went into recession due to broader political and international developments. In the early 1980s a dramatic shift in economic policy took place in New Zealand. Known as “Rogernomics”, a portmanteau of “Roger” for New Zealand’s former Labour Finance Minister Roger Douglas appointed in 1984, and “economics”. This reform shifted the national economy rapidly from Keynesianism to a neo-liberalist paradigm. Centred on the introduction of free-market policy to the exclusion of many regulatory functions of government these economic changes, that were introduced by the Labour Party and strengthened following a change to a National Party government in the 90s, included privatization of public assets, state-control of inflation, cutting of agricultural subsidies, and abolishment of former trade barriers. As has since been well-documented, such changes caused an increase in health and social inequities, indicated for example by a widening

of disparities in mortality (Ministry of Health, 2003) and socio-economic resourcing (Ministry of Health & University of Otago, 2006) between the indigenous Māori, as well as New Zealand-based Pacific Island minority populations, and non-Māori, non-Pacific New Zealanders during the 1980 and 1990s. Some commentators accused the governments during these administrative periods of ‘actively endeavouring to suppress any systematic information about the social consequences of its economic policies’ (Crothers, 2006: 3). At the same time, economic and financing monitoring systems were strengthened to the point that they became anchored in national legislation, for example with the passing of the 1994 Fiscal Responsibility Act³, which obliges The Treasury to publish immediately before an election a full account of Government finances.

4.2.2 Establishing the Social Reports

When the Labour Party administration took office in 1999, a Cabinet Committee called “Closing the Gaps”, chaired by the Prime Minister Hon Helen Clark and overseen by the Department of the Prime Minister and Cabinet, was established to coordinate a whole/all-of-government initiative to address the economic, health and social inequities that Māori and Pacific people experienced. Government departments, including the Ministry of Health and The Treasury, were required to report regularly to the Committee on initiatives being led by the ministries and work of the different sectors relating to the “Closing the Gaps” agenda. This led to standard reporting of such initiatives in many public reports since 2001 and to sectoral policy alignment with

³ While repealed in 2005, the 2004 Public Finance Amendment Act incorporated the same provision

Supporting the Reducing Inequalities in Health Strategy

Within the Ministry of Health, efforts to level the disparities in mortality and morbidity between Māori, Pacific Islanders and non-Māori, non-Pacific New Zealanders were jointly led by the directorates of Public Health (including the Pacific Health Branch) and Māori Health. After public debate about whether the “Closing the Gaps” initiative disadvantaged non-Māori, non-Pacific New Zealanders, the Cabinet Committee was renamed the “The Social Inequalities Cabinet Committee” and chaired, as well as reporting (Minister of Social Development and Employment, 2003a; 2003b), shifted from the Prime Minister to the Minister of Social Development and Employment, Hon Steve Maharey, in 2003. In line with these changes, the work of the Cabinet Committee was eventually transferred to the Ministry of Social Development, which has maintained its coordinating role to-date, including convening the Reducing Inequalities Officials Committee (RIOCI)¹. Since then, the mandate to set up reducing inequalities initiatives has returned to the powers of the respective ministries.

¹ See <http://www.msdc.govt.nz/work-areas/cross-sectoral-work/reducing-inequalities.html>

this overarching strategic goal. For example, looking back on a long tradition of focusing on the reduction of health inequities (Matheson, 2007), the Ministry of Health (2002a) published its *Reducing Inequalities in Health Strategy* in 2002. This policy document emphasized ministry understanding that health outcomes disparities were caused by the unequal distribution of the SDH.

Alongside this broader government initiative to achieve a higher degree of economic and social equity, renewed public interest in national social indicator development resurfaced again in New Zealand in 2000. Besides the publication of a key article compiling fundamental data sources for social reporting in the *New Zealand Journal of Social Policy* (Crothers, 2000), a trip by then Minister of Social Development and Employment, Hon Steve Maharey, to the United Kingdom of Britain inspired this progress (Crothers, 2006). During his overseas visit the Minister had been impressed by the British government's "Opportunity for All" poverty-reduction scheme, especially the scheme's targeted goals and, upon return to New Zealand, instructed his ministry to, within a very short period of a few months, develop a set of social indicators that could monitor targets for social achievements desired by the New Zealand government (Crothers, 2006). Hence, the Ministry of Social Development, created by the Government in October 2001, which in its core strategic function had a broad cross-sectoral social policy role, successfully put forward the proposal to lead the development of a social reporting scheme based on its Social Development Strategy (*Pathways to Opportunities*; Ministry of Social Development, 2001a).

Organizing the Social Reports

The Cabinet, as well as government agencies and civil society groups (Ministry of Social Development, 2002a), saw the Ministry of Social Development as the preferable lead agency for the monitoring of social indicators in spite of the fact that the national Statistics Department (Statistics New Zealand) is armed with the constitutional protection to publish independently from political processes, because Statistics New Zealand, according to officials from the Ministry of Social Development, was reluctant to define social well-being and to make more normative judgments. The Strategic Social Policy function within the Ministry of Social Development, the lead agent pressing for the social reporting scheme, had been

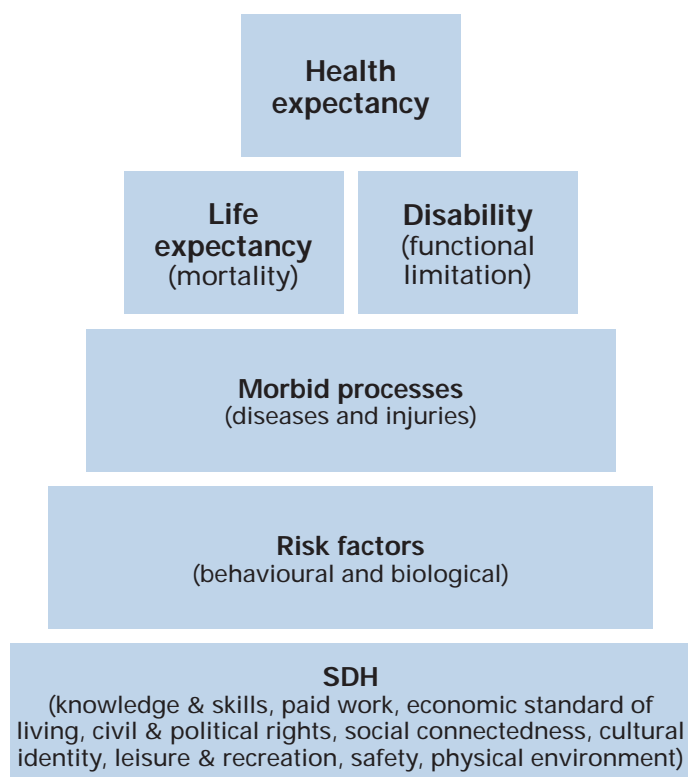
set up in the form of a task force to directly mirror the Treasury group, the Cross-Sector Strategy Group, which had previously influenced strategic social policy issues. Supported by the ministry's Knowledge Management Branch and a small reference group of social science academics and other researchers, the Strategic Social Policy task force rapidly developed, in collaboration with a broad range of 30 government departments, a set of key outcomes and social indicators. Returning conceptually to the foundations set by the 1972 and 1988 Royal Commissions, but in addition drawing on internationally ratified conventions (i.e. human rights conventions) and incorporating the most recent national and international research as to what constitutes social well-being, this work formed the basis of the first New Zealand *Social Report*.

One major breakthrough was to involve a range of other government departments to assist with the development of those indicators of interest to them. This assured not only a greater sense of ownership, and up-take, of the reports across government, but also that the proposed eight domains were populated with an optimal array of indicators chosen by experts from the respective sector. Importantly, Te Puni Kōkiri, the Ministry of Māori Affairs, was also involved throughout all steps of the development of the reporting framework.

The health domain of the Social Reports

The process underpinning the development of the *Health* domain involved the Ministry of Social Development approaching the Ministry of Health to request them to lead the development of the health indicators. The ministry agreed to take on this task and set up an advisory group consisting of representatives mainly from the Public Health and Māori Health Directorates and the Public Health Intelligence Unit. In alignment with the ministry's overall strategic approach, the advisory group developed, and proposed to the Ministry of Social Development, a pyramidal framework covering the relevant outcomes indicators (see Figure 1): health expectancy (operationalised as *independent life expectancy*) was conceptualized as the peak summary measure of population health as it integrates mortality (fatal or quantity of life dimension) with disability (functional limitation or quality of life dimension). This was broken down into its two components - *life expectancy* as a measure of the length of life (premature mortality)

Figure 1. Pyramidal framework covering outcomes indicators for the Social Reports' Health domain as proposed to the Ministry of Social Development by the advisory group assembled by the Ministry of Health



Source: Dr. Martin Tobias, Ministry of Health

and *disability requiring assistance* as a measure of quality of life (functional limitation). On the next level down were the morbid processes (disease and injury processes, i.e. *cancer, cardiac disorders, oral disease, mental disease, injury*) which produce the fatal and nonfatal outcomes on the higher level. On the fourth level of the pyramid were the behavioral and biological risk and protective factors that are the proximal causes of the morbid processes (operationalized for instance through indicators assessing *diet, physical activity, obesity, cigarette smoking, and alcohol use*). The SDH, which determine risk exposure, comprised the foundation level of the conceptual framework and were covered by the other seven outcomes domains of the *Social Report*.

The indicator model was presented to and discussed with the Ministry of Social Development and external academic expert committees specifically called by the Ministry of Health. A major constraint imposed by the Ministry of

Social Development was the limited number of indicators allowed per domain (initially no more than five indicators; later the number increased to six). Two top level indicators (*independent life expectancy; life expectancy*) were undisputed, and it was decided unanimously that disability status would be treated as a non-health specific variable and reported on throughout all outcomes domains rather than restricting it exclusively to the *Health* domain. However, debate was centered on the selection of measures indicating morbidity and risk factor indicators, eventually settling on *suicide* as a proxy for mental health status and two indicator measures from the risk level of the pyramid, namely *cigarette smoking* and *obesity*. In this debate, the Ministry of Social Development advocated for behavioral measures, whereas health officials had expressed their preference for morbidity indicators, acknowledging that the risks, which deficit-thinking can induce for instance in the form of victim-blaming, needed to be avoided. This was seen as particularly relevant

for the reporting of behavioral indicators such as *obesity* and *cigarette smoking*, which was especially problematic when reporting indigenous versus non-indigenous inequalities. However, there was agreement over the fact that the danger that using deficit-based, behavioral indicators posed could be managed, for instance by assuring contextualizing of outcomes inequities as the result of political and systemic pressures on populations as opposed to the result of lifestyle choices of individuals. Using positive, visionary and inspiring language in the *Social Report* texts was also seen as counteracting deficit-model thinking.

4.2.3 Refining the Social Reports

Although the Minister of Social Development promoted the 2001 *Social Report* prototype, as a first step towards the establishment of a regular national social reporting scheme, the frequency of the reporting was not determined from the start. Hence, the launch of the first *Social Report*, which attracted major public and media attention, was followed by a two-year trial period, in which the Ministry of Social Development aimed to assess the feasibility of publishing the *Social Reports* on an annual basis. The second *Social Report* was released in 2002 (Ministry of Social Development, 2002b), accompanied by the initiation of the *Social Report* website⁴ making the free-access reports available on-line. However, no changes were made to the domains and indicators: the second report was a simple online update of the first *Social Report*.

Consultations in compiling the second *Social Report*

In the course of compiling the second *Social Report*, the ministry with the help of an independent reviewer conducted an extensive nation-wide review seeking to evaluate the usefulness of the initiated social reporting scheme. This assessment encompassed several rounds of public and stakeholder consultations, including with various community groups, non-governmental organizations, academics, urban Māori groups and three iwi/tribes (Kai Tahu, Te Arawa and Tainui), Pacific peoples, trade unions and business people, as well as consultation with representatives from central, regional and local government, including members of parliament. The ministry summarized findings from the consultations in an official review paper, which pointed out that 'Support for the existence of a social indicators

report was virtually universal with those consulted commending its cross-sectoral, holistic approach, its simplicity and breadth and its ability to be used by a wide audience.

"They [the public and stakeholders] liked the fact that the report collected information from a range of sources and on a variety of topics, and appreciated the report's neutrality, its impartial view and its aim to be politically independent."

Ministry of Social Development (2002a), p1.

Nevertheless, the review paper also identified three overarching critiques that had been voiced in relation to the reporting scheme, namely: (1) 'the need for it to be linked to action and policy; (2) the need for the report to continue and concern over its vulnerability; and (3) the need for it to include or be linked to regional information.'

Maori views in the consultation process

The consulted Māori groups were generally positive about the fact that the *Social Reports* conceptualized well-being in a broad and holistic way, an approach which aligns well with aspects of Māori models of health (Durie, 1984; 1985; Pere, 1984) and associated Māori health development (Durie, 1998) and health promotion approaches (Durie, 1999). On the other hand, Māori voiced a range of concerns. Firstly, they wanted to see a strengthening the *Social Reports* influence in policy-making to avoid them becoming 'yet another report highlighting poor outcomes for Māori without leading to anything being done about them' (Ministry of Social Development, 2002a: 12). Secondly, pointing towards the (then draft) United Nations Declaration on the Rights of Indigenous Peoples as useful reference material to inform the *Social Reports*, several Māori groups felt concerned about the lacking prominence of the 1840 Te Tiriti o Waitangi/The Treaty of Waitangi⁵ in the 2001 report prototype. Indeed, they wanted to see the treaty included as an overarching

⁴ See <http://www.socialreport.msd.govt.nz/>

⁵ Te Tiriti o Waitangi/The Treaty of Waitangi is a treaty signed on 6 February 1840 by representatives of Māori chiefs from the North Island of New Zealand and the British Crown. It is considered the founding document of New Zealand. For more information see www.treatyofwaitangi.govt.nz and <http://www.waitangi-tribunal.govt.nz/treaty/>

framework to assure acknowledgement of the treaty-partnership between Māori and the Crown. Third, Māori expressed the desire for indicators measuring positive aspects of Māori life (i.e. the strength of whānau/Māori families) to be included in the *Social Reports* in order to balance out indicators highlighting poor outcomes.

Māori stakeholders also critically questioned why the reports did excluded Māori-specific health indicators (Ministry of Social Development, 2002a: 47).

