

Whāia Te Whanaungatanga: Oranga Whānau

The Wellbeing of Whānau:
The public health issues

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Whakapuakitanga: Foreword

This document contributes to a series of papers on public health issues developed by the Public Health Group of the Ministry of Health. It should be read in conjunction with the Ministry of Health's revised plan for public health called *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health* and *He Matariki: A strategic plan for Māori health*.

As a result of the 1995 Health and Disability Services Amendment Act, amendments to the Health Act 1956 and the Health and Disability Services Act 1993, the Ministry of Health is required to improve, promote and protect the public health. In accordance with the Act as amended, the Public Health Group (PHG) of the Ministry of Health is required to regularly consult the public, those involved in the provision of public health services and other appropriate persons.

I wish to thank staff of the PHG for their efforts in developing this paper. The extensive consultation undertaken by staff has ensured that the issues related to important public health matters have been well canvassed and systematically analysed. Such analysis provides a good basis for quality policy advice to the Minister.

The PHG invites comment on strategies to address the issues contained in this paper. Please send your comments to the address shown at the back of this paper.



Karen O Poutasi (Dr)
Director-General of Health

He Mihi

E ngā waka
E ngā hau e whā
E ngā iwi
Kia mihia te mano tini kua mene ki ngā Hawaiki katoa
Rātou te tutūtanga o te puehu
Te whiunga o te kupu i ngā wā takatū ai rātou
Heoi, waiho ake rātou ki a rātou
Tātou te urupā o rātou mā
Ngā waihotanga mai e hāpai nei i ō rātou wawata
Tūmanako hoki
Kia mau ki te kura whero
Kia mau ki te kura tāwhiwhi
Kei waiho tātou hei whakamōmona i te whenua tangata
Hokia ki ngā maunga kia purea tātou e ngā hau a Tāwhirimatea
Nō reira
Whakarongo, whakarongo, whakarongo
Ki te tangi a te manu e karanga nei
Tui, tui, tui, tuia
Tuia i runga, tuia i raro
Tuia i roto, tuia i waho
Tuia i te here tangata
Ka rongo te pō, ka rongo te ao
Tuia i te kāwai tangata
I heke mai i Hawaiki nui
I Hawaiki roa
I Hawaiki pāmamao
I hono ki te wairua
Ki te whai-ao
Ki te Ao-mārama
Tihei Mauri Ora

Ngā Whakamihi: Acknowledgements

I would like to thank the many individuals, groups and organisations who contributed to and commented on the draft discussion document *Whāia te Whanaukataka Oraka Whānau* which preceded this paper. In developing this paper, advice was sought from of a number of Māori health and community workers. The experience and knowledge of this group gave the paper its initial direction. The group comprised:

Peter Ruka	Te Runaka ki Otautahi
Alice Anderson	Plunket
Georgina Harris	Aronui Whānau Centre
Aroha Morgan	Aronui Whānau Centre
Luana Murray	Te Hauora o Te Taitokerau
Juline Hetet	Consumer Advocate
Maureen Agar	Plunket
Alice Anderson	Plunket
Inez Kingi	Tipu Ora
Lorna Dyall	Dyall, Hill and Associates
Makeke Herbert	Iwi Health Programmes – Murapara
John Ohia	Whaioranga
Raukura Tamahori	Health Promotion Central Auckland.

Comments on the draft discussion document *Whāia te Whanaukataka Oraka Whānau* were received from:

- Māori and iwi groups and individuals
- individuals and groups with an interest in public health
- ministries and government departments
- local government
- Health Funding Authority
- Crown health enterprises
- non-government organisations and other statutory bodies
- independent service providers
- academic departments.

A list of submissions received is provided at the end of the document.



Dr Gillian Durham
Director of Public Health, and
General Manager, Public Health Group

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Whakatuwheratanga: Introduction

*Hūtia te rito o te harakeke. Kei hea te komako e kō? Kī mai koe ki ahau – He aha te mea nui?
He aha te mea nui o te ao? Māku e kī atu – He tangata, he tangata, he tangata.
If you pluck out the centre shoot of the flax, where will the bellbird sing?
If you ask me what is the most important thing in the world,
I will reply – It is people, it is people, it is people.*

In 1995, the Public Health Commission (PHC) acknowledged the important role of whānau in promoting health practices and advancing health gain for Māori. The PHC stated that: ‘Given the central role that whānau play in the wellbeing of Māori individually and collectively, public health policy directed at improving the health status of Māori might best be directed at whānau’ (PHC 1995a: 25).

