Putting communities at the centre for a more effective and equitable health system in Aotearoa New Zealand

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ABSTRACT

Community-led action is essential for building a more effective and equitable health system. Yet Aotearoa New Zealand's history of top-down structural reforms has undermined progress toward "healthy futures for all". We draw on complexity science and system-change principles to explain why genuine devolution and community engagement are not just ideological preferences but practical necessities in a complex adaptive health system. Community agency and locally tailored innovation can drive emergent, system-wide improvements, but only if central structures enable and sustain these relationships. A key step is reframing our mental model of the health system from a linear machine to a complex system. We discuss how the turbulence of current policy changes fits into long-running patterns and why a clearer conceptualisation of complexity can guide policymakers toward tangible actions that reorient the system towards patients and communities. Finally, we outline some essential ingredients for how New Zealand can transition from rhetoric and good intentions to the effective implementation of an equitable, community-centred health system.

In Aotearoa New Zealand (New Zealand), decades of effort have failed to achieve equitable health outcomes.[1,2] A stark socio-economic gradient in health is well documented, and institutional racism within health and social services further compounds material inequities, especially for Māori and Pacific peoples.[3,4] Recent high-level inquiries and reviews have reiterated that successive governments have struggled to effectively devolve resources and deliver services at the local level for all communities.[5,6] Meanwhile, we know that in communities where the quality of service delivery is poorer and harder to access, the quality of the broader determinants of health, such as income, employment, housing and food, is also poorer.[7]

In 2021, at the same time as the country was dealing with the COVID-19 pandemic, New Zealand embarked on another round of health system reform in pursuit of "healthy futures", Pae Ora.[8] These Labour Government reforms aimed to create a more sustainable, accessible and fair system through several key changes. The *Pae Ora (Healthy Futures) Act 2022* (the *Pae Ora Act*) established a national health charter to guide system-wide stewardship; replaced 20 district health boards (DHBs) with a single national entity and four regional divisions under Health New Zealand – Te Whatu Ora; and created a co-governance arrangement with Māori through Te Aka Whai Ora, a new Māori Health Authority—a key recommendation from the Waitangi Tribunal's *Hauora* report.[5,9] The *Pae Ora Act* also introduced geographically defined "localities"; a model intended to grow and strengthen local networks of providers and community partnerships to drive better local decision-making and resource allocation. Localities promised not just another structural reorganisation, but the possibility of real devolution and genuine power-sharing with communities. The *Pae Ora Act* also reinforced the focus on local need by establishing Iwi–Māori Partnership Boards (IMPBs) as a key mechanism to embed Māori and local voices into health system governance. The IMPBs were to represent local Māori perspectives on health needs, priorities and service design.

In late 2023, the incoming coalition government signalled a significant shift in direction, returning to short-term, more easily measured targets and moving away from equity as an explicit health system goal. Under urgency, the *Pae Ora* reforms were "reset", resulting in the disestablishment of Te Aka Whai Ora – Māori Health Authority, a move seen by some as undermining decades of advocacy for independent Māori health leadership.[10] This rollback of Māori influence on health decision-making has been followed by other top-down decisions impacting trust within Māori communities, such as questioning current progress on Te Tiriti o Waitangi (Te Tiriti), de-emphasising te reo

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Māori and halting the use of ethnicity as an indicator of health need.[11]

Nonetheless, this reset did retain IMPBs, intended to give whānau and hapū a direct role in identifying what is working and what needs improvement in health services and the wider system, thereby providing some accountability to Māori communities. However, recent legislative changes have seen the IMPBs lose agency, retaining only an advisory capacity.[12,13] Some were already arguing that to function effectively, IMPBs would require dedicated funding and infrastructure, and better, more accessible data and information.[14] While IMPBs currently remain—albeit in a less potent form—the rollout of "localities" has been paused, delaying their mandatory establishment and locality plans until July 2029 and 2030, respectively. This delay leaves the reform's promise of more integrated and locally responsive health services uncertain.

Persistent inequities and past attempts at devolution

Multiple high-level reviews in recent years point to the urgent need for directing resources and decision-making power towards communities in need and addressing the determinants of health. The Waitangi Tribunal's *Hauora* report[5] identified breaches of Te Tiriti by the Crown, specifically in terms of health sector leadership, and recommended structural reform. Similarly, the *Health and Disability System Review*[6] that underpinned the *Pae Ora* reforms highlighted system fragmentation and a pattern of underserving communities, calling for substantial changes to achieve a genuinely population-focussed system.