International momentum on indigenous people's health and measurement

As indigenous people's health increasingly gains global priority, a conceptual framework for measuring indigenous people's social and health outcomes has been proposed (Marks, Cargo & Daniel, 2007). Indigenous scholars, lead by Dr Janet Smylie, University of Saskatchewan, Canada (co-principal investigators: Dr. Suzanne Crengle, University of Auckland, New Zealand, and Dr. Ian Anderson, University of Melbourne, Australia), have joined forces to investigate 'Action oriented indicators of health and health systems development for indigenous peoples in Australia, Canada, and New Zealand'. This research has culminated in various topical papers (Anderson, Anderson et al., 2006; Anderson, Smylie et al., 2006; Smylie et al., 2006), including a background paper on Māori health indicators (Ratima et al., 2006). Ratima et al.'s paper points out that 'Māori have repeatedly expressed concerns that while universal health indicators are important, they are limited in their capacity to capture the state of Māori health according to Māori concepts of health (Durie 1994; Pomare, Keefe-Ormsby et al. 1995). Others (Smylie et al., 2006) (2006: 2029) acknowledge furthermore that the Ministry of Health's (2002b) *He Korowai Oranga- Māori Health Strategy* framework provides a valuable model for achieving a balance of universal and indigenous-specific health indicators, given that it 'can recognise both universal indicators of health such as mortality and disability, and Māori-specific indicators such as social determinants, secure cultural identity, and control over one's destiny.' The authors of the same paper stress also that 'The development of He Korowai Oranga included consultation meetings and written submission as methods of gaining Māori input' (Smylie et al., 2006: 2029).

One specific example of the gap that is created by the lack of Māori-specific health indicators is that the *Social Reports* can, for this reason, not capture the communitarian dimensions of Māori constructions of health as prioritized in the *He Korowai Oranga- Māori Health Strategy* through the overarching aim of achieving "whānau ora" (the health of Māori families)⁶.

⁶ 'He Korowai Oranga asks the health and disability sectors to recognise the interdependence of people, that health and well-being are influenced and affected by the 'collective' as well as the individual, and the importance of working with people in their social contexts, not just with their physical symptoms.' (Ministry of Health, 2002b: 1). This notion is epitomized in the strategy's overarching aim of achieving 'whānau ora' / the health of Māori families. The strategic document gives the following definition of whānau: 'Whānau (kuia, koroua, pakeke, rangatahi and tamariki) is recognised as the foundation of Māori society. As a principal source of strength, support, security and identity, whānau plays a central role in the well-being of Māori individually and collectively. The use of the term whānau in this document is not limited to traditional

Moving ahead following the consultations

Despite some concerns, the consultations showed that overall the social reporting scheme was viewed as a step in the right direction, and had found broad support. The decision was made by government to commit to long-term, annual reporting, even though annual reporting was opposed by all or almost all contributing government agencies, who argued that not only was it impossible to update most indicators annually, but that social change proceeds slowly and looking at year-on-year changes could be meaningless, if not actually misleading. However, with the integration of the obtained feedback in the 2003 Social Report (Ministry of Social Development, 2003), the reporting scheme entered into a phase of substantiation and technical refinement.

In 2003, the *People* section, detailing demographic trend information, was introduced, and, in reaction to feedback obtained in the consultation rounds, three of the social outcomes domains were renamed to better and unambiguously reflect their core meaning (*Civil & Political Rights* instead of *Human Rights*; *Cultural Identity* instead of *Culture & Identity*; *Physical Environment* instead of *Environment*)⁷. In addition, certain standard practices were established: firstly to refine and improve indicators in each report, if new data sets had become available or better measures had been developed, and secondly to describe in detail all conceptual changes made in the new report in an appendix, in effect providing a high level of transparency of conceptual and technical changes. Also, as a result of the 2002 consultations (Ministry of Social Development, 2002a), the last major

definitions but recognises the wide diversity of families represented within Māori communities. It is up to each whānau and each individual to define for themselves who their whānau is.' (Ministry of Health, 2002b: 1)

Key desired outcomes for the goal of 'whānau ora' are that

'whānau experience physical, spiritual, mental and emotional health and have control over their own destinies

- whānau members live longer and enjoy a better quality of life

- whānau members (including those with disabilities) participate in te ao Māori and wider New Zealand society.' (Ministry of Health, 2002b: 1)

⁷ The 2003 (Ministry of Social Development: p. 138) report provides following explanation for the re-naming of the respective three outcomes domains:

'For The Social Report 2003, civil and political rights replaces human rights as a desired social outcome. The more specific notion of civil and political rights excludes economic, social, and cultural rights. These were included under the heading of human rights in the earlier report. We have done this because the protection of economic, social and cultural rights is already covered in the social report by the desired social outcomes relating to health, paid work, knowledge and skills, economic standard of living, and cultural identity. Including these outcomes again in a human rights domain just creates unnecessary duplication.

The culture and identity domain from 2001 has been replaced by a cultural identity domain. We received feedback the 2001 domain was confusing as to whether culture referred to arts and heritage or to identity and belonging. The 2003 desired social outcome focuses explicitly on the contribution cultural identity and a sense of belonging make to social well-being.

Physical environment replaces the environment domain for The Social Report 2003. The new physical environment domain focuses on the contribution to social well-being of both the natural and built environments.'

change to the overall reporting structure came one year later, when a new outcomes domain (*Leisure and Recreation*) was added, bringing the number of outcome domains to ten altogether and increasing the number of indicators from 38 to 43 (Ministry of Social Development, 2004).

Since these changes were instigated, reports (Ministry of Social Development, 2005a; 2006a; 2007a) have maintained the 2004 format. Each reporting cycle commences with the Ministry of Social Development holding meetings with all contributing agencies (about 40 government departments), in which the situation and performance of the previous *Social Report* is critically discussed and assessed. On top of this internal evaluation process, the ministry envisages that every five to ten years an external review is commissioned, similar to the comprehensive, national consultation meetings held in 2002. Employing this process, the *Social Reports* are able to dynamically respond to feedback, and adapt to contemporary national policy needs.

One noteworthy addition to the national *Social Reports* was the introduction of the *Regional Indicators* reports since 2005 (Ministry of Social Development, 2005b; 2006b; 2007b). These documents disaggregate national data to the regional and Territorial Authority-level, visually mapping how social well-being varies across New Zealand, ranking outcomes by shading regions along a color spectrum from best to worst. Individual regional booklets, downloadable from the *Social Reports* webpage, provide further geographical break-downs of the regional data, including decomposition by ethnicity, sex and age. These additions support decision-making at the regional and local level, responding to local and regional policy needs that have arisen from legislative change (e.g. the passing of the 2002 Local Government Act, which, for instance, vests responsibility for the health and social needs of communities residing within their boundaries to local and regional government, including District Health Boards), but also servicing requests from civil society groups for geographic disaggregation of social outcomes.

Possible threats to sustainability

Although the reports have now entered a phase in which, following testing, a firm reporting framework has emerged, a critical issue is that social reporting has not been enshrined in national legislation. This is despite the Ministry of Social Development having investigated the desirability

of the drafting of a Social Responsibility Act with the function to constitutionally ground social reporting (Ministry of Social Development, 2002a), mirroring the provisions made for economic reporting under the 1994 Fiscal Responsibility Act. However, some interests claimed that introducing such legislation would equate to "political correctness" (Crothers, 2006), and the act was never put before Cabinet. In effect, this means that, given the *Social Reports* are ministry-based, they could be abolished by future governments.

Posing another potential threat for the continued existence of the *Social Reports*, policy changes have emerged recently which challenge the *Social Reports'* significant interface with broader all-of-government initiatives to reduce inequalities. Government has navigated toward having four overarching themes ("Building national identity"; "Families, young and old"; "Transforming the economy"; and "Sustainable New Zealand"). Health policy staff shared the perception that the whole-of-government agenda on reducing inequalities had lost influence and thought that the Ministry of Social Development has, to some degree, bundled the social inequalities agenda into the *Social Reports*, which still carries on its monitoring. Ironically, this move coincides with the release of official reports indicating, with regards to health outcomes, a narrowing of the inequalities between Māori and Pacific people on the one hand and non-Māori non-Pacific New Zealanders on the other (Blakely et al., 2007) which can be interpreted as providing medium-term evidence for the success of health policy initiatives in this arena implemented over the last nine years.

One option for future of the Social Reports was to develop a mathematical model, which could proxy and predict social development in a more summarized, compressed form, using all the relevant indicators. However, the challenge is to generate inter-sectoral indicators, for which very few models exist to-date. For this endeavour, a health-centric approach might prove pivotal given the high level of information available about health outcomes and how they are influenced by other sectors through the SDH.

4.3 An assessment of the Social Reports' policy impact

When the *Social Report* was first mooted, it was hoped that its assessment would become as socially

relevant as gross domestic product (GDP), i.e. the nation would use social indicators in assessing “how well we are doing”.

The *Social Reports* list the following four key policy functions (reprinted in every *Social Report*, for example Ministry of Social Development, 2007a: 5):

- ❶ **‘to provide and monitor over time measures of well-being and quality of life that complement existing economic and environmental indicators’.** Besides providing an account of the level of New Zealanders’ social well-being over time, the Social Reports also make apparent how population groups of particular policy interest (i.e. the indigenous Māori population; ethnic minority populations, especially Pacific people; low socio-economic strata; women; the elderly; the disabled) are faring.
- ❷ **‘to compare New Zealand with other countries on measures of well-being’.** Detailed comparisons with the upper and lower quintile of OECD countries, plus neighbouring Australia, were seen as providing important context to national social outcomes and as strengthening the government’s accountability with respect to between-country equity.
- ❸ **‘to provide greater transparency in government and to contribute to better informed public debate’.** Given its commitment to evidence-based policy-making and New Zealand’s recent social policy renaissance, the ministry also saw a need for the *Social Reports* to be established as a public record assuring the government’s accountability in the social policy arena.
- ❹ **‘to help identify key issues and areas where we need to take action, which can in turn help with planning and decision making’.** The *Social Reports* were envisaged to assist government with the identification of adverse social trends at an early stage, in turn supporting the formulation of further research needs and the design of policy solutions. However, the reports were designed with the belief that they would not always be able to illuminate the drivers of these trends, because of the multiplicity and cross-cutting nature of national and international factors impacting on New Zealander’s social well-being. In line with

this approach, the reports were also not seen to function as an evaluation tool for the effectiveness of specific public policies, but instead for broader government direction.

An additional function, while not explicitly noted in the report, is the role that the *Social Reports* were expected to serve with respect to the monitoring of social equity. Indicative of this function, issuing Ministers of Social Development, on the basis of the reports’ findings, commented on equity in social outcomes in their introductions to the reports. In 2002: ‘the disparity between groups within the population in terms of their standard of living and their health and educational outcomes remains relatively high’ (Ministry of Social Development, 2002b: 1); in 2003: ‘a third cross-cutting issue is the need to address continuing inequalities and high level of disadvantage in Māori and Pacific communities’ (Ministry of Social Development, 2003: 7); in 2006: ‘although there are still disparities between Europeans and other ethnicities, the report shows real gains for these other groups.’ (Ministry of Social Development, 2006a: 1).

These various functions were underpinned by the government’s overarching vision of an equitable, fair, socially inclusive, prosperous and environmentally sustainable society that embraces diversity and is based on the value of equality of opportunity (Ministry of Social Development, 2001). An assessment of the currency of the reports in government, especially also the economic sector, and beyond is helpful in considering the usefulness of developing such reports for policy-makers.

4.3.1 Currency in government

The *Social Reports* have gained some level of currency within central and local government, mostly in intersectoral and less so in sectoral public agencies. To bring together a great number of government institutions to develop the social reporting framework jointly and then produce annual *Social Reports*, has been a good strategy that helped to achieve the report’s current level of prominence and application.

At the highest level of policy-making, at the Cabinet, the *Social Reports* have played the role of bringing social conditions together into one picture and increasing visibility (thereby working

towards an understanding of social well-being in the same way but not to the same extent that economists have made visible economic well-being). Besides the 43 indicators from the *Social Reports*, about a dozen or so well-established economic measures (i.e. *Gross Domestic Product*, *Unemployment rates*, *Cash rates*) and maybe another dozen key indicators around sustainability, mainly the environment, have significant currency in today's policy environment. When all of these indicators need to be considered together is when the *Social Reports* become most useful. However, at this level of policy-making the weakness of the reports is that the ten outcomes domains are still siloed and that there exists a lack of information about the explicit, direct conceptual cross-links.

Cabinet ministers

Cabinet ministers, above all the Minister of Social Development, have used the reports as a platform to reflect on the causes of improvements in the nation's social well-being, for instance expressing the opinion in 2004 that 'recent government policies have made an important contribution to these improvements' (Ministry of Social Development, 2004: 3), but also on behalf of the government thanking non-governmental organizations in the latest report for their contribution to the observed improvements in social outcomes over time (Ministry of Social Development, 2007a). Similarly, talking about better support for low-income families through the introduction of income-related rents, the Minister of Social Development stated in 2005 that 'it is exciting to see these policies beginning to pay dividends' (Ministry of Social Development, 2005a: 3). In these instances, the minister used findings from the *Social Reports* as an evaluative measure for public policy, although it is questionable whether outcomes described in the report can really be linked to policy, especially specific policy initiatives, in the short term.

The Ministry of Social Development

Within the Ministry of Social Development, the *Social Reports* have achieved a good level of currency and application. One key function that they have taken on in this ministry is to serve as an overall guide for the monitoring of New Zealand's whole/all-of-government "Reducing Inequalities" policy initiative. The responsibility for this initiative had shifted to the Ministry of Social Development after Cabinet agreed to a

work program for this initiative (Chair of the Cabinet Social Development Committee, 2004) in 2004, which specifically aimed for improved coordination of policy across agencies. To fulfill its monitoring mandate within this policy framework, the ministry published a document summarizing trends of social well-being disparities for Māori and Pacific populations, providing absolute and relative outcomes measures and tabulating them together with those respective government policy initiatives expected to reduce the outcomes disparities (Strategic Social Policy Group, 2004). This work effectively aligned the whole/all-of-government initiative with the social monitoring regime, even structuring the reporting according to the *Social Reports*' well-being domains (see Strategic Social Policy Group, 2004). However, this reporting has not been repeated since 2004, maybe due to a weakening of the reducing inequalities agenda within government as mentioned earlier with reference to the four overarching themes ("Building national identity"; "Families, young and old"; "Transforming the economy"; and "Sustainable New Zealand"). Although, this trend has been observed elsewhere, e.g. South Australia, and does not necessarily indicate a reduced role for health and SDH. In the South Australia example, a health-in-all-policies strategic approach was employed to connect health equity and SDH issues to the *South Australia Development Plan* (ref. <http://www.health.sa.gov.au/pehs/publications/public-health-bulletin.htm#2008>).

Statistics New Zealand

The national Statistics Department, Statistics New Zealand, also made use of the *Social Reports* in a similar way, namely by applying the outcomes domains and indicators used in the *Social Reports* for monitoring of the social aspects of New Zealand's Sustainable Development Program on (Statistics New Zealand, 2002a). Moreover, Statistics New Zealand officially acknowledged the Social Report as a prominent source of national information on social capital (Statistics New Zealand, 2002b).