This publication builds on that early work on the various Māori public health issues and priorities identified in *He Matariki* (PHC 1995a). It briefly outlines some historical events that influenced the current state of whānau health in contemporary New Zealand society. It describes the health challenges that impact on individuals within whānau and on whānau as a collective. It reviews policy developments over recent years and describes the programmes that have developed to address the various cost, location, cultural and structural barriers that whānau experience in accessing health care programmes and services. Finally it examines issues associated with whānau intellectual and cultural property rights, and other associated research and information issues.

In so doing it assumes:

- whānau health and wellbeing is central to the health and wellbeing of Māori
- whānau have a positive role to play in improving the health and wellbeing of Māori.

Whānau sometimes mirror the stresses and strains of their interactions with wider New Zealand society. Nonetheless, the whānau structure, as a pivotal social and cultural force, remains an important source of safety and security for its members.

Consultation process

In 1997, the consultation process for the draft document which preceded this publication involved seven hui nationwide. The reports from these hui represented the oral submissions of 175 participants (Appendix 1). Thirty written submissions were also received from a range of Māori, non-Māori, professional and non-professional organisations, and some groups and individuals (Appendix 2). Overall there was general agreement from the 37 combined hui reports and written submissions received of the need for this publication on whānau wellbeing and health issues. The social aspects of the determinants of health received the most attention, with consistent interest from both hui participants and written commentaries. Many submissions sought clarification on various issues and made recommendations on ways to clarify and strengthen specific aspects of *Whāia te Whanaukataka Oraka Whānau: Discussion document*. The main themes that emerged from submissions will be addressed in relevant sections of this document.

Te reo

Te reo in the draft discussion document which preceded this publication was written in the Ngai Tahu dialect. Most of the small number of submissions received on this issue identified the need to reduce confusion in the use of this dialect. Suggestions provided to achieve this included using a more generic dialect, not translating proper nouns and titles into the Ngai Tahu dialect, providing English translations to proverbs and having a more complete glossary of Māori terms. Of particular note was the submission received from Te Puni Kōkiri (TPK) stating that:

although respecting the tikanga of Kai Tahu, TPK believed that the Ministry should use a more generic Māori dialect for the document. Many Māori do not speak te reo and those that do speak little reo find the dialect change difficult to comprehend. TPK has already received feedback from Māori to suggest that this is the case.

In response to these submissions received, the Ministry of Health has changed te reo used in the consultation draft document into a more generic dialect and has addressed the other suggestions provided.

Definitions

Today Māori society has recognised and adapted to organising itself around two particular concepts of family, the nuclear family of mother, father and child/children, and the extended family of three generations or more (whānau) (Taiapa 1994).

Family

Families can be described by their composition (single-parent family, nuclear family, extended family), by their socioeconomic status (high/ middle/ low income family), by their age distribution (child dependent family, young family), by their ethnicity (Māori/Pākehā family) or by the way in which the family interacts with society (political/ problem/ dysfunctional) (Durie 1994a).

Whānau

Durie (1994a) defined whānau as more than simply an extended family network. A whānau is a diffuse unit, based on a common whakapapa (descent from a shared ancestor) and within which certain responsibilities and obligations are maintained. However, the term 'whānau' has been broadened in more recent times to include a number of non-traditional situations where Māori with similar interests (but not direct blood relationships) form a cohesive group (Durie 1994a).

Metge (1995) argued that the term whānau has various definitions, and reflected the diverse range of relationships which exist in different circumstances and included:

- a set of siblings
- all the descendants of a relatively recent ancestor but not their spouses and whāngai
- all the descendants of a relatively recent ancestor and their spouses and whāngai
- all the descendants of a recent ancestor and their spouses and whāngai who interact together on an ongoing basis
- descent groups also known as hapū and iwi
- a nuclear family

- a group of unrelated Māori who interact on an ongoing basis
- a group of people gathered for the purpose of supporting an individual or individuals
- a large group of people gathered for a common purpose (Metge 1995).

Essentially, these definitions present similar aspects and unique differences which reflect the range of traditional and contemporary configurations that comprise 'whānau' in New Zealand society.

