

Māori Health

Introduction

The health and disability sector has responded to growing Māori leadership throughout numerous changes to ensure there is a Māori voice in health decision-making and by developing more appropriate services for Māori. For the first time health legislation requires health agencies to recognise and respect the principles of the Treaty of Waitangi and to explicitly address Māori health issues.

Key strategies for improving Māori outcomes include mainstream effectiveness, focusing on health priorities, reducing inequalities, and investing in Māori provider and workforce development. More recently the health and disability sector has also acted on the wider determinants of health by working alongside other sectors.

Disparities between Māori and non-Māori health persist, however, and the health and disability sector must pick up the pace to enhance the progress it has made in these areas and to address contemporary and emerging issues. With these foundations in place, it is imperative that [He Korowai Oranga, the Māori Health Strategy](#), is released.

Māori Health Strategy - He Korowai Oranga

[He Korowai Oranga](#) is a draft Māori Health Strategy intended to guide the whole health and disability sector, including the Ministry of Health and particularly the District Health Boards (DHBs) in implementing their responsibilities for Māori health.

The strategy was signalled in the New Zealand Health Strategy and is currently awaiting Cabinet approval. Release of the strategy is a priority as Māori and DHBs have been looking to it to provide certainty around planning. (DHBs are, in the meantime, incorporating aspects of the draft strategy into their planning).

Aim – Whānau ora

The overall aim of He Korowai Oranga is whānau ora - healthy Māori families supported to achieve their maximum health and well-being. Four pathways are proposed for achieving whānau ora:

- whānau, hapū, iwi and Māori community development
- Māori participation throughout the health and disability sector
- effective health and disability services
- working across sectors.

Achieving whānau ora requires thinking beyond burdens of disease and health inequalities, to recognise and build on the integral strengths and assets of

whānau, and encourage whānau development. Rather than proposing ad hoc initiatives and programmes, the strategy sets out to improve decision-making and processes throughout the sector, so the whole system works to improve Māori health.

Implementation – Whakatātaka

Whakatātaka, an action plan to guide implementation of the strategy over the first two to three years, is also awaiting Cabinet consideration.

Whakatātaka outlines roles, responsibilities, performance expectations, measures and initiatives for achieving the strategy.

The action plan includes:

- Māori expenditure targets for DHBs
- a monitoring framework so progress towards whānau ora can be assessed
- support for whānau and Māori community development
- continued development of relationships between Māori and the Crown
- Māori provider and workforce development
- expansion of best practice cultural competence tools for providers
- support for Māori traditional healing practices
- identification and reduction of access barriers to effective services for Māori
- improving Māori health and whānau ora information, including ethnicity data and Māori health research.

Implementation will be funded from within the health funding package, particularly the primary care funding. No separate funding has been allocated specifically to the strategy, since the intention is to realign service planning and delivery so the whole of Vote:Health works to benefit Māori, not just tagged funding. DHBs will be expected to give priority to the strategy in their prioritization and funding decisions, and will be monitored on their expenditure.

Treaty of Waitangi and the health and disability sector

The Treaty of Waitangi is a key influence over the health sector, which was the first to include reference to the Treaty in social legislation. The three principles of partnership, participation and protection are integral to the NZ Public Health and Disability Act 2000, which requires DHBs to involve Māori in decision-making and service delivery, improve Māori health outcomes and reduce disparities. Treaty principles also underpin the four pathways of He Korowai Oranga.

The 2001 Waitangi Tribunal report on the Napier Hospital Claim (WAI 692) also highlighted the relevance of the Treaty to health. The Tribunal upheld claims that insufficient consultation took place about the closure of Napier hospital, and that the Crown had failed to provide for the health and well being of the claimants. The claim was a local one (hapū), and the Government's response to the

Tribunal's recommendations is still being worked through. The findings of the Tribunal have implications for wider health policy.

An area of policy uncertainty is the relationship between the Treaty and the new Human Rights legislation. There is the potential for Māori status as a Treaty partner and 'rights' as indigenous people to be eroded through misinformed application of the Human Rights legislation. Further discussion on the relationship between the Treaty and the Human Rights legislation is provided in a separate briefing on the Human Rights Act.