The rhetoric of shifting the health system toward primary care and community-based approaches is decades old and has been central to influential frameworks in health, such as the Ottawa Charter for Health Promotion.[15] New Zealand's *Primary Health Care Strategy* (2001) envisioned a community-oriented, prevention-focussed model of care. At this time, some steps were taken: Primary Health Organisations (PHOs) were formed and some services were devolved to DHBs and community providers. However, much decision-making power and accountability remained centralised, with underlying incentive structures, including fee-for-service funding and private ownership in general practice, meaning profit interests continued to dominate.[16] Further, the Waitangi Tribunal (2019) identified systemic underfunding of Māori primary health care organisations and providers from the outset, compounded by limited Crown data that would enable effective monitoring and tracking of its own performance in achieving health equity.[17] In short, past reforms, despite stated intention, did not substantially alter the system's power dynamics.[1] There was little shift toward genuine community involvement or shared local health goals.

Centralised decision-making and control have persisted through successive reforms,[8] despite strong evidence that community-centred health systems are more efficient and effective, particularly over the long term.[18,19,20] Evidence shows that community-led or devolved initiatives have achieved measurable health gains, especially in populations with lower life expectancy linked to socio-economic deprivation. In these settings, the most enduring improvements arise from effective action on the determinants of health.[21–25] Indeed, health systems that embrace intersectoral approaches also tend to be more resilient to complex challenges such as climate change and pandemics,[26] reflecting the Sustainable Development Goals' emphasis on local resilience and partnership.[27] By deliberately accounting for local context, health organisations and policymakers can align action with the assets, relationships and capacities already present within communities, ensuring that services and intervention are more responsive and locally acceptable.[28]

Despite the recognised benefits of devolution, a persistent challenge has been the integrity of its implementation. When poorly executed, devolution can lead to reduced expertise and capacity at the local level,[29] not because of weak intent, but because responsibility is transferred without the corresponding knowledge, authority or resources. Like many other high-income countries, New Zealand's health system has remained shaped by paternalistic policy paradigms, often disconnected from community realities.[18] Policy and management decisions have tended to prioritise financial control, technological solutions and institutional or political interests over local experience and lived realities. This helps to explain why successive attempts at "devolution" or "partnership" have struggled to deliver in practice.

The passing of the *Pae Ora Act* in 2022 launched an ambitious suite of reforms aimed at finally breaking the cycle of inequities in health. The reform agenda recognised that structural reorganisation was needed not only at the centre, but also of the structures that reached into local

communities. By creating formal local structures for partnership and community input, the reforms were attempting to move beyond tokenistic consultation toward genuine co-ownership with local communities. Early on, there was cautious optimism, tempered by the lessons of previous attempts at "devolution". Earlier reforms, such as the establishment of Area Health Boards in the 1980s and DHBs in 2001, failed to transfer real agency to communities.[30,31] Despite new governance structures, decision-making remained highly centralised, with continued tight control over funding and narrow accountability requirements that constrained local flexibility.[32]

The reforms initially held promise. From the outset, there was recognition that structural change alone would be insufficient, without accompanying cultural and relational change. Transformation would require shifts in the ways people and organisations worked together across the system.[8] Yet, as implementation unfolded, this focus on culture change was largely lost. In practice, the creation of new central entities, on their own, cannot alter entrenched system behaviours if existing practices and power relationships remain. The minority view on "Māori commissioning" within the *Health and Disability System Review*[6] similarly cautioned that, without integrity in implementation, a genuine commitment to equity and shared decision-making, *Pae Ora* risked becoming yet another missed opportunity for meaningful change.

Viewed through the lens of complexity science, this missed opportunity points to a deeper need to understand how system behaviour emerges from relationships, incentives and feedback. It is these dynamics that need to change if any future reforms are to successfully improve the performance of the whole health system.

What can complexity science tell us about implementation and whole-system reform?

Globally, health systems are increasingly understood as complex adaptive systems.[33,34] Population distributions of health outcomes emerge from countless interactions among diverse actors and forces: hospitals, primary care, public health agencies, communities, patients, social services, economic and political dynamics, cultural norms and more.[35] In a complex system, relationships and interactions drive outcomes.[36] Effects are often non-linear, with small changes amplified through feedback loops. Population-level patterns, such as persistent health inequities, are emergent properties: they arise from systemic interactions over time, rather than from any single cause or policy that can be adjusted in isolation. Health systems themselves are not only complex, but they are nested within broader complex social systems. Grasping complexity is not just an academic exercise, it is essential for identifying actions that lead to meaningful change. For example, the socio-economic gradient in health is not simply the result of personal choices or bad policy, but rather the interplay of economic, educational, healthcare and social factors, along with government responses, that reinforce each other within places and across generations.[37]