Oranga

The concept of oranga is defined as wellbeing in *He Matariki* (PHC 1995a). Wellbeing is a subjective experience and can be classified as an outcome that is influenced by a number of factors. Such factors would include the various aspects of a healthy Māori identified at the *Te Ara Whakamua* hui held in 1994, which included:

- a sense of identity
- self-esteem, confidence and pride
- control of his/her destiny
- a voice that is heard
- intellectual alertness, physical fitness, spiritual awareness
- personal responsibility, co-operative action
- respect for others
- knowledge of te reo Māori and tikanga Māori
- economic security
- whānau support (TPK 1994e).

Functions of whānau

Along with whānau membership comes a range of roles, obligations and responsibilities, and a number of functions. Durie (1994d) identified five primary needs that are satisfied by the family and whānau. These are:

- *manaakitanga* – the roles of protection and nurturing
- *tohatohatia* – the capacity of the whānau and the family to share resources
- *pupuri taonga* – the role of guardianship in relation to family/whānau physical and human resources and knowledge
- *whakamana* – the ability of the family/whānau to enable members
- *whakatakato tikanga* – the ability of whānau to plan for future necessities.

Models of health

A number of Māori models of health have been developed which assess Māori health status in a holistic manner. These include Durie's *Whare Tapa Whā* (1994a), Pere's *Te Wheke* (Pere 1984), and the Royal Commission on Social Policy *Ngā Pou Mana* models (Royal Commission on Social Policy 1988).

The *Whare Tapa Whā* (four cornerstones of the house) comprises four components which when applied to the whānau policy context are:

- *te taha hinengaro*, which refers to the mental wellbeing of the whānau as well as each individual within it
- *te taha tinana*, which refers to the physical aspects of health as well as the physical symptoms of ill health
- *te taha wairua*, which is the spiritual health of whānau, and includes the practice of tikanga Māori in general
- *te taha whānau*, which refers to the whānau environment in which individuals live. It includes the cohesiveness of the whānau unit, the health of the environment created within the whānau (for example, whether it is safe and supportive), and the relationship of the whānau to its community (Durie 1994a).

Te Takenga Mai: Background

This section provides an overview of selected historical events during pre- and post-colonisation which impacted on traditional whānau, hapū and iwi structures. The outcome of these historical incidents and the adverse effects of colonisation resulted in the depopulation of Māori in the late 19th and early 20th century. The long-term effects of these occurrences continue to adversely impact on whānau wellbeing and health in contemporary New Zealand society.

Māori society prior to colonisation

Prior to colonisation, Māori society was organised around whānau, hapū and iwi kinship groups, which identified with a common ancestor (Te Rangi Hiroa 1949). Whakapapa (genealogical connections) identified the relationships between the whānau, hapū and iwi structures. Traditional Māori society recognised both male and female descent lines – mana wāhine and mana tāne (Metge 1995). The world was divided up into physical and spiritual realms, and these impacted on the wellbeing of whānau (Marsden 1975). Social norms of behaviour were influenced by the relationship between tapu and noa. Durie (1994a) argued that the strategies used to protect whānau from tapu often equated with currently recognised public health strategies. Whānau were collectively responsible for family functions such as raising children. Often children would be whāngai or raised by adults other than their birth parents (Metge 1995). This collective whānau lifestyle resulted in an effective form of social organisation in which ‘a public health system evolved which was based on a set of values that reflected the close and intimate relationship between people and the natural environment’ (Durie 1994a).

Māori society following colonisation

There were a number of factors, outlined in the following sections, that adversely impacted on whānau, hapū and iwi structures following colonisation (Orange 1987). In 1840 the Māori population was estimated to be around 100,000 and Pākehā numbered approximately 2,000. Within 10 years, following a number of historical events which included unprecedented immigration, colonists soon outnumbered Māori (Pool 1991).

Firearms, diseases, Christianity

Following colonisation, the effects of firearms, diseases and Christianity adversely impacted on traditional whānau, hapū and iwi structures and the health and wellbeing of Māori. The combination of these key elements and the significantly increased immigration resulted in significant changes to the population profile in New Zealand (compared to 1840).