The remainder of this paper identifies key activities and issues under the Treaty principles of Partnership, Participation and Protection.

Partnership

Partnership with DHBs

DHBs involve iwi and Māori in their decision-making through partnerships at the board level and just over half had formalised these relationships by June 2002.

Current issues around partnership at the DHB level include:

- an ongoing need to support iwi and Māori communities with funding and information to enable them to fully participate in decision-making
- how DHBs will relate to non-iwi-based Māori communities, particularly in areas with large urban Māori populations
- the evolving role of the Māori co-funding organisations (MAPO) (in the northern regions) which combine governance and operational functions
- a recent Crown Law opinion which distinguishes between the Crown as the Treaty partner and DHBs as Crown agents. The Ministry and DHBs are still working through these issues.

The Ministry has supported Governance training for local Māori 'partnership groups'.

Partnership at the central government level

Most iwi consider the primary Treaty relationship to be with the Crown rather than DHBs. The Ministry of Health has been working with key iwi to identify options for partnership at the central government level and will be providing advice on these over the next few months.

A number of Treaty based relationships (seven), including those with the three MAPO, were transferred to the Ministry of Health when it took over the Health Funding Authority's functions. The long term basis of these relationships needs to be determined.

On the horizon

Many iwi have a desire for greater control over their own affairs without intermediaries such as DHBs. Related to this is frustration on the part of many iwi at having to rearrange themselves to respond to shifting government structures. Other issues include the contracting model which has high transaction costs and often a mismatch between the needs of communities, activities of providers, and the required contract outputs.

The next ten years may see direct devolution of social service funding to iwi and major urban Māori groups. Options already being explored include:

- one government agency acting on behalf of others to streamline contracting with iwi for a range of social services, and
- a full devolution model where iwi would purchase services on their own behalf.

Participation

District Health Boards (DHBs)

DHBs and their advisory committees are required to have Māori membership. All boards have at least two Māori members with more where there are larger Māori populations. Issues include:

- membership of local iwi versus Māori from other areas
- a need to increase governance and Treaty skills so all board members can fulfill their joint responsibilities to improve Māori health.

The Ministry of Health is supporting governance training for Māori board members, and has developed a Treaty training package for all board members.

Māori providers

Māori providers increased significantly in the 1990s to over 200. Māori providers are still relatively new and limited in size, service configuration and geographical scope. With some exceptions, most are still in the development phase and will need sustained support to enable them to reach their full potential.

At the operational level, Māori Development Organisations provide avenues for addressing development, quality and coordination issues.

Issues for Māori providers

Funding for Māori specific services totaled only 2.5% of Vote:Health in 2000/01 and DHBs will be expected to increase their investment in this area in future years. The Ministry will be working with DHBs to establish appropriate Māori health expenditure targets for inclusion in their 2003/04 Crown Funding Agreements.

Māori providers have expressed anxiety about some boards seeking to reduce their deficits, but at this stage it appears no services have been cut.

Of greater concern is the fact that there has not been any increase for administrative overheads and contracts for some years, and pressure is building for providers. In addition, Māori primary care providers often service high need, low income populations with little access to insurance or capacity to pay fees. Combined with shortages in skilled Māori workers, these pressures have led to sustainability concerns for some providers.

The new primary care funding provides an opportunity to address some Māori provider sustainability issues, while continuing to direct funding to the areas of highest need. Several Māori providers are now looking at developing into Primary Health Organisations (PHOs), and are working with the relevant DHBs.

Māori Provider Development Scheme

The Māori Provider Development Scheme (MPDS) remains an important source of support while providers address the some of the provider issues around funding, skill development and sustainability.

The MPDS has progressed into the fifth year. The MPDS currently allocates \$10 million (including GST) each financial year to developing managerial and clinical/professional capacity of Māori providers and workforce. Over the next year the funding level and criteria for the MPDS will be aligned with the objectives of He Korowai Oranga.