The Ministry of Health

Within the Ministry of Health, policy application of the *Social Reports* was moderate. The health domain indicators reported in the *Social Reports* were of limited use for national health policy-makers, because national health information systems provided a much higher level of detail and analysis, but for some ministry staff the reports

acted as reference documents for health-relevant data across a wide range of sectors (i.e. health, social services, education and justice). Nevertheless, of much more importance for ministry staff was the signal function that the reports carried. For health policy-makers they confirm a holistic, determinants-based, intersectoral approach to policy-making, which has been promoted by the health sector for some time. That another agency (Ministry of Social Development) took ownership of, and promoted to other government agencies, such a determinants-based approach received Ministry of Health endorsement. Ministry of Health staff also argued in favor of the *Social Reports* that they increased the understanding of other public agencies with respect to how their initiatives impact on other sector's outcomes (i.e. health). The *Social Reports* were also attributed an important function in terms of raising awareness of the SDH and they were viewed as useful tools for health officials to influence others sectors towards also adopting a determinants-approach. The report was also seen as an important step to raising awareness of government officials to the root causes of outcomes inequities, disrupting a sole focus on outcomes disparities alone.

The Treasury

Whereas the Treasury had participated significantly in the development of the *Social Reports* due to its general involvement in social policy lead by its Cross-sector Strategy Group, it has backed off social policy issues over the last years, refocusing on its core duties after the abolishment of its cross-sectoral policy function. For the Treasury, the *Social Reports* are one of a range of information sources analysts access, but are not part of The Treasury's strategic planning process.

The Treasury raised a range of concerns with respect to the *Social Reports*, arguing firstly that the data was sometimes difficult to interpret and some measures were not specific enough for policy purposes (e.g. The Treasury questioned what information the *participation in cultural and arts activities* indicator provide about quality of life).

The Treasury also argued secondly that where there are trends in different direction, the diversity of data makes it difficult to interpret (e.g. in the 2007 report the number of workplace injury claims per 1000 had declined between 2001 and 2005, but over the period 1977 to 2003 the number of people who are obese roughly doubled. The Treasury was not sure whether to interpret this overall as an improvement

or not.). A third issue raised was that data in the *Social Reports* does not cover the same time periods (sometimes more than 3 years out of date), making it harder to identify overarching trends. For The Treasury, fourthly, the presented data does not give the full policy picture in the area of concern (e.g. data on school leavers by ethnicity (Ministry of Social Development, 2007: 37) shows increases in all ethnicities achieving the National Certificate of Educational Achievement (NCEA) level 2; but a vital element of the overall picture is missed unless the *increase* in the number of Māori boys leaving with no qualifications is also noted). Finally, The Treasury was concerned about the quality of data being mixed, arguing that, for instance, the figures for early *childhood education participation* (Ministry of Social Development, 2007 : 34) are in no way as robust as for instance *NCEA level 2 achievement rates* given on the next page.

In line with one of its earlier official papers (Petrie, 2002), The Treasury expressed strong support for the development of consistent policy indicators and thought that, to that extent, the *Social Reports* were an important step towards the proper evaluation of the impact of social policy. In addition, for The Treasury the *Social Reports* did not achieve, and are unlikely ever to achieve, the same currency as gross domestic product (GDP) as a measure of overall well-being, arguing that GDP is clearly defined and has a clear relationship to well-being. The measures in the *Social Reports*, in contrast, were perceived as more ambiguous: Outside of the "economic" measures, such as *unemployment rate*, it was not clear for The Treasury how the measures in the *Social Reports* added together to offer more information on the overall well-being of New Zealanders. The Treasury expressed the need for deeper assessment of how policies impact on key indicators so judgments on cross-sector policy can be made. The department saw as the greatest value of the *Social Reports* that they create an opportunity for formalizing the use of indicators and developing a more systematic tool for assessing the impact of social policy. In other words, the Treasury saw the *Social Reports* as a method of better budget accountability.

The Ministry of Economic Development

Similarly to The Treasury, a senior official from the Ministry of Economic Development confirmed that the ministry has made minor to no use of the reports to-date. However, policy-makers from other ministries saw the Treasury and the

Ministry of Economic Development as in dire need of broad-level, summarized, cross-sectoral policy information on social development and believed that the *Social Reports* should constitute a key document for these government agencies. In conclusion, the failed engagement of The Treasury and the Ministry of Economic Development with the *Social Reports* needs to be critically highlighted. It seems that The Treasury and the Ministry of Economic Development's interests in the Social Report should grow, if these departments were aware that well distributed economic gain leads to improved health outcomes, leads to improved economic performance.

Local and regional government

Local and regional councils make moderate use of the *Social Reports* mostly to support their strategic development (i.e. to inform their 10 year Long Term Council Community Plans (LTCCP)). The publication of the *Regional Indicator Reports*, despite failing to provide a break-down to local authority-level, found wide approval and increased the use of the *Social Reports* amongst these users. One application of the *Social Reports* was to brief councilors about their communities' social outcomes by reference to these authoritative statistics. The *Social Reports* had here raised awareness to social inequities. The Chief Executive Officer of a District Council, for instance, stated that the *Social Reports* were used by the council to focus interventions on the biggest outcomes inequalities, both within New Zealand (by comparing regional outcomes) and internationally (by reference to the comparisons of New Zealand social outcomes with those of other countries). As a result of such an approach the council had addressed worse regional outcomes with respect to roads, water and sewerage infrastructure and investment. The Chief Executive Officer of a District Council, for instance, stated that the *Social Reports* were used by the council to focus interventions on the biggest outcomes inequalities,

"... as a .. result of such an approach the council had addressed worse regional outcomes with respect to roads, water and sewerage infrastructure and investment".

District Health Boards

Amongst planners and funders from District Health Boards the *Social Reports* are used, although often to a limited extent, as a reference document, to inform service planning and needs assessments, particularly in the context of local partnerships and community outcomes. One District Health Board Planning and Funding Division reported had integrated the reports as part of a 'toolkit' of reference resources used on a standard basis for planning and funding, but the division pointed out that the *Social Reports* present a compilation of secondary data source only, while the District Health Board will usually return to the primary data sources for in-depth analysis.

Two over-riding concerns expressed by policy makers were:

- ❶ the perceived disjunct between what is reported on and how this is transferred into decisions and the evaluation of policy development and interventions (this may be linked to the lack of a clear conceptual framework on social domains, cause and effect); and
- ❷ there was a sense that a lack of ownership and accountability for the different domains hindered the reports' policy impact (in other words, a mapping of social outcomes to interventions and ministries responsible for these interventions needed to take place).

4.3.2 Currency "beyond government"

The *Social Reports* have been used beyond government, achieving varying degrees of currency and up-take either as a strategic planning tool, for advocacy purposes or to provide statistical contexts in grass-roots community organizations, iwi authorities and other Māori groups, health advocacy agencies, health and social service providers, amongst public policy and public health academics and other researchers, and the media. But they have not found traction within the business sector.

Grass-roots organizations

Many informants shared the opinion that the *Social Reports* have been a useful stimulus for civil society groups and have generated significant

public debate and discussion about the causes of social inequalities.

Many informants identified community-focused organizations as the sites, where the *Social Reports* had major currency. However, while grass-roots organizations were generally satisfied with the *Social Reports*, only some used the reports, mostly to access reference information on social well-being. Some community agencies highlighted information needs that they wanted the *Social Reports* to fill with respect to their particular communities. For instance, one community organization assembling disabled people argued that the *Social Reports* made a derisively small use of data on disability, despite data being available for disaggregation for many indicators. According to the community organization, disabled people wanted to use data that reflects themselves as part of New Zealand society, and find little use in documents that effectively exclude them in discussion about it. While stating support for systematic monitoring of the use of Te Reo Māori/ the Māori language, the organization perceived the omission of measures on New Zealand sign language (one of three official languages) needed to also be addressed in future reports. However, community-run social and health services, if they knew of the reports, often welcomed the *Social Reports*, but lacked time and staff resource to make significant use of the reports beyond for ad-hoc statistical reference.

Māori organizations, also widely regarded as prime audiences and users of the *Social Reports*, had made some use of the social reporting, but proposed improvements be made to enhance the reports' applicability. One iwi/tribal authority, which had utilized the *Social Reports* to inform the production of a socio economic and health profile of its iwi/tribe, argued that opportunities for users to request data specific to their needs would increase the currency of the *Social Reports* highly among tribal bodies, explaining that as an iwi authority they needed iwi-specific data to enable planning and being responsive to the social needs of their tribal members.

This may be pointing to a different type of service rather than a report - it may report to a more live question and answer, or on-line, service to respond to information needs on social well-being. The

report was seen as not assisting the iwi body in this manner. However, there was overall support for social reporting.

Academia and researchers

A number of academics and researchers in the field of public health and public policy have supported the development of the *Social Reports* first-hand, and, amongst academics working in this field, there seems to be unanimous support for the existence and role of the *Social Reports*. Many academics working in relevant disciplines regularly use the *Social Reports* as resources for their teaching and writing.

One researcher based in a church-affiliated social service argued that social statistics always had to be fought for and that they, hence, needed continuous airspace in order to generate public will to tackle social issues, including equity concerns.

Public health advocacy agencies

Support for the *Social Reports* was strong amongst public health advocacy agencies, and the reports have achieved a high level of currency amongst these policy actors. These non-governmental organizations reported using the *Social Reports* to inform a range of advocacy activities. A public health association, for instance, uses the *Social Reports* regularly as a credible source of authoritative, official information on the social determinants of health. In its advocacy roles, the association routinely draws on information arising from the *Social Reports*, i.e. when it seeks to influence the SDH at the local and central government level and as a reference source for submissions to Parliament, in the first instance using information from the *Social Reports* to argue for health impact assessment of significant government policies such as those involved in budget commitments. Importantly, the association also utilized the information to inform its position statements, which form the basis for their articles, media releases and media interviews. Given that health advocacy agencies generally grounded their work in a determinants-approach and endeavored to improve health equity, they did not use the *Social Reports* to inform their strategic planning, but rather as a solid foundation for their advocacy work or, in other words, to raise equity concerns in the wider community as a way to mobilize popular and political support for action on inequities

documented in the reports. Generally, public health advocacy agencies expressed a preference for government-sourced information about SDH that, while not necessarily accurate, was seen as well peer-reviewed and as having the additional benefit of reducing the disputes about the source and quality of data, which is often used as an excuse for action by politicians. Some agencies wanted to see more equity and determinants indicators to be included in the *Social Reports* on a standard basis. In summary, *Social Reports* are widely used and are highly valued amongst health advocacy groups.

The media

The release of the *Social Reports* has received a high level of media coverage every year, reflecting on findings from the reports as much

as politically fuelled by accompanying media statements released by the ministry or the issuing minister. This mainstream media coverage of the *Social Reports* has an awareness-raising function, facilitating public debate on the pinpointed social issues.

The business sector

The business sector represented by business roundtables and chambers of commerce was generally not aware of the existence of the *Social Reports* and expressed little interest in this governmental reporting series due to the business sector being of the opinion that the reports lacked any application for businesses. This unsuccessful engagement of the business sector in the *Social Reports* significantly limits the reports' impact.



5 Innovative features of the Social Reports

The *Social Reports* have a number of defining features, which reflect some of the country's learning in the context of national monitoring of the social determinants of population health and well-being. Although an expression of a nationally determined need for action in this area and, as described in the previous section, a product of historic developments somewhat unique to New Zealand, these features carry significant lessons regarding innovations and adaptations for countries who may be considering establishing or adapting a social reporting scheme.

This section identifies eight of these features in more detail:

- 1 Assuring civil society participation, transparency and accessibility
- 2 Monitoring the SDH
- 3 Monitoring equity in the *Social Reports* by (1) socially disaggregating data and (2) using good diagrammatic tools
- 4 Using social reporting to foster intersectoral action
- 5 Broadening understandings of health
- 6 Highlighting strengths and policy opportunity
- 7 Developing social indicators in societies with indigenous populations
- 8 Securing on-going, regular social reporting

5.1 Assuring civil society participation, transparency and accessibility

Civil society groups, especially disadvantaged populations and their advocates, play a significant role in putting health equity concerns on the public policy agenda; not only do these political

actors have insider knowledge about their own situation and solutions to the challenges they face in achieving health equity, but in democratic societies they also have the power to hold consecutive governments accountable for strategic decisions and their effects.

The Ministry of Social Development has aimed to assure civil society participation in the development of the *Social Reports* through various means. Conceptually, the *Social Reports* were grounded in national documents defining how New Zealanders understood social well-being. This knowledge had resulted from two national Royal Commissions inquiries (Royal Commission on Social Security, 1972; Royal Commission on Social Policy, 1988), which were based on major public consultations held in the early 1970s and late 1980s. Furthermore, civil society input was sought in a formal round of nation-wide public consultations, including with indigenous stakeholder groups, after the release of the first *Social Report* in 2002. The consultations were facilitated and findings of it reported by an independent consultant (Ministry of Social Development, 2002a). Thematically, these public consultations grounded, and re-assessed respectively, the *Social Reports*' conceptual make-up, in their core investigating how accurately the reports reflected the contemporary values and aspirations of New Zealanders with regards to social outcomes. The consultations, however, also provided a platform for wider public discourse about the usefulness and function of public social reporting in New Zealand.

As part of a broader Government commitment to 'making the public service more open to the public' (Ministry of Social Development, 2003: 7), for the issuing Minister of Social Development 'Social reporting also plays a role in promoting an open and transparent government' (Ministry

of Social Development, 2003: 3). In consequence, in addition to standard reporting of social outcomes, the *Social Reports* detail both relevant political affairs and motivations (in the *Ministerial Foreword* of each report) and conceptual and technical developments of the reports (often footnoted throughout the report, but concentrated in the reports' appendices). The often very detailed technical descriptions target the level of information required by statisticians and quantitative researchers for expert evaluation of the report's quality and the validity of the measures used, and at the same time help to effectively manage the amount of statistical detail provided in the main text.

This high level of process information about what motivates changes to the Social Reports and the thorough documentation of the conceptual and technical changes to the reports have created a publicly transparent reporting series. Besides ministerial directive, a couple of other factors, have contributed to securing the *Social Reports'* transparency: Firstly, given that the reporting scheme is an attempt to establish a nationally and internationally unique monitoring system, desired by national social scientists and social policy-makers for some time, it is not surprising that the writers of the report wanted to document the steps taken carefully. In effect, such detailed documentation allows third parties to conduct independent process evaluations of the ministry-led reporting. Secondly, the fact that this initiative is located within and spearheaded by the Ministry of Social Development with its various responsibilities in the social sector and its accountabilities to various often highly politicized civil society groups explains a high level of transparency. Considering that the relatively recently created ministry is under constant scrutiny by politicians, government departments and diverse civil society groups, it is not surprising that transparency is high.

In addition, easy public access to official reports needs to be guaranteed, when civil society participation in policy-making is desired. Given that New Zealand is a country with high rates of internet use and literacy, public access to the *Social Reports* is on a basic level facilitated by assuring that reports can be downloaded online and are open-access from a special homepage hosted by the Ministry of Social Development's webpage. Hard copies of the *Social Reports* (and the *Regional*

Social Indicator Reports) can be ordered from the Ministry of Social Development free of charge and access to the raw data can also be obtained for external analysis without costs.