Because of these dynamics, intended actions often have unpredictable effects. A policy that succeeds in one community may fail in another because local histories, relationships and resources differ.[38] Yet across sectors, complex systems display recognisable patterns of behaviour; feedback loops, adaptation and path dependence mean that while specific outcomes cannot be predicted, broad tendencies can. In health systems, for example, we can anticipate that when decision-making remains highly centralised and community knowledge is excluded, inequitable health outcomes are likely to persist. Similar patterns can be seen in other domains, such as education or environmental management, where top-down initiatives struggle when they overlook local realities. Conversely, changing the "rules of interaction"—for instance, through community co-design of services, shared governance or directing more funding toward locally led prevention—can trigger new system dynamics that support innovation and longer-term improvement.[39]

Knowledge of complexity helps explain how we are reproducing patterns of health outcomes over time. It strengthens the argument for empowering local communities to participate in creating conditions where new configurations of practice, service delivery, and innovation can emerge, thereby altering the system's trajectory. Essentially, a "butterfly effect", where small, early changes can generate large effects.[40,41]

The "butterfly effect" and local community-led innovation

The concept of sensitivity to initial conditions (the "butterfly effect"), illustrates how small changes can lead to significant differences in outcomes

over time. In health systems, this suggests that local, community action can have disproportionately large, long-term impacts. For example, a small community-led initiative might shift a feedback loop by building local trust, increasing engagement with preventive care, or modelling an integrated service which others then replicate, thus putting the system on a new trajectory. Over time, these local "seeds" can grow into widespread change (analogous to a butterfly's tiny wings eventually altering the weather).

New Zealand's COVID-19 response demonstrated the importance of community-led action—both in a crisis and, by extension, in system change. Faced with urgent threats, many bureaucratic barriers fell away, resources were rapidly mobilised and, in some cases, communities were empowered to act. The government's early pandemic response showed unprecedented coordination across sectors. Community providers, including many Māori and Pacific health organisations, NGOs, iwi and hapū, played central roles in testing, vaccination, outreach and social support, filling longstanding gaps left by inadequate policy.[42,43] Māori providers, backed by iwi leadership, established health hubs, distributed care packages and delivered tailored public health messages in te reo Māori and Pacific languages. Pacific church and community leaders mobilised to boost vaccination uptake. Parts of the pandemic response demonstrated that trust-based, flexible, community-embedded approaches yielded faster and more effective solutions than centralised control could achieve on its own. The national public health response tapped into pre-existing relational infrastructure built on trust and local connections. We saw a glimpse of the system becoming more adaptable and resilient when bottom-up action was enabled. But we also saw resistance to this from government and policy organisations, and ultimately a quick return to the status quo, even for those initially enabled.[44]

This experience reinforced a critical lesson. Relationships and trust are not peripheral to system performance—they are causal.[45,46] A major flaw of past New Zealand health reforms has been the repeated disruption of health system and community relationships. Each restructuring tends to reset institutional memory, weaken local networks and further distance the "centre" from community realities.

One principle of change in complex systems is the need for feedback mechanisms that keep the system aligned with its desired goals.[47] The "localities" were intended to provide precisely that—channels through which information about what is working (or not) on the ground could flow back up, and through which communities could hold the system accountable. Without these feedback loops, the system risks once again becoming "insensitive to initial conditions" at the local level—small local issues risk growing into big problems before the centre notices.

The implications of putting localities "on hold" are significant. In their absence, it is unclear how the system will now ensure local health needs and priorities are identified and addressed. To date, no model has been articulated that states how the benefits "localities" promised will be achieved. Removing or weakening formal structures for local community input and action removes essential feedback loops, which were only just beginning to be built back into the system. It sets the stage for a return to the familiar scenario where a policy looks fine in theory but fails in practice because it was not cognisant of local context.

A way forward: embracing community-led action in a complex health system

Amid growing awareness of planetary challenges,[48] demographic change and economic constraint, New Zealand must find ways to make its health system both more effective and more sustainable. International evidence shows that community-led action is not a "nice-to-have" but essential for long-term system performance. This requires moving beyond short-term targets and centralised control, towards valuing local knowledge and long-term learning. Even if formal locality networks are paused, the intent behind them should continue through other mechanisms that strengthen community agency and cross-sector collaboration.