Māori workforce development

Māori continue to be under-represented at all levels of the health and disability workforce. The Health Workforce Advisory Committee has identified expansion of the Māori health workforce as a major issue.

Although Māori comprise approximately 15% of the total New Zealand population, only 5% of the regulated health workforce are Māori¹. Māori in the health workforce are also less qualified than their non-Māori counterparts.

A lack of such workers is one constraint holding back the development of Māori (and mainstream) providers and the health and disability sector's capacity to deliver accessible and appropriate services to Māori.

Despite the inroads that the MPDS, the Clinical Training Agency (CTA) and mental health and education initiatives have made, a number of key issues remain to be addressed including:

¹ Health Workforce Advisory Committee. 2002. *The New Zealand Health Workforce: A Stocktake of Issues and Capacity 2001*. Wellington. Health Workforce Advisory Committee. p52

- a whole of government approach with an emphasis on the wider issues Māori participation in education
- promotion of the health sector to Māori students as a desirable profession, possibly beginning at Form 2
- dissemination of quality information through appropriate processes to inform Māori whānau of the opportunities to engage in a health career
- a need for the Health and Education sectors to recruit and retain Māori students in tertiary programmes for professional development
- innovative use of Māori role models in the health sector to promote health professions as a career choice
- new qualification systems to recognise the considerable knowledge and skills of Māori community health workers

The Ministry will be developing a Māori workforce plan in implementing He Korowai Oranga.

On the horizon

The first DHB elections had disappointing results with only three Māori elected out of 119 who stood. The move to a single transferable vote (STV) system may help but it is unlikely elections will ever ensure an adequate Māori voice on DHB boards, which will put pressure on Ministerial appointments.

Māori providers are now entering a new stage of development and there is a range of possible directions they could take including:

- joint ventures with mainstream providers
- collaboration with other Māori providers to increase critical mass and sustainability
- developing into cross-sectoral providers, offering a range of health and social services for whānau

All providers include non-Māori clients, and some are taking on mainstream contracts for the general population. An example is a Māori trust in the Auckland region which has the regional contract to provide needs assessment and service co-ordination services for everyone in the area.

New forms of workers will also be needed to support the emerging focus on whānau ora, whānau and community development and population health approaches.

The key issue is to ensure policy and funding arrangements remain flexible enough for Māori themselves to decide in which direction they wish to develop.

Protection

Inequalities framework

New Zealand analysis and international evidence shows that it is possible to raise the aggregate levels of health of populations, but not eliminate the social gradients in health². The task of improving Māori health means not only addressing issues of access to and effectiveness of health services, but also tackling the underlying social and economic conditions that impact on people's health. From a Māori perspective, historical events and decisions have had a significant impact on present health patterns, through both narrowing the economic base and reducing Māori political influence³.

The Ministry of Health has developed a strategic framework for reducing inequalities. The framework highlights four points of interventions: the social, economic and cultural factors that fundamentally determine the health of populations; the intermediary pathways, through which the social, economic and cultural determinants affect health; health and disability services; and the impact of disability and illness on individuals' economic and social status. The framework will assist policy makers, services planners, funders, and providers to achieve Government's aim of reducing inequalities in health⁴.

Māori health status

Māori suffer a greater burden of disease, relative to non-Māori. After eliminating variations caused by age, gender, and socio-economic deprivation, Māori still experience a higher prevalence of most disease groups, including diabetes, cardiovascular disease, cancer and respiratory diseases, as well as infectious diseases such as meningitis, rheumatic fever, hepatitis B, and tuberculosis.

The relatively poor health status of Māori results from the following factors, each of which interact:

- poorer social and economic status of Māori
- health services failing to reach Māori to the extent indicated by their high health need
- greater exposure to behavioural / lifestyle and physiological risk factors
- lack of appropriate information

Intersectoral approach

A key government goal has been to reduce inequalities in Health, Education, Employment and Housing. Examples include Strengthening Families and Intersectoral Community for Action initiatives.

² Ministry of Health. 2000. *Social Inequalities in Health: New Zealand 1999*. Wellington. Ministry of Health.