However, access could be further improved, so argue some users of the reports, if all collated data was to be made available online for 'data drill' (i.e. housing data available online with users able to search by specific geographic area, ethnicity, age, socio-economic status and gender). For diverse health outcomes (i.e. communicable and non-communicable diseases), risk behaviours, health systems variables, population groups and various SDH such information is currently already provided through the Ministry of Health's Public Health Intelligence PHIOne internet resource¹. This alternative tool for the visualization of health and related information makes freely available for users online, interactive atlases with linked tables and charts that allow data to be viewed in multiple dimensions and broken down to District Health Board (DHB) and Territorial Authority (TA) level. It combines national health survey data, hospitalisations and disease registrations as well as risk behaviour data and data related to one of the ministry's core strategic approaches, the Healthy Eating Healthy Action (HEHA)² framework that aims for the improvement of nutrition, increase of physical activity and achievement of healthy weight for all New Zealanders. This health information tool elegantly highlights health inequities and the unequal spread of health-relevant socioeconomic resources.

5.2 Monitoring the SDH

As described in more detail above, in its pyramidal indicator framework developed for the *Social Reports* (see Figure 1), the Ministry of Health conceptualised health outcomes (at the level of mortality and morbidity) as mediated by risk behaviours which, in turn, were seen as mediated by the SDH. For the ministry, the SDH hence mark the most fundamental level of the health indicator pyramid. The ministry was of the opinion that the SDH were assessed by the nine other social outcomes domains reported in the *Social Reports*, in effect conceptually linking health domain indicators with the other social indicators

¹ See <http://www.phionline.moh.govt.nz/>

² See <http://www.moh.govt.nz/healthyeatinghealthyaction>

assembled in various outcomes domains under a determinants-approach.

However, statistically, the size or level of the relationship has not been attributed, although it could be in a rough way from the existing literature. Hence, New Zealand's *Social Reports* can be used to document changes in social outcomes only, but can not describe any cause/effect relationship between SDH and diverse health outcomes. Such causal links could convincingly be established in social reporting, however, when reports reference research that has provided authoritative evidence for the respective causal link between a health outcome (e.g. obesity) and another social factor measured in the social report (e.g. income). Similarly, looking to the future the indicator report needs to more closely link the relationship between individual domains (e.g. the *Health* and *Economic Standard of Living* domains).

5.3 Monitoring social equity in the Social Reports

Besides standard monitoring of overall social outcomes, surveillance of equity in social outcomes, both within countries and across countries, is also a key function of many social reports. Only such social reports that monitor within-country inequities equip policy-makers with guidance as to which population groups ought to be prioritized and receive targeted policy provision to improve overall outcomes and increase equity. In order to fulfil this equity monitoring function, the *Social Reports* carefully disaggregate social outcomes along various social dimensions of interest (e.g. the "Social Determinants of Health Inequities"; see Solar & Irwin, 2010) and, on a more pragmatic level, use innovative, state-of-the-art diagrammatic representations of the findings that offer easily understandable and interpretable policy references.

Surveillance of between-country equity is also not uncommon in national level social reporting schemes. In the case of New Zealand, the *Social Reports* are closely linked with efforts of the OECD, comparing New Zealand outcomes with the outcomes of the medium and upper quartile of outcomes of OECD States, and often with neighboring Australia. This provides policy-makers with guidance as to which social outcomes New Zealand needs to improve on.

Disaggregating social outcomes

Disaggregation of social outcomes makes inequalities between different population groups evident. Without such social disaggregation, social reports are unable to facilitate policy attention to the fact that health (and other social) resources are generally concentrated amongst the privileged, while the burden of ill-health disproportionately affects diverse marginalized and disadvantaged social groupings. The *Social Reports* place major emphasis on disaggregation of social outcomes and since 2005 reports contain a separate section within the *Introduction*, which discusses the key issues related to data disaggregation in the report. This information guides readers in their understanding of the importance of social disaggregation and highlights the current data restrictions in this respect. The 2004 report explains:

" Ideally, each indicator used in the report would be able to be broken down by subpopulations of interest, such as age, sex, ethnicity, socio-economic status, disability status, and region. In the cases of age, sex and ethnicity (subject to the caveat below), most indicators can be disaggregated. The majority of the indicators rely on data sources that do not allow us to disaggregate by socio-economic status, disability status, and region, because either they do not collect this type of information, or because they are based on sample sizes too small to permit disaggregation" .

Ministry of Social Development (2004), p9.

While alerting to these data limitations, the report refers to alternative government sources of information about specific disadvantaged sub-populations, effectively directing the interested audience.

One strong push to present disaggregated data originates from legislative changes. For instance, as postulated by local government and civil society

Measuring ethnicity

Major inequities between different ethnic groups (especially between the indigenous Māori and the non-Māori group), and state obligations arising from the signing of the 1840 Te Tiriti o Waitangi/The Treaty of Waitangi, has generated a strong interest in ethnicity as a determinant of health and other social outcomes. In the *Social Reports*, ethnicity break-downs of social well-being are presented for three different ethnic groups or clusters of ethnic groups: relative to New Zealand Europeans; these are the indigenous Māori; Pacific peoples (a conglomerate of populations originating from diverse Pacific Island States); and members of the 'Other' ethnic group (basically anybody who identifies as non-Māori, non-Pacific and non-New Zealand European). Of course, data disaggregation is only possible, if the required demographic data is collected reliably.

Certainly, great national effort has gone into improving information systems with respect to the collection of ethnicity data in New Zealand. For example, the Ministry of Health has taken significant steps to assure that health and disability service providers collect ethnicity data in a standardized fashion, assuring a high quality of such data. Of central importance in this context is the chosen definition of ethnicity¹, because it requires health service clients to self-identify their ethnic affiliation or affiliations. The release of the ministry's protocols about ethnicity data collection in 2004 has been a further important advance to assure standardized collection across the health and disability sector (Ministry of Health, 2004). These protocols are grounded in the national Statistics Department's definition of ethnicity (Department of Statistics, 1988), assuring consistency (and hence data comparability) across all government departments with regards to the collection of ethnicity data (Ministry of Health, 2004). This joint effort has made it possible for government to robustly monitor ethnic inequities. Māori groups, including Māori academics, activists and government workers, have been a driving force behind the advancement of ethnicity data collection. For instance, Te Puni Kōkiri/ The Ministry of Māori Affairs has published a discussion paper that reflects on and provides leadership and guidance with regards to the measurement of Māori ethnic identity (Kukutai, 2003).

¹ According to the Ministry of Health (2004: 5) protocols for the standard collection of ethnicity data for health and people with disabilities describe ethnicity as follows:

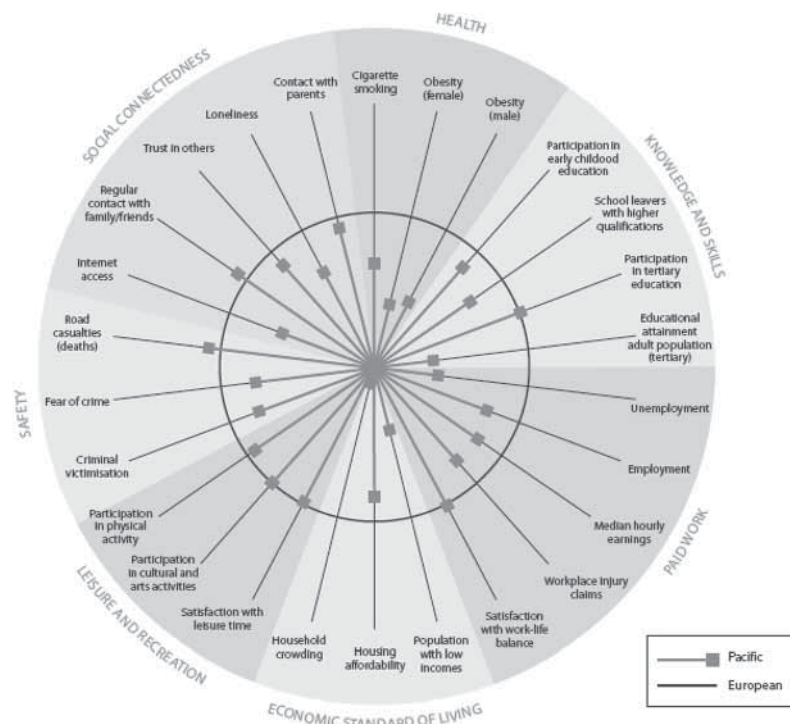
- Ethnicity is self-perceived so the person concerned should identify their ethnic affiliation wherever feasible.
- A person can belong to more than one ethnic group.
- The ethnicities with which a person identifies can change over time.⁷

groups (Ministry of Social Development, 2002a), the *Social Reports* have responded to a growing demand for regional and local-authority level breakdowns of social outcomes necessitated by the introduction of the 2002 Local Government Act (Ministry of Social Development, 2007). This act made local and regional councils responsible and accountable for previously more centralized issues, including shared responsibility for the public health portfolio. In consequence, the *Social Reports* profile differences at regional and local-authority level since 2006 in annual companion documents to the *Social Reports*, the *Social Report Regional Indicators* (Ministry of Social Development, 2005b; 2006b; 2007b), for whichever indicator sub-national data is available. This secures local and regional government agencies and civil society equal access to findings of social well-being outcomes catered to their specific planning needs. In terms of the health system, this local and regional-level information on the distribution of social well-being is well-suited for the regionally

operating District Health Boards, by statute responsible for the health of the populations residing within their boundaries. These boards often host the regional public health units and maintain strong links with local and regional Māori and Pacific health service providers and the recently set up Primary Health Organizations.

However, the current disaggregation practices of the *Social Reports* encounter some limitations, which are more difficult to address: Firstly, analyses by social groupings only highlight differences in sub-group averages, but do not sufficiently account for intra-group variations. A second limitation is that, while the reports provide break-downs of indicators by various determinants, they fail to monitor outcomes of some socially disadvantaged populations, i.e. Asian populations, refugee communities, sexual minorities and transgendered people, likely because these populations are elusive and often not identified in official surveys and due to the difficulty of estimating statistics for

Figure 2. Diagrammatic comparison of selected indicators of social well-being for Pacific Peoples, relative to New Zealand Europeans, 2004-2006, 2007 Social Report



Interpreting "Social wellbeing for Pacific peoples, relative to Europeans"

The circle ○ represents average outcomes for Europeans. The spokes —■ represent average outcomes for Pacific peoples. Where a spoke falls outside the circle, the outcome for Pacific peoples is better than for Europeans. The further the spoke is from the circle, the better the outcome for Pacific peoples relative to Europeans. Where a spoke falls inside the circle, the outcome for Pacific peoples is worse than for Europeans. There are, however, some important limitations on this style of presentation. In particular, we cannot directly compare the size of changes for different indicators. Where possible, the data represents three-yearly averages. Most of the data is from 2004–2006 except for obesity (2003), participation in cultural and arts activities (2002), assault mortality (2002–2004), road deaths (2002–2004) and contact with parents (2001).

Figure 3. Summary of findings from the Health domain, 2007 Social Report

Summary of indicators

Indicators	Current level of updated indicators (most recent year) and the change from the previous result ☺ better ☹ same ☹ worse ⓧ not updated ⊖ not comparable	Longer term change	Variation within the population	Comparison with the OECD
HEALTH				
Health expectancy	⊖ Males 64.8 years Females 68.5 years (2001)	Improved for females	Lower for males and Māori	No comparison available
Life expectancy	☺ Males 77.9 years Females 81.9 years (2004–2006)	Improved, faster for males than females	Lower for males, Māori and those living in deprived areas	Average for both males and females
Suicide	☹ 13.1 deaths per 100,000 (three-year moving average age-standardised rate for all ages, 2002–2004) Youth 15–24 years, 17.7 deaths per 100,000 (three-year moving average 2002–2004)	Improved since 1998	Suicide deaths higher for males, youth, young adults and Māori; attempted suicide higher for females	Average for all ages, poor for youth
Cigarette smoking	☺ 24 percent of population aged 15–64 years (age-standardised rate 2006)	Improved to 1991, steady since	Higher rates among young people, Māori, Pacific peoples and those living in deprived areas	Good for males, poor for females
Obesity	⊖ 21 percent of population 15+ years (2003) 10 percent of children 5–14 years (2002)	Prevalence of obesity doubled between 1989 and 2003	Higher for Pacific peoples, Māori, and females in deprived areas	Poor

small populations. A third important limitation of the current disaggregation format is that it does not provide break-downs by tribal areas. Health officials were of the opinion that the *Social Reports* were best placed to measure social outcomes for Māori against non-Māori which was seen as monitoring the government's commitment to its citizens. According to the same source, the reports should not be used to monitor iwi/tribes on the social outcomes of iwi/tribe members, because this could potentially result in comparison of who are good iwi/tribes and who are bad iwi/tribes. Iwi/tribal authorities, on the other hand, expressed the wish that such information be made available in the *Social Reports* to inform their strategic planning purposes³.

Besides disaggregating the outcomes of each social indicator as appropriate and possible, given data availability, the *Social Reports* also add in their *Conclusions* further equity analyses, often exploring trends of social outcomes of a particular population of policy interest. A mapping exercise showed that since 2003 *Social Reports* have provided *Conclusions* discussing results for disaggregated data: for ethnicity (Ministry of Social Development, 2003, 2004, 2005a, 2006a, 2007a), sex (Ministry of Social Development, 2003, 2004, 2005a, 2006a, 2007a), age (Ministry of Social Development, 2003, 2004, 2005a), geographic location (Ministry of Social Development, 2004, 2005a), and socio-economic status (Ministry of Social Development, 2004). Where historical data is available, the *Social Reports* present previously unavailable time series information, often tracing trends over a 30-year period. Stating that time trend analysis is not possible for all indicators, the reports also alert the reader at the same time to the fact that definitions and associated measurement of some social constructs (i.e. ethnicity) are subject to changes over time, hence challenging comparability of findings and the validity of some trend analyses. However, time trend analyses provide most useful medium-term to long-term policy evaluation measures, enhancing the applicability and usefulness of the reports.

Using good diagrammatic tools

Presenting data in a visually pleasing and simple, yet succinct form and in a summary format is another important step, if the aim is to enhance policy-makers', as well as civil society and non-

expert, up-take of social reports. With respect to providing equity analysis, two diagrammatic features of the *Social Reports* deserve being highlighted.

Firstly, Rae Diagrams are used throughout the reports, generally to summarize outcomes of a certain social grouping relative to another. An additional is that each diagram is accompanied by a box which guides the reader in the interpretation of the diagram and, if necessary, alerts to data limitations and weaknesses of the diagrammatic representation. One example is the diagramming of social well-being outcomes for Pacific peoples relative to New Zealand Europeans between the years 2004 and 2006, which is replicated in Figure 2. Overall, these diagrams are good tools for making social outcomes inequities between two groups visible, in a summary form and in a one-page format. On the other hand, one of the problems with the Rae Diagrams has been the incomparability of extent of change across indicators, which has led to some misinterpretation by stakeholders.