Throughout the 19th century, the musket significantly changed the balance of power between hapū and iwi as those with access to the weapons used them to gain military advantage. The period between 1810–1835 saw mass destruction of whole hapū and iwi. Durie estimated that at least 30,000 people died by musket warfare, which equated to around one-fifth of the Māori population (Durie 1994a). The impact of introduced diseases was equally significant for Māori because they

had not developed immunity to common infectious illnesses. Whole whānau, hapū, communities and sometimes large regions were depopulated by the impact of diseases (Durie 1994a). Diseases continued to impact on whānau, hapū and iwi in the early 20th century (eg, influenza epidemic of 1918). Since the arrival of the Pākehā in the late 18th century, Māori have been exposed to Christian teaching, but this had had little initial impact on the traditional Māori belief systems. Around 1830 Māori began to take up Christianity in extraordinary numbers (Elsmore 1989).

Land acquisition

Land acquisition by non-Māori had a significant impact on the wellbeing and health of whānau, hapū and iwi. In some instances land was *gifted* by Māori to non-Māori for specific purposes such as for schools or churches. Land loss by this means was comparatively small.

Other more significant land acquisition strategies involved *forced sale and land confiscation*. By 1852, Māori had lost half their land, including almost all of the South Island, through government and private purchase (Evison 1994). During the 1850s Māori moved towards developing collective responses to prevent further land losses. Responses included the Kingitanga movement, which placed a rāhui or prohibition on land sales (Cox 1993).

A further land acquisition strategy involved *government policies and legislation*. Communal kaitiaki responsibility for land was fundamental to the whānau structure, organisation and identification. Government policies and legislative changes forcing individualisation of land ownership and title included the Government's refusal to recognise collective land ownership (Belich 1986). Other policies, particularly associated with *land confiscation*, were effective in removing land ownership from whānau, hapū and iwi. Law changes and other methods of land acquisition over time resulted in a reduction in Māori ownership of land, from 26,709,342 hectares in 1840, to 2,667,000 hectares in 1901 (Durie 1994a). The loss of land resulted in the alienation of Māori from their cultural and spiritual source of identity and wellbeing. The loss of an economic base further compromised whānau health status. This process resulted in the fragmentation of traditional structures, and the dislocation of support systems which adversely affected individual and collective health and wellbeing.

Urbanisation

Following World War II there was an immense upheaval in Māori life as whānau migrated in ever-increasing numbers to the cities. In 1945, 25.7 percent of Māori lived in urban areas. By 1975, the bonds to land for 70 percent of the Māori population were severed. This resulted in the roles of whānau, hapū and iwi as the source of social support being undermined, and Māori became socially isolated in a new environment that was in direct opposition to the collective patterns of behaviour that had characterised Māori social, cultural and political organisation (TPK 1998). The speed of urbanisation created – and continues to create – immense social dislocation for whānau, resulting in changed lifestyle patterns and negative health outcomes (Pool 1991).

Demographic context

This section describes issues associated with demography, age distribution, population growth, gender, education, employment, and income, and identifies future trends and their implications for the future of whānau growth.

Demography

At the 1996 Census a total of 579,714 New Zealand residents said on their census forms that they had Māori ancestry, representing 16 percent of the total resident New Zealand population (Statistics New Zealand 1997a). While the level of growth has fallen markedly over recent years, Māori numbers have continued to grow at a faster rate than non-Māori. Māori population growth between 1991 and 2011 is expected to be 26 percent, which is higher than the 19 percent projected for the total population during the same period (Statistics New Zealand 1996). The demographic future of the Māori population has implications for the provision of a range of social services affecting whānau through the labour market, education, and housing, as well as health (PHC 1995a).