³ Durie, M. 1998. *Whaiora: Māori Health Development*. 2nd Ed. Auckland. Oxford University Press.

⁴ See briefing on "Reducing inequalities and improving population health and disability outcomes".

Working intersectorally requires better co-ordination of strategies among sectors, and supporting and strengthening the capacity of Māori communities. Iwi and the Government are working on initiatives to develop a 'whole-of-government approach' to services. Appropriate consultation with Māori, whānau, hapū, Iwi and Māori communities is an important part of this development.

Working across sectors is a pathway in He Korowai Oranga.

Mainstream effectiveness for Māori

Historically, many health programmes have been effective for the majority population yet have often not worked for Māori⁵. Mainstream health and disability organisations have been working to improve the effectiveness of their services to Māori. For example many hospitals now have Māori and whānau units to better meet the needs of Māori patients and ensure cultural safety.

Prioritising specific health conditions, which are amenable to health sector intervention as in the population health objectives of the New Zealand Health Strategy, has also been an important development.

Despite improvements in mainstream services, the high-unmet Māori health need remains a significant concern. Recent research⁶ indicates that Māori and Pacific people tend to present later in the course of a condition and do not appear to derive the same benefits from the services, compared to the rest of the population.

The determinants of unmet health need are complex and ongoing effort is needed to develop approaches to improving mainstream services, providers, and systems so that they prioritise Māori health. Whakatātaka includes actions to improve mainstream effectiveness by DHBs such as identifying and addressing barriers to appropriate and effective care for Māori and expanding of best practice in cultural competence in the services they fund or deliver.

Primary Health Care Strategy

Particular effort has gone into ensuring primary health care services meet the needs of Māori more effectively. This is where many conditions can be prevented or managed early. It is expected that the move to population health approaches in the new PHOs will improve health outcomes for Māori, but evidence of their effectiveness and their ability to reach more Māori with high health need will not be discernible for some years.

⁵ Ministry of Health. 2000. Social Inequalities in Health: New Zealand 1999. Wellington. Ministry of Health.

⁶ Tukuitonga, C. and Bindman, A. 2002. Ethnic and gender differences in the use of coronary artery revascularisation procedures in New Zealand. *The New Zealand Medical Journal*. Vol 115, No 1152: 179-82; Ministry of Health. 1999. *Taking the Pulse: The 1996/97 New Zealand Health Survey*. Wellington. Ministry of Health.

Disability issues

Areas identified as needing further work include the need to:

- develop needs assessment processes and criteria appropriate to Māori
- improve service co-ordination between primary care services, disability providers and Māori community health initiatives.

The Ministry of Health has a Māori disability action plan, which will help to focus health and disability activities to improve services for disabled Māori.

Monitoring and Evaluation

Monitoring DHB progress on Māori health

DHBs are monitored on their performance on Māori health objectives. During the establishment phase Māori indicators concentrated on ensuring that DHBs were building relationships with iwi and Māori communities and planning for the development of Māori workforce and providers.

It is too soon to assess how DHBs will perform with regard to their Māori health objectives and functions, however the early signs are encouraging. There has been a discernible shift in DHBs' preoccupation with hospital issues to planning for population improvement.

Ethnicity data collection

Ongoing problems with the quality and comprehensiveness of ethnicity data continue to hamper attempts to monitor Māori health. The issue is exacerbated by changes in the Census ethnicity question.

Ethnicity data has been identified as a priority in a range of contexts including He Korowai Oranga, the Ministry's WAVE report, and the National Health Committee quality report. The Ministry has an internal working group to address this issue.

Collection of ethnicity data has been a requirement for hospital services and some primary and community services for some years, but the quality of the data collection has been questionable because of misunderstandings about the importance of collecting such data and use different definitions. Collecting accurate standardised ethnicity data has become even more urgent as funding for DHBs and PHOs will in future be linked to ethnicity and health needs.

Monitoring outcomes

The emerging focus on wider determinants of health, inequalities and whānau ora require new ways of monitoring outcomes and effectiveness. The Ministry is developing performance indicators in each of these areas.