A second noteworthy feature is the tabulated summary of findings at the end of each report, which contains not only current outcomes, long term changes and an international comparison per indicator, but also explicates trends in health equity or, as it is called in the *Social Reports*, "variations within the general population". This table makes available snapshot-type summary comments about the essence of changes in social well-being and presents a valuable tool for policy. Figure 3 presents an example for the short summary of findings in the 2007 report's health domain.

Between-country comparisons

The *Social Reports* compare New Zealand's social well-being internationally with Australia and the median and upper quartile outcomes of the OECD countries, hence providing measures of between-country inequities, which allow New Zealanders to assess how they fare in comparison to neighbouring Australians and the citizens from other high-income countries. As a policy tool, these international comparisons are of importance because they allow policy-makers to gain contextual understanding and set priorities to address inequities at the international level. Some civil society groups have expressed the wish for comparisons with more countries than Australia to be made available as part of the *Social Reports*. These international comparisons were seen as fulfilling an important facilitation role with respect to equity advocacy.

³ Statistics New Zealand compiles *Iwi Profiles* for iwi/tribes upon request including some social statistics (refer <http://www.stats.govt.nz/census/about-2006-census/iwi-profiles.aspx>)

The usefulness of the *Social Reports* could be enhanced further if not only overall social outcomes were compared with other countries, but if the reports added standard assessment of comparative within-country health equity. This move would facilitate greater, more layered understanding with respect to how national health equity outcomes compare internationally.

5.4 Using social reporting to foster intersectoral action

In the first *Social Report*, the issuing Minister of Social Development acknowledged that for many years governments had generally received disjointed advice on social policy and that different sectors had worked in silo rather than in an integrated and collaborative fashion (Ministry of Social Development, 2001). In New Zealand the Ministry of Social Development has taken on the leading role with regards to intersectoral social policy advice and intervention. In fact, the *Social Reports* have been an intersectoral endeavour from the start. In strategic terms, intersectoral collaboration on the *Social Reports* is likely to have enhanced a sense of ownership and the application of the report findings amongst participating government agencies. The social monitoring system then has the potential to encourage not only joint intersectoral action, but, on a second impact trajectory, to also gain entry into and influence over sectoral policy. The Minister of Social Development explains social policy as embedded within the policy of other public policy arenas as follows:

“This means not making an artificial distinction between economic, social and environmental policy. For policies in all these areas are about building a better society, for now and into the future. We need to recognise these inter-relationships. A well performing economy and a healthy environment are critical for delivering a fairer society. A fairer society is one of the important preconditions for a more prosperous economy and a sustainably used environment”.

Ministry of Social Development (2005), p5.

As described in the section on the *Social Report's* policy impact, it can be concluded that the *Social*

Reports, although still an establishing monitoring framework, have indeed been successful in fulfilling the Minister's original intentions; they have started to assist a higher level of coordination amongst social policy initiatives, which interface with public policy from several sectors.

5.5 Broadening understandings of health and health determinants

By monitoring various social, including cultural, dimensions and determinants of health, social reports present the opportunity to contribute towards the establishment of broader and more holistic conceptualizations of health in public policy. For Ministry of Health staff, the *Social Reports* affirmed and supported national population-health based policy-making by taking a determinants-approach focused on the social factors that influence health and other social outcomes, which, in turn, is well-aligned with health promotion approaches. Especially given that it was led by another government agency, this approach was seen as counter-acting in-house pressures to focus more exclusively on the reduction of disease.

Of particular importance in this respect are indigenous conceptions of health, because they present a compelling case for the necessity to extend western, individualized, medical models of health to also incorporate spiritual and cultural well-being of communities (Awofeso, 2005). Māori health models, e.g. Durie's 1984 “Te Whare Tapa Wha” and Pere's 1984 “Te Wheke” models, conceptualise health in a holistic fashion by explaining health as influenced by the spiritual realm, the psychological sphere, the physical body and the extended family and wider community. Such Māori health models, and associated Māori health promotion model (e.g. “Te Pae Mahutonga”; Durie, 1999), have found wide application in New Zealand society and informed the Ministry of Health's (2001) milestone Māori health strategy, *He Korowai Oranga*. They have entered, or at the very least have broadened out, the understanding of health for most New Zealand health practitioners, especially those working in public health. That the *Social Reports* holistically monitor physical and mental health measures alongside assessment of various other dimensions of cultural and community well-being has found wide endorsement by Māori stakeholders (Ministry of Social Development, 2001a).

Māori approaches to health also differ from western models in that they are communitarian in nature. Setting the direction for Māori health development in the health and disability sector for the next five to 10 years, *He Korowai Oranga* defines as its principal goal 'whānau ora'⁴. While these communitarian aspects of Māori health have not found entry into social indicators as yet, they are an important dimension of health in New Zealand and will need to be integrated in the *Social Reports* in the future in order to reflect government direction as set by the Māori Health Directorate of the Ministry of Health through its Māori-specific health strategies.

5.6 Highlighting strengths and using language that is responsive to policy opportunity

It is not surprising that such innovative New Zealand models of health and well-being have created a conducive environment for well-being approaches, within government as within civil society. In fact, it can be argued that the New Zealand health and social sectors have shifted significantly from approaches concerned solely with the reduction of disease and risk to building of strength and highlighting health (and well-being) opportunity. This is an important difference. The work of several government agencies is proof of such a transformed approach. Capturing the essence of a strengths-based approach and highlighting opportunities, a prime example from the health sector is the 1998 New Zealand Youth Suicide Prevention Strategy titled *Kia Piki te Ora o te Taitamariki - Strengthening Youth Wellbeing* (Ministry of Health, 1998).

That the *Social Reports* also at times take a strengths-based approach is apparent, for instance, in the fact that they report on the social connectedness domain. This domain is closely related to the idea of social capital, a concept that locates power and resource in community activities, inter-individual relationships and exchange of support. Even the labelling of indicators is important in this regard. For example, in 2003 an indicator which was initially called *dependent disability* was renamed into *disability requiring assistance*, due to this being perceived as a less stigmatizing expression (see Ministry of Social Development, 2004: 154-155). Negative, disempowering concepts are here

redefined, shifting them into a more appropriate and positive sphere with the potential to empower disadvantaged groups. When a government is starting to report on community assets, then this can be interpreted as a useful trajectory for empowering communities. And in analysis, it can be argued that the underlying policy assumption is that reporting on strength is a valuable strategy to enhance these important community-owned resources.

Statements of desired outcomes for all outcome domains reported in the 2007 report are listed in Annex 4 of this discussion paper, together with the respective indicator measures. From studying these statements, it becomes obvious that they provide positive visions and objectives for the future in each social well-being domain instead of exclusively aiming for the reduction of specific risks. In effect, the statements highlight opportunity. The health domain provides a useful example in this regard. Its statement of desired outcomes reads as follows:

"All people have the opportunity to enjoy long and healthy lives. Avoidable deaths, disease, and injuries are prevented. All people have the ability to function, participate, and live independently or appropriately supported in society".

Again, the difference lies in the language used, and in the case of the *Social Reports*, the statement explicitly talks about 'opportunity' and 'ability', 'prevention' and 'participation in society' as the milestones of health. A re-branding of the current indicators to promote the more positive side of New Zealand rather than its deficits was advocated for by several informants to this study, although, at the same time, practical measurement limitations to this endeavor were acknowledged.

5.7 Developing social indicators in societies with indigenous populations

As increasing attention is being placed on developing measures of indigenous peoples' social and health outcomes, international social

⁴ Whānau – Te Reo Māori language term describing the smallest tribal unit, the extended family; ora - Te Reo Māori language term, which according to the Ngata Dictionary can be translated as 'health' or 'fitness'.


reports have commenced reporting on indigenous social well-being. One striking example is the *Social Panorama of Latin America* report (Economic Commission of Latin America and the Caribbean) launched in 2006, which contains a chapter monitoring indigenous populations' social outcomes (p.141-213)⁵. In addition, social determinants of health of indigenous populations are collectively being explored by indigenous peoples at the global level. In 2007, for instance, the "International Symposium on the Social Determinants of Indigenous Health" was held in Adelaide, Australia. As stated in the final report of the symposium prepared for the Commission on Social Determinants of Health (ref. *Social determinants and Indigenous health: The International experience and its policy implications*; Mowbray, 2007: 3), 'the papers and Symposium gave examples of instrumental and constitutive value attributed by Indigenous Peoples to culture and world views as a determinant of their health and well being.'

Being a bicultural nation by virtue of Te Tiriti o Waitangi/The Treaty of Waitangi, New Zealand can be seen as consisting of Māori whānau/families, hapu/sub-tribes and iwi/tribes on one hand and non-Māori settlers represented formally by the British Crown or settler governments respectively on the other hand. Some argue that because settlers have arrived to New Zealand from various parts of the world and given that also Māori groups and individuals can have multiple ethnic affiliations, New Zealand society is well described as multicultural. These political and historic complexities, especially the guarantee of indigenous rights and the systematic settler colonization of New Zealand, have created a unique cultural environment.

Such circumstances are reflected in the *Social Reports*, above all their *Cultural Identity* domain. 'Cultural identity' as per the definition provided in the *Social Reports* is a multi-layered construct, with culture being understood in its broadest sense, as expressed through 'customs, practices, languages, values, and world views that define social groups such as those based on nationality,

ethnicity, region or common interests' (Ministry of Social Development, 2007: 76).

The *Social Reports* also explain why cultural identity should be measured to indicate social well-being by referring to trajectories through which a strong sense of cultural identity mediates social well-being: A strong cultural identity is seen as granting access to social capital by providing a sense of belonging and, as a consequence, a sense of social security. Sharing social networks accesses support and builds collective values and aspirations. Social networks can function to break down barriers and build a sense of trust between people. The negative impact of social exclusion is juxtaposed, when the *Social Reports* also point out that if strong cultural identity is expressed in the wrong way, it can contribute to barriers between groups. The *Social Reports* highlight the fact that exclusionary practices of the dominant authorities can impinge on the sense of belonging for members of minority cultures. In this context, the *Social Reports* acknowledge explicitly that Māori culture including Te Reo Māori /the Māori language has been marginalized 'through much of New Zealand's history' (Ministry of Social Development, 2007: 77). The desired outcomes for the cultural identity domain mirror the government's idea of what optimal expression of cultural identity in New Zealand should look like:



"New Zealanders share a strong national identity, have a sense of belonging and value cultural diversity. Everybody is able to pass their cultural traditions on to future generations. Maori culture is valued and protected".

Ministry of Social Development (2007), p76.

However, measuring cultural identity as a domain of social well-being is a recent concern, and in consequence it is not surprising that indicator measures in the *Social Reports* (e.g. *people identifying as Maori who can speak in Maori*) are still emerging. It needs to be noted that defining and monitoring "strong/good" and "weak/bad" cultural identity carries significant danger; if the government has the power to defining what constitutes a "good" and what a "bad" cultural identity, therefore allowing inclusion and the

⁵ The Commission's 2007 report includes a chapter reflecting on health programmes and policies for indigenous peoples in Latin America and the Caribbean (Economic Commission of Latin America and the Caribbean, 2007: 55-59) and comparative demographic analyses for the indigenous peoples of Latin America as they relate to public policy issues. This report refers to the special regime of collective indigenous rights based on the principle of self-determination by recognizing equal entitlement of the indigenes to human rights protection, e.g. marked by the global ratification of international human rights legislation (i.e. the 2007 United Nations Declaration on the Rights of Indigenous People). In this context, the report also stresses the increasing importance of indigenous people as political actors.

opposite, then assessments according to these criteria may further disempower marginalized indigenous and ethnic groups.

5.8 Securing on-going, regular, "neutral" social reporting

As described previously, although the periodicity of the *Social Reports*' publication was not determined from the establishment of the regime, the *Social Reports* have been published in annual periodicity since first released in 2001. Policy staff from the Ministry of Social Development point out that one of the advantages of publishing the *Social Reports* on a yearly basis is that the *Social Reports* have established as a regular commodity, likely creating less political pressure on its annual findings than if the report was published less regularly.

According to these ministry staff, an annual publication cycle adds to the consistency of reporting and the public transparency of the *Social Reports*, especially considering that changes in the reporting structure (i.e. modifications of indicator measures) are explained in great detail in a specific section contained in each report. In terms of political impact, setting up a routine, transparency dynamic was seen as increasing political interest in the *Social Reports* as annual milestone measures, increasing policy debate about social outcomes.

However, social scientists suggested tri-annual publication as a better mode of operation, wanting to see a social report published just before election time to increase its policy impact. Similarly, Ministry of Health staff reported that all or almost all government agencies involved in the development of the Social Reports opposed annual reporting, arguing that it is impossible to update most indicators annually and that social change proceeds slowly. Indeed, the agencies thought that looking at year-on-year changes might be meaningless or even misleading.

Another point is that the health domain indicators in the *Social Reports* (e.g. *obesity, smoking*), although constituting a strong set of indicators, should be changed periodically. Otherwise, if they were made into accountability indicators, one would run into the problem of "targets", i.e. behavioral indicators would skew towards considering them more important and worthy than other indicators.

Given that the *Social Reports* in New Zealand are currently published by a ministry (and not

as in other countries by a statistics department), another important issue is the danger of the disestablishment of the *Social Reports* by future governments, especially if these do not retain the current emphasis on social policy. To counter this peril, a cementing-in of the *Social Reports* by means of statutory obligation to report on social outcomes has been explored by the Ministry of Social Development (2002a), but has not been achieved. However, many key-informants to this case study, government officials and civil society representatives alike, were of the opinion that the establishment of a Social Responsibility Act to directly mirror the existing 1994 Fiscal Responsibility Act, which requires The Treasury to publish their accounts before every election, would be a central, desirable step and should include government obligation for social reporting.

In addition, some policy officials and opposition-party politicians have challenged the *Social Reports*' appropriateness in reporting positive trends (i.e. some objections were raised with regards to overly enthusiastic reporting of health improvements for Māori), and attributing these back to recent government policy. The 2002 review of the first Social Report had highlighted some level of confusion amongst stakeholders about the very issue of whether indicators reports can be used to assess the impacts of policies (Ministry of Social Development, 2002a). However, although improvements in social outcomes might have been reported enthusiastically at times, senior policy staff agreed that although ministers have, in rare occasions, requested changes to be made to the reports, "neutral" reporting has never been challenged, especially considering that reports simply compile information from previously published official statistics.

"Ideally, there should be a cut-out between such governmental reporting and its exposure to the public: preferably by constituting an independent advisory board or perhaps by drawing on the statutory independence guaranteed to the Government Statistician. Such a cut-out would also clip the temptation of the issuing government ministers to gloat over 'successes'".

Crothers (2006), p5.