A complex systems lens reminds us that researchers, policymakers and health professionals are not external observers pulling levers—we are part of the system we seek to change.[49] Every intervention becomes an event within that system, interpreted and responded to in unpredictable ways. In community settings, interventions act less as fixed "doses" and more as catalysts that interact with existing conditions, often triggering ripple effects that cannot be fully anticipated.[50] This perspective demands both humility and continuous learning. Health equity cannot be mandated from above, it must be co-created by

working with the system's adaptive nature and supporting all actors—including communities—to shift practices and resource flows.[23] Complexity science also highlights that a system's underlying purpose and mindset are far more powerful levers of change than structural changes alone.[47] In human systems, true purpose is revealed through everyday practice. If the stated aim is better health for all, then the actions that shape funding, planning and accountability must consistently reflect that purpose.

Primary care remains a key nexus for change and must be better funded, focussed on universal access and incentivised to respond to local contexts.[51,52] While capitation can improve access, it does not address workforce shortages, system capacity gaps or the higher costs of caring for people with complex needs.[53] Short electoral cycles also prioritise visible, short-term gains over enduring community health outcomes.[1] To change this dynamic, funding models could be tied to locally defined health goals, rewarding providers for improving population wellbeing rather than increasing service volume.

Investment should also extend beyond clinical settings to the places where health is created or lost—homes, schools, workplaces and neighbourhoods. This means shifting from treating illness in silos to promoting wellbeing across communities. Investment strategies should enable local organisations to better collaborate on shared goals, recognising that social determinants—such as housing, education and food systems—are integral to the health ecosystem. Lessons we already hold need to be taken up from initiatives, like Whānau Ora and Healthy Families NZ, which are demonstrating how to work across sectors and build local capacity.[23,25]

An integrated prevention and primary care system should be re-centred around community need and insight, underpinned by stable, long-term funding that enables collaboration and innovation across local organisations. At present, financial, political and professional incentives often undermine locally led prevention efforts.[54] Instead, commissioning models should embed mechanisms that allow communities to define what success looks like, moving beyond top-down key performance indicators to measures that reflect local values and priorities.[55–57]

Centring communities requires more than consultation or co-design, it demands a rebalancing of relationships between central- and local-government and communities,[58] with a focus on increasing local agency and genuine co-ownership of health goals. Community partnerships should hold real decision-making authority over portions of health budgets so they can direct resources toward local priorities. Central agencies, in turn, should act as enablers; setting broad outcomes and standards, while allowing flexibility in how local communities determine and achieve them. Critically, resources must align with responsibilities. Many Māori, Pacific and community providers operate with limited and insecure funding; strengthening their capacity is not ancillary but foundational to system resilience.[25,44]

In a complex system, outcomes cannot be fully planned or controlled, so continuous learning and adaptation are vital. A learning health system relies on data and insight to refine programmes and policies in real time as conditions change, but it also depends on reflection and responsive action. Digital technologies and emerging tools, such as artificial intelligence, hold promise for addressing workforce shortages, improving timely access to care and creating more integrated data systems. However, even the most sophisticated technology and tools will not improve outcomes for all communities if the underlying conditions of the delivery system remain unchanged. If local and primary care organisations continue to face inadequate resourcing and barriers to collaboration they will struggle to respond effectively to community needs. Greater local data sovereignty must therefore be central to the design of learning health systems. Routinely collected data should be made available through trusted, free and user-friendly platforms, and communities should be supported to interpret and apply evidence to their own contexts.[59] Over time, data and local insights can become a shared asset for collective action rather than a mechanism of control. Tracking data in context can build a richer understanding of community needs and assets, supporting locally grounded solutions that are trusted and sustainable.[23]

A learning and adaptive health system

History shows that top-down change, without grassroots agency, fails to improve the health of the whole population. The 2022 reforms wisely, but timidly, combined structural change with community empowerment. If implemented well, it is an approach that still holds promise. Eliminating the postcode lottery in health requires systems that foster inclusive and trusting relationships,

strengthen community networks, support local innovation and adapt in response to new information. Small, community-level changes can spark significant shifts, but only if the broader system supports and nurtures them. Community-led health action is not a threat to unity—it is an essential lever for system learning and improvement.

New Zealand needs to learn from its past missteps. Either we repeat failures or embrace pae ora. Without an ability to learn, we risk a future where: we are unable to respond to emerging local changes before they become larger problems; inequitable health outcomes persist or worsen for some communities; public trust further erodes amidst continual restructurings; and we are unable to respond with speed to current and emerging health threats. But, if we equip and empower communities and frontline providers to act more collectively, we can create the feedback that supports resilience and enables the health system to learn, adapt and innovate. We need a health system rebuilt with patients and communities at the centre, not just redesigned for them. Only by shifting the locus of control closer to where health is created can we have lasting, meaningful improvements in health for everyone.

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