6 Key lessons learnt

A range of implications arise from this country case study which profiled and analyzed the conceptual and technical development, policy impact and some defining features of New Zealand's *Social Reports*. In essence, they could be described as some of the “lessons learned” with respect to addressing the SDH to achieve health equity in national level social reports, and, as such, might inform other countries about the potential of social reports to generate awareness to and, in turn, policy action on the SDH.

LESSON 1: Social reports can be successfully used to make SDH and health equity visible

- ❖ *Social reports can function well to monitor progress on the SDH. Although sometimes not explicitly stated (this is the case in New Zealand's Social Reports), social reports effectively monitor a range of SDH, measuring outcomes from diverse social domains alongside health outcomes. Some social reports explicitly acknowledge their function with respect to monitoring SDH, therefore providing leadership in this area.* The European Union's social reporting is a prime example in this respect: In its 2003 report it features a detailed section on physical and social determinants of health as well as an investigation of the health impact of social capital and social exclusion across the European Member States (Eurostat & European Commission, 2003: 51-68).
- ❖ *To monitor within-country social (including health) equity, social reports ought to present data disaggregated along the “Social Determinants of Health*

Inequity”. Within-country inequities can only be made visible if social outcomes are disaggregated by various “Social Determinants of Health Inequity” (i.e. ethnicity, gender, geographic residency), often in alignment with a state's priority populations for targeted policy attention (i.e. Māori and Pacific Island populations in New Zealand). When they socially disaggregate data, social reports can be used to trace equity for specific populations.

- ❖ *National level social reports should include cross-countries comparisons of social (including health) equity in order to account for between-country inequity.* While this aspect is not realized in the New Zealand case, including the monitoring of health equity across diverse countries in social reporting schemes would be a significant improvement, adding an additional dimension of health equity analysis to inform policy interventions. To not only compare social outcomes as such, but also the present level of health equity internationally would provide policy-makers and the public with a contextualized understanding of how one country is faring in relation to other countries with respect to within-country equity. This information could be applied to the design of policy interventions aimed at a reduction of between-country disparities in health equity.
- ❖ *Social reports need to be published periodically to assure time-series of social outcomes are available for trend analyses.* Whereas annual publication of social reports seems only justifiable if data becomes available for meaningful up-

date annually, it is important that social reports are published periodically. In New Zealand, annual reporting has been criticized by many policy actors from within government and social scientists arguing that the reports should rather be released tri-annually or possibly timed to coincide with pre-election.

- ❖ ***It needs to be ensured that an on-going focus on findings with respect to equity, which have arisen from social reporting, is maintained.*** To maximize their policy impact, issuing ministers and other politicians, the media, and civil society actors should freely use the social reports to point out social outcomes equity concerns. Coordination in this respect could be achieved for instance by a systematic marketing of these results through the issuing department, i.e. through employing a marketer with the task to keep these area in the limelight.
- ❖ ***Social reports can meaningfully be used as a platform to raise awareness to the health outcomes of disadvantaged populations.*** Sometimes disadvantaged populations are invisible in social and health monitoring, certainly at times due to small numbers (small ethnic minorities) or due to methodological issues or a lack of national data. However, if statistical difficulties regarding the measurement of these populations could be overcome, social reports should be a platform to enhance the reporting of findings for marginalized, vulnerable, underreported populations (i.e. refugee and other small ethnic communities, sexual and gender minorities).

LESSON 2: Social reports can set the basis for policy action on the SDH, within and outside the health sector, in government and beyond

- ❖ ***When exposing social inequalities in a highly visible report that achieves significant national media coverage, social reports present a useful policy tool to produce political will, and action within government and beyond, with respect to addressing the SDH to achieve health equity.*** The New Zealand case shows that social reporting schemes have the potential to produce political will and, in turn, action on the SDH to achieve health equity, in government and beyond, sectorally as intersectorally. Considering that social reporting integrates a suitable, standardized set of key indicators that are relevant to a broad range of sectors, social reports are likely to build a more cohesive administrative force, not only involving diverse government departments, but also civil society actors. However, reports by themselves do not achieve this, but there has to be an interaction between the information they make visible, and concern for public pressure, or pressure by advocacy groups, as well as participation in the policy-making process of these groups. One good indication of the impact that social reports have is the level of budgetary implications for government ministries that they can achieve.
- ❖ ***Social reports can be used to validate and strengthen a health sector approach focused on addressing the SDH, at least at the strategic level.*** By compiling in one report both key health indicators and a range of indicators from other social sectors such as education and justice, as well as economic and environmental indicators, social reports could theoretically encourage health practitioners, especially health planners, to consider in their activities the factors outside the health sector, which impact on health. However, evidence for cases in which health practitioners have been able to bring this down to the service level could not be produced in this case study. On a more strategic level on the other hand, the high-level picture that social reports provide by monitoring a broad range of social factors aligns well with approaches concerned with influencing the SDH to achieve more equitable health outcomes, so that publication of social reports can work to strengthen social determinants-based policy frameworks. Clearly, intersectorality can be strengthened by having a clearer causal framework in evidence.
- ❖ ***Social reports can be used to enhance intersectoral coordination in support of policy action on the SDH.*** Especially when social reports are produced jointly by multiple government agencies, they have

the potential to be a starting point for the cultivation of a culture of continued inter-sectoral thinking and action.

- ❖ ***For policy actors from civil society concerned with health equity, social reports present a good advocacy tool by providing official, authoritative, government-sourced data on the state of health (and social) equity.*** In New Zealand, official social reports have achieved a good public profile and are applied for multiple purposes, not only by government, but also by diverse civil society groups. Health advocates, important policy actors, are one of the key audiences for social reports if these successfully monitor key issues of interest for these organizations, namely health equity and the SDH.
- ❖ ***Extending the healthsector focus on health and well-being to the notion of social well-being.*** The concept of social well-being, extending the healthsector's understanding of health and well-being further into the social realm, adds to policy efforts addressing SDH to achieve health equity by further establishing a social model of health as the foundation of health planning. While outcomes in the health domain might still be assessed according to classical medical-model thinking by measuring prevalence and demographic distribution of disease and risk factors, describing other social domains as determinants of social well-being increases or reinforces an understanding of health outcomes as influenced by policy-making from both within and outside of the health sector. This has conceptual implications for health policy staff involved in the development of the social reports and their understanding of how other outcomes domains are interconnected with health outcomes, and, in turn, how policy in other sectors impacts on health outcomes. Health officials valued engaging in a process of shared meaning-making and language-finding with officials from other sectors, while involved in the development of the New Zealand Social Reports. Intersectoral working and developing a shared inter-sectoral approach is likely to aid individual policy-makers' understanding of the SDH.
- ❖ ***National social reports are useful for countries with regard to developing national agreement on standard social indicators for national, and international, benchmarking.*** While international standards have been set by international organizations such as the UN, the European Union and the OECD and can provide some orientation for national decision-making with respect to the selection of the most appropriate set of national social indicators for monitoring, the process of putting together national social reports fulfills a national benchmarking function. To produce national level social reports, government, academic leaders and civil society, need to collaboratively agree upon standard social indicators, hence enhancing and standardizing national thinking with respect to social outcomes.
- ❖ ***The business sector and its government counterparts need to see themselves and their interests clearly in social reports.*** Well distributed economic gain leads to improved health outcomes, and leads to improved economic performance. In consequence the private and public economic sector needs to see themselves and their interests clearly in social reports. In New Zealand, failure to engage these sectors in the Social Reports has minimized the reports policy impact significantly.

LESSON 3: Social reports have the potential to inform the evaluation and design of public policy and intervention

- ❖ ***Social reports can be used to assess the (medium and long-term) impact of policy initiatives to reduce social and health inequity.*** One further advantage of introducing social reporting for governments interested in reducing inequalities and working with the SDH is that such a cross-sectoral and integrated monitoring system has the potential to provide an impact evaluation of governmental policy in this area. While short term policy evaluations might be questionable due to the cross-cutting nature of social outcomes, medium- to long-term changes of social outcomes have successfully been linked to medium- to

long-term all-of-government initiatives (i.e. the Social Reports have successfully linked increases in ethnicity-based social outcomes inequity to New Zealand undergoing government-directed economic policy reform in the 1980s and 1990s). However, it is clear that more research and standardized guidance is needed in order to identify how to evaluate policy impacts in the short to medium term.

- ❖ ***Preferably, social reports explicitly link their findings to policy action.*** Information generated in social reports ought to be applied to direct or enhance the design and implementation of policy interventions. Reports would be strengthened if they explained strategic or operational improvements that resulted from previous findings.

LESSON 4: Social reports need to be developed with a number of core process, conceptual and technical considerations in mind

- ❖ ***If the public, especially diverse disproportionately burdened populations, have the chance to actively participate in the conceptual development of social reports, and the reports are transparent with respect to changes made and easily available free of charge, an emphasis on equity in social reports is likely be strengthened and public debate and up-take of the reports' findings increased.*** The New Zealand case has shown that social reports, if easily accessible, user-friendly and transparent, can strengthen the interface between government agencies and the public, including various stakeholder groups as well as the private and non-governmental organization sector. Comprehensive community consultation and offering civil society, especially marginalized population groups, participation in the development process of social reporting regimes can make a positive contribution in this regard.
- ❖ ***If possible, social reports should be based on positive, as opposed to deficit-based, concepts to enhance up-take, especially from civil society. They should also be***

responsive to new social priorities.

Although traditionally health indicators often measure the prevalence of disease or risk behaviours, social reports also incorporate a number of more "positive" concepts such as for example social connectedness as a form of social capital which rests within communities. For civil society, especially marginalized populations, social reports that do not only locate deficits and disparities, but also at the same time document strengths of the respective population are likely to receive more attention and endorsement, resulting in better currency and application of the reports.

- ❖ ***To be able to guide action towards addressing between-country inequities, national level social reporting ought also to share some alignment with international social reporting, i.e. by using internationally standardized social indicators.*** Social reports produced for national level reporting ought to utilize, where possible and in alignment with national policy needs, social indicators used in other countries in order to guarantee international comparability of social outcomes.
- ❖ ***When social reports do not link their findings to research on the cause/effect relationship between SDH and health outcomes, they are unable to make causal statements in this manner.*** Evidence indicating the pathways through which social factors impact on health comes from research. These pathways need to be made explicit so that the data in the social reports can be used to identify causes, or at minimum, associations. This information needs to be obtained from well designed studies and, once good research has demonstrated a link (preferably a causal link) between a social condition (e.g. housing) and health, then social reports are very good at showing the inequities in the SDH. A future challenge for social reports will be to establish associations between both the diverse well being domains (i.e. health and education or health and social connectedness) and between individual social indicators. While predictive economic models have been constructed, taking into account various

indicator functions, no equivalent measure exists for social outcomes as a whole as yet. For high-level policy-making the Social Report were seen as a good starting point, providing steady, serial updates, but critique centered around the reports lack of explicit predictive potential at this point. The reports contain no sense of dynamics and how the different domains quantitatively interact with each other—these are the weak links and the next steps to take for New Zealand.

- ❖ ***Social reports ought to closely link the relationship between individual outcomes domains.*** Social Reports increase their applicability for policy-makers, if they are able to statistically capture the relationship between their diverse outcomes domains. In the New Zealand report this has not been realized, which leaves doubts regarding the interconnectedness of the various individual outcomes domains.
- ❖ ***Countries with indigenous populations appear to have the collective need for a distinct set of social indicators that, developed by indigenous people, have the ability to document trends in indigenous people's social (including health) outcomes.*** With increasing national and international acknowledgement of indigenous rights (e.g. the 2007 United Nations Declaration on the Rights of Indigenous Peoples), paralleled by associated progress in many countries with political leadership officially apologizing

to indigenous people for human rights abuses inflicted against them by successive colonial governments, the need for a distinct set of social indicators catering for the information needs of indigenous peoples increases. Besides presenting social outcomes carefully disaggregated by the indigenous versus non-indigenous categories, a distinct set of social indicators addressing indigenous concerns can be created for inclusion into social reporting schemes. This is an emerging field of social reporting, that, while being able to draw on some contemporary conceptual frameworks and indicator lists developed by indigenous people, needs to be further extended in national-level social reports.

- ❖ ***It is advisable to anchor a responsibility to publish social reports in national legislation.*** Although social reports are often published by governmental Statistics Departments, which are generally equipped with statutory independency, if social reports are published by other public departments, their fate often relies on political good-will to monitor social outcomes, leaving social reports vulnerable to political opposition and changes in government. To counter the threat of disestablishment of social reporting regimes, countries have the option to cement social reporting as a statutory responsibility, an option that has been explored in New Zealand but not as yet implemented.

List of abbreviations

ECOSOC	United Nations Social and Economic Council
MDGs	Millennium Development Goals
OECD	Organization for Economic Co-operation and Development
SDH	Social Determinants of Health
UN	United Nations
UNSD	United Nations Statistics Division
WHO	World Health Organization

References

Anderson, M., Anderson, I., Smylie, J., Crengle, S., & Ratima, M. (2006). *Measuring the Health of Aboriginal and Torres Strait Islander peoples: a background paper for the project 'Action-oriented indicators of health and health systems development for Indigenous peoples in Australia, Canada and New Zealand'*. Report No 16. Melbourne, Australia: Onemda VicHealth Koori Health Unit.

Anderson, M., Smylie, J., Anderson, I., Sinclair, R., & Crengle, S. (2006). *First Nations, Inuit and Metis health indicators in Canada: a background paper for the project 'Action-oriented indicators of health and health systems development for Indigenous peoples in Australia, Canada and New Zealand'*. Report No 18. Melbourne, Australia: Onemda VicHealth Koori Health Unit.

Awofeso, N. (2005). *Re-defining 'Health'*. Retrieved May 12, 2007, from http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/

Banda, J., & Menozzi, C. (2003). *Setting the scope for social statistics*. New directions in social statistics meeting, New York, August 15. <http://isi.cbs.nl/iamamember/cd3/abstracts/papers/3443.pdf>

Bauer, R. (1966). *Social Indicators*. Cambridge, Mass., London: The M.I.T. Press.

Blakely, T., Tobias, M., Atkinson, J., Yeh, L.-C., & Huang, K. (2007). *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004*. Wellington, N.Z.: Ministry of Health.

Braveman P. (1998). *Monitoring equity in health: a policy-oriented approach in low- and middle-income countries*. Department of Health Systems, World Health Organization, Geneva.

Braveman, P. (2003). Monitoring Equity in Health and Healthcare: A Conceptual Framework. *Journal of Population Health Nutrition*, 21 (3):181-192.

Braveman, P. (2006). Health disparities and health equity: concepts and measurement. *Annual Review of Public Health*, 27: 18.1-18.28.

Cant, G., Hill, D., & Watson, M. (1979). *Social Indicators for Development Planning in New Zealand*. Wellington, N.Z.: New Zealand National Commission for UNESCO & New Zealand Social Development Council.

Chair of the Cabinet Social Development Committee (2004). *Reducing Inequalities: Next Steps*. Wellington, N.Z.: Office of the Minister of Social Development and Employment. Retrieved May 2, 2008, from <http://www.ms.govt.nz/documents/publications/strategic-social-policy/reducing-inequalities/reducing-inequalities-next-steps.pdf>

Crothers, C. (2006). *The Development of Indicators in New Zealand: Indicatorisation*. Paper for Social Indicators (WG06) stream ISA Durban, July 26. Retrieved November 26, 2007, from <http://www.soc.duke.edu/resources/sinet/papers06/Crothers.pdf>

Davey, J. (1993). *Tracking Social Change in New Zealand: From Birth to Death III*. Wellington, N.Z.: Institute of Policy Studies.

Davey, J. (1998) *Tracking Social Change in New Zealand: From Birth to Death IV* Institute of Policy Studies: Wellington.

Davey, J. (2000). From Birth to Death: A Social Monitoring Framework from New Zealand. *Social Indicators Research*, 49 (1): 51-67.

Davey, J. (2003) *Tracking Social Change in New Zealand: From Birth to Death V*. Institute of Policy Studies: Wellington.

Department of Statistics (1977). *Social Trends in New Zealand*. Wellington, N.Z.: Department of Statistics.

Department of Statistics (1978). *1978 List of Social Indicators*. Wellington, N.Z.: Department of Statistics.

Department of Statistics (1980). *1980 List of Social Indicators*. Wellington, N.Z.: Department of Statistics.

Department of Statistics (1988). *Report of the Review Committee on Ethnic Statistics*. Wellington, N.Z.: Department of Statistics.

Donabedian A (1980), *The definition of quality and approaches to its assessment (Explorations in Quality Assessment and Monitoring, Vol 1)*. Ann Arbor, Mich.: Health Administration Press

Durie, M.H. (1984). An integrated approach to mental health. *Community Mental Health in New Zealand*, 1, 1.

Durie, M. H. (1985). A Maori perspective of health. *Journal of Social Science and Medicine*, 20, 5, 483-486.

Durie, M. (1998). *Whaiora: Maori health development*. Auckland: Oxford University Press.

Durie, M. (1999). *Te Pae Mahutonga: a model for Māori health promotion*. Health Promotion Forum of New Zealand Newsletter 49.

Economic Commission of Latin America and the Caribbean (2006). *Social Panorama of Latin America 2006*. LC/G.2326-P. Santiago, Chile: United Nations.

Economic Commission of Latin America and the Caribbean (2007). *Social Panorama of Latin America 2007-Preliminary version*. Retrieved May 2, 2008, from http://www.eclac.cl/publicaciones/xml/9/30309/PSI2007_Sintesis_Lanzamiento.pdf

Eurostat & European Commission (2001). *2001- The social situation in the European Union*. Luxembourg: eurostat & European Commission. http://ec.europa.eu/employment_social/spsi/docs/social_situation/SSR2001_en.pdf

Fiscal Responsibility Act 1994 (1994). *Statutes of New Zealand, 1994, No. 17*

Gakidou, E., Murray, C. J., & Frenk, J. (2000). Defining and measuring health inequality: an approach based on the distribution of health expectancy. *Bulletin of the World Health Organization*, 78: 42-54.

Harper, S.B., & Lynch, J.W. (2006). Measuring inequality in health. In M. Oakes & J. Kaufman (eds.) *Methods in Social Epidemiology*. San Francisco: John Wiley & Sons.

Hosseinpoor, A.R., Van Doorslaer, E., Speybroeck, N., Naghavi, M., Mohammad, K., Majdzadeh, R., Delavar, B., Jamshidi H., & Vega, J. (2006). Decomposing socioeconomic inequality in infant mortality in Iran. *International Journal of Epidemiology*, 35: 1211-1219.

- Hunt, P. (2004). The Right to Health: An Interview with Professor Paul Hunt. *Essex Human Rights Review*, 2 (1): 57-61.
- Kelly, M. P., Morgan, A., Bonnefoy, J., Butt, J., & Bergman, V. (2007). *The social determinants of health: Developing an evidence base for political action/ Final report to the World Health Organisation Commission on the Social Determinants of Health*. Chile and United Kingdom: Universidad del Desarrollo and National Institute for Health and Clinical Excellence.
- Keppel, K., Pamuk, E., Lynch, J.W., et al. (2005). Methodological issues in measuring health disparities. National Center for Health Statistics. *Vital Health Statistics 2*, (141): 1-16.
- Kukutai, T. (2003). *The dynamics of ethnicity reporting: Māori in New Zealand*. Wellington, N.Z.: Te Puni Kokiri.
- Local Government Act 2002. (2002). *The statutes of New Zealand, 2002, No 84*
- Manor, O., Matthews, S., & Power, C. (1997). Comparing measures of health inequality. *Social Science & Medicine*, 45: 761-771.
- Marks, E., Cargo, M. D., & Daniel, M. (2007). Constructing a health and social indicator framework for indigenous community health research. *Social Indicators Research*, 82 (1): 93-110.
- Matheson, D. (2007). Health inequalities: unfair, measurable and remediable? The case of New Zealand. *The 19th IUHPE World Conference on Health Promotion and Health Education*, June 10th -15th, 2007 Vancouver, BC.
- Menozzi, C. (2003). *Review of past efforts towards a systematic development of social statistics*. Briefing paper for the Expert Group Meeting on Setting the Scope of Social Statistics, New York, 6-9 May. www.unstats.un.org/UNSD/Demographic/meetings/egm/Socialstat_0503/docs/no_14.pdf
- Minister of Social Development and Employment (2003a). *Six-monthly Report on Reducing Inequalities: January to June 2003*. Wellington, N.Z.: Office of the Minister for Social Development and Employment.
- Minister of Social Development and Employment (2003b). *Six-monthly Report on Reducing Inequalities: July to December 2003*. Wellington, N.Z.: Office of the Minister for Social Development and Employment.
- Ministry of Health (1998). *Kia Piki te Ora o te Taitamariki - Strengthening Youth Wellbeing*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health (2002a). *Reducing inequalities in health strategy*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health (2002b). *He korowai oranga: Māori health strategy*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health (2003). *Decades of Disparity: Ethnic mortality trends in New Zealand 1980 – 1999*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health (2004) *Ethnicity Data Protocols for the Health and Disability Sector*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health and University of Otago (2006). *Decades of Disparity III: Ethnic and socio-economic inequalities in mortality, New Zealand 1981-1999*. Wellington, N.Z.: Ministry of Health.
- Ministry of Health and University of Otago (2007). *Tracking Disparity: Trends in ethnic and socioeconomic inequalities in mortality, 1981–2004*. Wellington, N.Z.: Ministry of Health.
- Ministry of Social Development (2001a). *Pathways to Opportunities*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2001b). *The Social Report 2001*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2002a). *The Review of the Social Report 2001*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2002b). *The Social Report 2002*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2003). *The Social Report 2003*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2004a). *The Social Report 2004*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2005a). *The Social Report 2005*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2005b). *The Social Report 2005: Regional Indicators*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2006a). *The Social Report 2006*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2006b). *The Social Report 2006: Regional Indicators*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2007a). *The Social Report 2007*. Wellington, N.Z.: Ministry of Social Development.

Ministry of Social Development (2007b). *The Social Report 2007: Regional Indicators*. Wellington, N.Z.: Ministry of Social Development.

Møller, V. (1997). South Africa's Emergent "Social Indicators Movement". *Social Indicators Research*, 41 (1-3): 1-14(14).

New Zealand Planning Council (1985). *From Birth to Death*. Wellington, N.Z.: New Zealand Planning Council.

New Zealand Planning Council (1989). *From Birth to Death II*. Wellington, N.Z.: New Zealand Planning Council.

OECD (1982). *The OECD List of Social Indicators. OECD Social Indicator Development Programme*. Paris: OECD.

OECD (1986). *Living Conditions in OECD Countries*. Paris: OECD.

OECD (2001). *Society at a glance: OECD Social Indicators*. Paris: OECD.

OECD (2002). *Society at a glance: OECD Social Indicators*. Paris: OECD.

OECD (2005). *Society at a glance: OECD Social Indicators*. Paris: OECD.

OECD (2006). *Society at a glance: OECD Social Indicators*. Paris: OECD.

Pere, R.R. (1991). *Te wheke: A celebration of infinite wisdom*. Auckland: Ao Ako Global Learning New Zealand.

- Petrie, M. (2002). *Institutions, Social Norms and Wellbeing*, New Zealand Treasury Working Paper 02/12. Wellington, N.Z.: The Treasury. <http://www.treasury.govt.nz/publications/research-policy/wp/2002/02-12/twp02-12.pdf>
- Ratima, M., Edwards, W., Crengle, S., Smylie, J. & **Anderson, I.** (2006). *Maori Health Indicators: A Background Paper for the Project 'Action-oriented indicators of health and health systems development for Indigenous peoples in Australia, Canada and New Zealand'*. Discussion Paper No.17, Onemda VicHealth Koori Health Unit, The University of Melbourne, Melbourne.
- Royal Commission on Social Policy (1988) *The April Report*. Wellington, N.Z.: Royal Commission on Social Policy.
- Royal Commission on Social Security (1972). *Social Security in New Zealand*. Wellington, N.Z.: Royal Commission on Social Security.
- Sen, A. K. (2001). Health Equity: Perspectives, Measurability, and Criteria. In Evans, T et al. (Eds.), *Challenging Inequities in Health: From ethics to action* (pp. 68-75). Oxford: Oxford University Press.
- Public Finance Amendment Act 2004 (2004). *Statutes of New Zealand, 2004, No. 113*
- Smylie, J., Anderson, I., Ratima, M., Crengle, S., & Anderson, M. (2006). Indigenous health performance measurement systems in Canada, Australia, and New Zealand. *Lancet*, 367: 2029–31.
- Solar, O., & Irwin, A. (2006). Social determinants, political contexts and civil society action: a historic perspective on the Commission on Social Determinants of Health. *Health Promotion Journal of Australia*, 17 (3): 180-184.
- Solar, O., & Irwin, A. (2010). *A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 3 (Policy and Practice)*. Geneva, World Health Organization.
- Statistics New Zealand (2002a). *Monitoring Progress Towards a Sustainable New Zealand: An experimental report and analysis*. Wellington, N.Z.: Statistics New Zealand. <http://www.stats.govt.nz/NR/rdonlyres/BD1610D1-77E2-4025-A43D-9190BC131AD9/0/MonitoringSusDevelopment.pdf>
- Statistics New Zealand (2002b). *The measurement of social capital in New Zealand. Country paper - Statistics New Zealand*. International Conference on Social Capital Measurement, London, 25-27 September. Retrieved November 26, 2007, from <http://www.oecd.org/dataoecd/23/0/2381968.pdf>
- Strategic Social Policy Group (2004). *Attachment 1- Reducing Inequalities Indicators for Māori and Pacific Peoples*. Wellington, N.Z.: Ministry of Social Development. Retrieved May 1, 2008, from <http://www.msd.govt.nz/work-areas/cross-sectoral-work/reducing-inequalities.html>
- Tarlov, A. (1996). Social determinants of health: The sociobiological translation. In D. Blane, E. Brunner, & R. Wilkinson (Eds.), *Health and social organization* (pp. 71-93). London, U.K.: Routledge.
- Udjo, E. O., Orkin, M., & Simelane, S. (2000). *Levels of social indicators in South Africa in relation to international goals of development*. Paper presented at the Economic Commission for Europe Seminar: Statistics for Social Development, Geneva 2000 and Beyond, Geneva 2000 Forum, Geneva, 27 June. http://unece.org/stats/documents/geneva_2000/crp.8.e.pdf
- United Nations (1954a). *Report on international definition and measurement of standards of living*, E/CN.3/179. New York: United Nations.
- United Nations (1954b). *International definition and measurement of standards and levels of living*, E/CN.3/179-E/CN.5/299. New York: United Nations.

United Nations (1961). *International Definition and Measurement of Levels of Living: An Interim Guide*, E/CN.3/270/Rev.1- E/CN.5/353. New York: United Nations.

United Nations (1970). *An integrated system of demographic, manpower and social statistics and its links with the system of national economic accounts*, E/CN.3/394. New York: United Nations.

United Nations (1975). *Towards a System of Social and Demographic Statistics*, Studies on Methods, Series F, No. 18. New York: United Nations.

United Nations (1978). *Social Indicators: Preliminary Guidelines and Illustrative Series*, Statistical Papers, Series M, No. 63. New York: United Nations.

United Nations (1979). *Improving Social Statistics in Developing Countries: Conceptual Framework and Methods*, Studies in Methods, Series F, No. 25. New York: United Nations.

United Nations (1989). *Handbook on Social Indicators. Studies and Methods, Series F, No. 49*. New York: United Nations.

United Nations (1996). *Social statistics: follow-up to the World Summit for Social Development. Report of the Expert Group on the statistical implications of recent major United Nations conferences: note by the Secretary-General*, E/CN.3/AC.1/1996/R.4.

United Nations (2000). *Harmonization and rationalization of development indicators in the United Nations system: report of the Secretary-General*, E/CN.3/2000/15.

United Nations (2001). *Activities and plans of the United Nations Statistics Division and the Statistical Commission in support of the harmonization and rationalization of indicators: report of the Secretary-General*, E/CN.3/2001/16.

United Nations (2002). *Harmonization of development indicators: report of the Secretary-General*, E/CN.3/2002/25.

United Nations (2003a). *Harmonization of indicators and reporting on progress towards the millennium development goals: report of the Secretary-General*, E/CN.3/2003/21.

United Nations (2003). *Interim report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health, Mr. Paul Hunt, A/58/427*. [http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/306eaf7b4938ba9c1256dd70051435d/\\$FILE/N0356469.pdf](http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/306eaf7b4938ba9c1256dd70051435d/$FILE/N0356469.pdf)

United Nations (2006). *Economic, Social and Cultural Rights: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*. E/CN.4/2006/48. <http://daccessdds.un.org/doc/UNDOC/GEN/G06/114/69/PDF/G0611469.pdf?OpenElement>

United Nations (2007). *United Nations Declaration on the Rights of Indigenous Peoples*.

US Department of Health, Education, and Welfare (1969). *Toward a social report*. Washington: Government Printing Office.

Wagstaff, A., Paci, P., & van Doorslaer, E. (1991). On the measurement of inequalities in health. *Social Science & Medicine*, 33 (5): 545-57.

Wolfson, M., & Rowe, G. (2001). On measuring inequalities in health. *Bulletin of the World Health Organization*, 79 (6): 553-560.

World Health Organization (1948). *Constitution of the World Health Organization*. Geneva, Switzerland: World Health Organization.

World Health Organization (2006). World Health Statistics 2006. Geneva, Switzerland: World Health Organization.

World Health Organization (2007a). World Health Statistics 2007. Geneva, Switzerland: World Health Organization.

WHO (2007b). *Briefing note: Proposed operational approach to monitor social determinants of health and health equity: criteria for indicator selection and long list of potential indicators*. For discussion at the Knowledge Networks' Symposium 26-28 September 2007, Rio de Janeiro, Brazil.

WHO (2007c). *Briefing note: Monitoring global health inequities*. For discussion at the 9th Meeting of the Commission on Social Determinants of Health 24-26 October 2007, Beijing, China.

World Health Organization Advisory Committee on Health Statistics and Monitoring (2006). *Meeting Report from the 2nd Consultation Meeting in Geneva*. Geneva: WHO Advisory Committee on Health Statistics and Monitoring.

Zapf, W. (2000). Social Reporting in the 1970s and 1990s. *Social Indicators Research*, 51 (1): 1-15.

Annexes

Annex 1: Selected national social reporting schemes

Selected national social reports			
Country Institution	Title	First Edition	Periodicity
Australia Australian Bureau of Statistics	Social Trends	1994	1 year
Austria Statistik Austria (before 2000 Statistisches Zentralamt)	Sozialstatistische Daten	1977	4/5 years
Canada Statistics Canada	Canadian Social Trends	1990	Quarterly (since 2006 triennially)
Denmark Danmarks Statistics/ Statistics Denmark	Levevilkår I Danmark	1976	4/5 years (last published 1997)
Federal Republic of Germany Statistisches Bundesamt	Datenreport	1983	2 years
France Institut Nationale de la Statistique et des Economique	Données Sociales	1973	3 years
United Kingdom of Great Britain National Statistics	Social Trends	1970	1 year
Hungary TÁRKI Social Research Institute (non-governmental)	Social Report	1990	2 years
Israel Israel Central Bureau of Statistics ² ADVA Centre: Information on Equality and Social Justice in Israel (non-governmental)	Society in Israel	1976, 1980	1 year
	Israel Social Report	1995-2002	?
	Israel: A Social Report	2005	—
Italy Istituto Nazionale di Statistica/ Statistics Italy	Sintesi della Vita Sociale Italiana	1990	?
Republic of Ireland Central Statistics Office (CSO)	Measuring Ireland's Progress	2003	1 year
Netherlands Social and Cultural Planning Office	Social and Cultural Report	1974	2 years
New Zealand Ministry of Social Development/ Te Manatū Whakahiato Ora	New Zealand Social Report/ te pūrongo oranga tangata	2000	1 year
Norway Statistisk sentralbyrå / Statistics Norway	Sosialt Utsyn/ Social Trends (English version)	1974	2 years (before 1998 3/4 years)
Poland United Nations Development Programme (UNDP) Friedrich-Ebert-Foundation, Representation in Poland (non-governmental)	(National) Human Development Report	1996	2-3 years (previously 1 year)
	The Social Report Poland 2004/2005	2005	—

Selected national social reports			
Country Institution	Title	First Edition	Periodicity
Portugal Instituto Nacional de Estadística/ Statistics Portugal	Portugal Social 1985-1990	1992	?
South Africa ³ Center for Social and Developmental Studies (non-governmental)	Indicator South Africa: The Barometer of Social Trends	1983-1998	2 years
Spain Instituto Nacional de Estadística /National Statistics Institute	Panoramica Social	1974	—
	Indicadores Sociales	1991	1994, 1997, 1999
Sweden Socialstyrelsen/ The National Board of Health and Welfare	National Report on Social Conditions in Sweden	1997	2001, 2008
	Perspektiv pa Valfarden Social Report	1998	—
Switzerland Schweizerischer Informations- und Datenarchivdienst für die Sozialwissenschaften (SIDOS) (non-governmental)	Sozialbericht	2000	4 years

1 The annex tabulates selected social reports released by national governments or leading research institutions. Considering that social reporting has become a well-established public function in many nations, the list presented here does not aim to be comprehensive, but presents selected social reporting schemes only. Updating these earlier results and including additional social reporting schemes, the presented table is based on findings from a paper published by The Canadian Council on Social Development (Noll, H.-H. (1996). Social Indicators and Social Reporting -The international Experience. In: Canadian Council on Social Development (ed.): Symposium on Measuring Well-being and Social Indicators. Final Report. Ottawa. <http://www.ccsd.ca/noll1.html>).

Additional social reports were sourced in an internet search using the key words 'social report', 'social indicator', 'social panorama' in the Google search machine. In addition, a number of national governmental statistics departments were contacted requesting information regarding their nation's social reporting activities.

2 For a paper detailing social reporting activities of the Israel Central Bureau of Statistics refer to Kamen, C.S. (2002). Quality of Life Research at the Israel Central Bureau of Statistics: Social Indicators and Social Surveys. *Social Indicators Research*, 58 (2): 141–162.

3 For further information about South African social reports refer to following two papers: Møller, V. (1997). South Africa's Emergent "Social Indicators Movement". *Social Indicators Research*, 41 (1-3): 1-14(14); and Udjo, E. O., Orkin, M., & Simelane, S. (2000). *Levels of social indicators in South Africa in relation to international goals of development*. Paper presented at the Economic Commission for Europe Seminar: Statistics for Social Development, Geneva 2000 and Beyond, Geneva 2000 Forum, Geneva, 27 June. http://unece.org/stats/documents/geneva_2000/crp.8.e.pdf

Annex 2: Selected supranational and international social reporting schemes

Selected supranational and international social reports			
Institution	Title	First edition	Periodicity
EUROSTAT & European Commission ²	Social Indicators for the European Community	1977	1980, 1994
	Social Portrait of Europe	1991	1995, 1998
	The social situation in the European Union	2000	1 year
Organization for Economic Co-Operation and Development (OECD)	Living Conditions in OECD Countries	1986	—
	Society at a glance: OECD Social Indicators	2001, 2002, 2005, 2006	—
The World Bank	World Development Report	1978, 2001	1 year
	Social Indicators of Development	1987	1 year
United Nations Department of Economic and Social Affairs	Report on the World Social Situation	1997 (according to the 2007 report, the series commenced in 1952)	2 years
United Nations Economic Commission for Latin America and the Caribbean (ECLAC)	Social Panorama of Latin America	1992	1 year
United Nations Development Programme (UNDP)	Human Development Report	1990	1 year

1 The annex tabulates selected social reports released by supranational organizations and international agencies respectively. These tables are based on findings presented in the paper quoted above that was published by The Canadian Council on Social Development (Noll, H., 1996), updating these earlier results and including additional social reporting schemes.

Additional social reports were sourced in an internet search using the key words 'social report', 'social indicator', 'social panorama' in the google search machine.

2 For a more comprehensive list of social reporting schemes of the European Union see Noll, H.-H. (2005). *Monitoring Social Europe: Komparative Soziale Indikatoren und Sozialberichterstattung als Instrumente für Wissenschaft und Politik*. ZUMA-Workshop, 16.-17. November, Mannheim, Germany. http://www.gesis.org/sozialindikatoren/Veranstaltungen/PDFs/Workshop2005/Praes_Noll_Einleitung.pdf

Annex 3: E-mail survey

Kia ora Mr/Ms ... ,

The World Health Organization has commissioned me to conduct a case study on the New Zealand Social Reports/ te pūrongo oranga tangata. To be more specific, the focus of this case study is to investigate the Social Reports' potential to generate awareness to the social determinants of health and health equity. This study was designed in collaboration with the New Zealand Ministry of Health. It is being conducted as part of the World Health Organization's broader country-stream of work associated with the Commission on Social Determinants of Health (http://www.who.int/social_determinants/en/).

The New Zealand Social Reports are published by the New Zealand Ministry of Social Development on an annual basis since 2001. They use a set of statistical indicators to monitor trends across 10 "domains", or areas of people's lives. Together these domains provide a picture of well-being and quality of life in New Zealand. An electronic copy of the latest report is attached to this e-mail, and you can download open access, electronic copies of all reports at <http://www.socialreport.msd.govt.nz> for your information.

One aspect of the commissioned case study is to assess how current the Social Reports are in broader New Zealand society. For this purpose, you have been identified as an important key-informant. I would, hence, like to invite you to contribute to the World Health Organization case study by answering the brief questionnaire attached as a Word document and listed below (7 questions). Filling in the questionnaire is expected to take no more than 15 to 20 min of your time. The respective questions are followed by grey boxes for your answers; these boxes will self-extend to the length of answer that you require. If you agree to participate, please return the filled-in questionnaire within the next 10 days via e-mail to my e-mail address. If you prefer to answer by postal mail, please let me know and I will provide you with the questionnaire in printed form as well as a free postal envelope. Your answers will be treated confidentially and won't be accessible to anybody else than myself and staff of the World Health Organization's Equitable Health Systems & Policy Team.

The findings from this e-mail survey will make a central contribution to the New Zealand case study. The case study will be used by the World Health Organization to internationally profile the New Zealand experience as a valuable model.

If you have any further questions regarding the study, please, do not hesitate to get in contact with me. Thank you very much and best wishes.

Frank Pega, MSc(Dist.), BSc(1Hons.)
Consultant
Equitable Health Systems & Policy Team
Department of Ethics, Equity, Trade and Human Rights
Evidence and Information for Policy Cluster
World Health Organization

WHO case study on New Zealand's Social Reports/ te pūrongo oranga tangata

QUESTIONNAIRE

For e-mail survey participants from the community, health, social and local government sector:

1. Please list the civil society groups (e.g. communities and non-governmental organizations) you represent.
2. Has your community/organization made use of the Social Reports? If yes, for which purposes?
3. If used, which information provided in the Social Reports assisted the strategic planning and decision-making of your community/organization most?
4. In your community/organization, have the Social Reports raised equity concerns and generated awareness to the factors outside the health sector that impact on the health of communities?
5. Please list all other civil society groups that, according to your knowledge, make use of the Social Reports.
6. In which sectors of society do you think the Social Reports are most current?
7. In which sector of society do you think the Social Reports are least current?
8. When the Social Report was first mooted, it was hoped that it would become as socially relevant as gross domestic product (GDP), i.e. the nation would use social indicators in assessing "how well we are doing". To what degree have the Social Reports achieved this goal?
9. What would it take for social indicators to become as current in broader New Zealand society as indicators that measure economic development and environmental sustainability?

For e-mail survey participants from The Treasury, The Ministry of Economic Development, and the business sector:

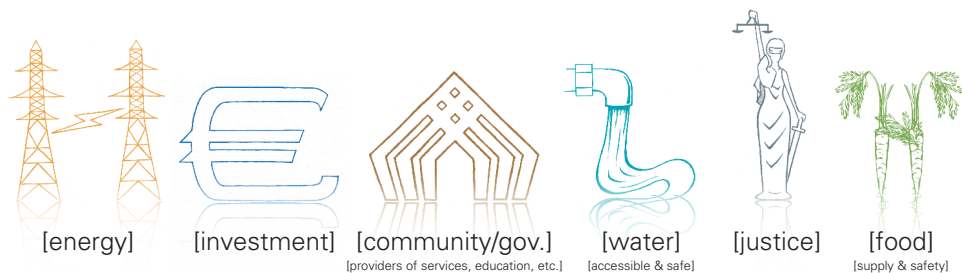
1. Has your department/organization made use of the Social Reports? If yes, for which purpose?
2. If used, which information provided in the Social Reports assisted your department's/organization's strategic planning and decision-making most?
3. If used, in your department/organization, have the Social Reports raised equity concerns and generated awareness to the factors outside the health sector that impact on the health of communities?
4. According to your knowledge, how current are the Social Reports in Zealand's business community?
5. Please list any major stakeholders from the business sector that, according to your knowledge, make use of the Social Reports.
6. In which sectors of society do you think the Social Reports are most current?
7. In which sector of society do you think the Social Reports are least current?
8. When the Social Report was first mooted, it was hoped that it would become as socially relevant as gross domestic product (GDP), i.e. the nation would use social indicators in assessing "how well we are doing". To what degree have the Social Reports achieved this goal?
9. What would it take for social indicators to become as relevant within broader society as indicators that measure economic development and environmental sustainability?

Annex 4: Social outcomes domains, desired outcomes and social indicators

Domain	Desired outcome statement for indicators	Indicators
Health	Everybody has the opportunity to enjoy a long and healthy life. Avoidable deaths, disease, and injuries are prevented. Everybody has the ability to function, participate and live independently or appropriately supported in society.	Health expectancy
		Life expectancy
		Suicide
		Cigarette smoking
		Obesity
Knowledge and Skills	Everybody has the knowledge and skills needed to participate fully in society. Lifelong learning and education are valued and supported.	Participation in early childhood education
		School leavers with higher qualifications
		Participation in tertiary education
		Educational attainment of the adult population
Paid Work	Everybody has access to meaningful, rewarding and safe employment. An appropriate balance is maintained between paid work and other aspects of life.	Unemployment
		Employment
		Median hourly earnings
		Workplace injury claims
		Satisfaction with work-life balance
Economic Standard of Living	New Zealand is a prosperous society, reflecting the value of both paid and unpaid work. Everybody has access to an adequate income and decent, affordable housing that meets their needs. With an adequate standard of living, people are well-placed to participate fully in society and to exercise choice about how to live their lives.	Market income per person
		Income inequality
		Population with low incomes
		Housing affordability
		Household crowding
Civil and Political Rights	Everybody enjoys civil and political rights. Mechanisms to regulate and arbitrate people's rights in respect of each other are trustworthy.	Voter turnout
		Representation of women in government
		Perceived discrimination
		Perceived corruption
Cultural Identity	New Zealanders share a strong national identity, have a sense of belonging and value cultural diversity. Everybody is able to pass their cultural traditions on to future generations. Maori culture is valued and protected.	Local content programming on New Zealand television
		Māori language speakers
		Language retention
Leisure and Recreation	Everybody is satisfied with their participation in leisure and recreation activities. They have sufficient time to do what they want to do and can access an adequate range of opportunities for leisure and recreation.	Satisfaction with leisure time
		Participation in physical activity
		Participation in cultural and arts activities
Physical Environment	The natural and built environment in which people live is clean, healthy and beautiful. Everybody is able to access natural areas and public spaces.	Air quality
		Drinking water quality
Safety	Everybody enjoys physical safety and feels secure. People are free from victimisation, abuse, violence and avoidable injury.	Assault mortality
		Criminal victimization
		Fear of crime
		Road casualties
Social Connectedness	People enjoy constructive relationships with others in their families, whanau, communities, iwi and workplaces. Families support and nurture those in need of care. New Zealand is an inclusive society where people are able to access information and support.	Telephone and internet access in the home
		Regular contact with family/friends
		Trust in others
		Loneliness
		Contact between young people and their parents

SOCIAL DETERMINANTS OF HEALTH

ACCESS TO POWER, MONEY AND RESOURCES AND THE CONDITIONS OF DAILY LIFE —
THE CIRCUMSTANCES IN WHICH PEOPLE ARE BORN, GROW, LIVE, WORK, AND AGE



WORLD HEALTH ORGANIZATION
AVENUE APPIA
1211 GENEVA 27
SWITZERLAND
WWW.WHO.INT/SOCIAL_DETERMINANTS

ISBN 978 92 4 150086 9