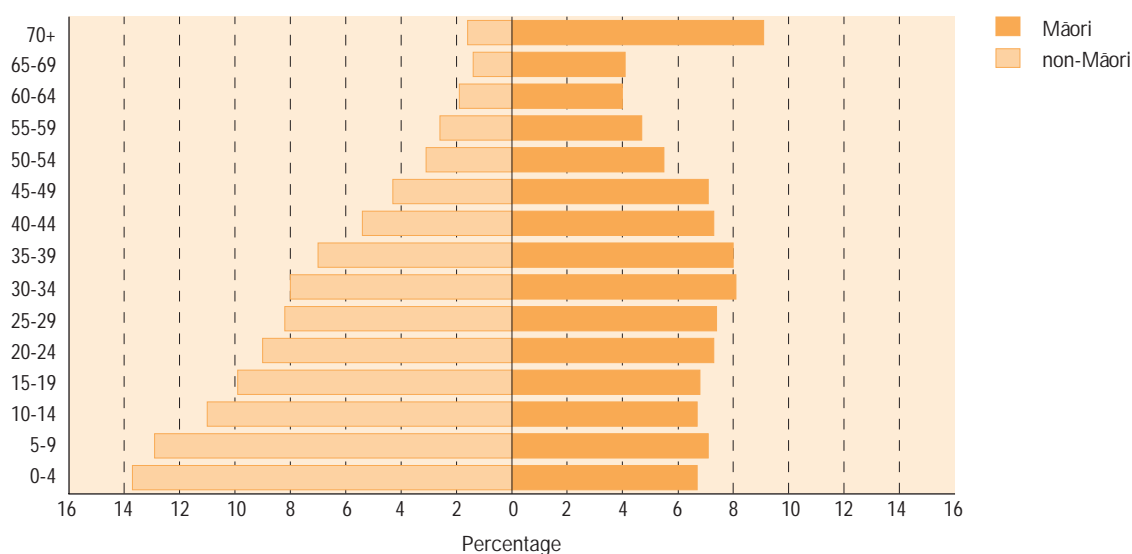
Of the 579,714 people who said they had some Māori ancestry in 1996, three out of every four (74 percent) reported belonging to at least one iwi while one in five (19 percent) said they were unable to name an iwi to which they were affiliated. Ngapuhi remains by far the largest iwi nationally with 16 percent of the Māori descent population indicating Ngapuhi affiliation in 1996 (Statistics New Zealand 1997b).

Age

In 1996 the median age of people belonging to the Māori ethnic group was 21.4 years (50 percent of the population was younger than this age and 50 percent was older). This median age was considerably lower than the median age of 32.3 years for the total New Zealand population (Statistics New Zealand 1997a). Figure 1 shows that at the 1996 Census 31.9 percent of the sole Māori population (that is, those who identified their ethnic group as Māori and no other ethnic group) were aged less than 15 years. The same census figures show that 17.8 percent of the sole Māori population and 18.9 percent of the mixed Māori population were aged 15–24 years, and 40.7 percent of the sole Māori population and 35.9 percent of the mixed Māori population were aged 25–54 years. Finally, the 1996 Census revealed that only 9.6 percent of the sole Māori population and 7.6 percent of the mixed Māori population were aged 55 years of age or over (Statistics New Zealand 1997a).

In general, iwi have young populations with fewer than 5 percent of their members aged 65 years and over. Of the larger iwi, Tuwharetoa and Tuhoe have the youngest populations. Forty percent of Tuwharetoa and 42 percent of Tuhoe were under the age of 15 years in 1996. By contrast, 34 percent of Māori affiliated to Ngai Tahu were in this age group. The younger age structure of Tuhoe is also apparent from their median age of 18.7 years, compared to the median age for Ngai Tahu of 23.4 years (Statistics New Zealand 1997b).

Figure 1: Age distribution of Māori and non-Māori populations at 1996 Census (mixed ethnic origin)



Source: Statistics New Zealand: 1996 Census of Population and Dwellings: Māori

Population growth

Population growth is determined by three factors – fertility rates, mortality rates and migration. With declining fertility and mortality rates, improvements in life expectancy and population changes through migration, Māori are experiencing a falling growth rate (Wereta 1994).

Fertility

In the past, Māori have had large families. Although there is a common perception that this is still the case, the reality is very different. The average number of children born to Māori women aged 15 years and over at the 1996 Census was 2.1. This was slightly higher than the average of 1.9 live births for non-Māori women aged 15 years and over. Māori women aged between 15 and 24 were almost three times more likely than non-Māori women of the same age to have had at least one child (28 percent versus 10 percent). This reflects the tendency for Māori women to start and finish their childbearing earlier than non-Māori women (Statistics New Zealand 1997a). Figure 2 shows the dramatic decline in Māori fertility between 1960s and the early 1980s. From 1980 to 1994 there has been very little variation in the fertility trend for Māori.¹

¹ The total fertility rate in this paper is defined by the data source as ‘the average number of births a woman would have during her reproductive life if she was exposed to the fertility rates characteristic of various childbearing age groups in that year’ (Statistics New Zealand, *Demographic Trends 1995*, p 35).

Figure 2: Fertility rates for the total population and Māori population for the years 1962–1994



Source: Statistics New Zealand 1996: Demographic Trends (1996:35)

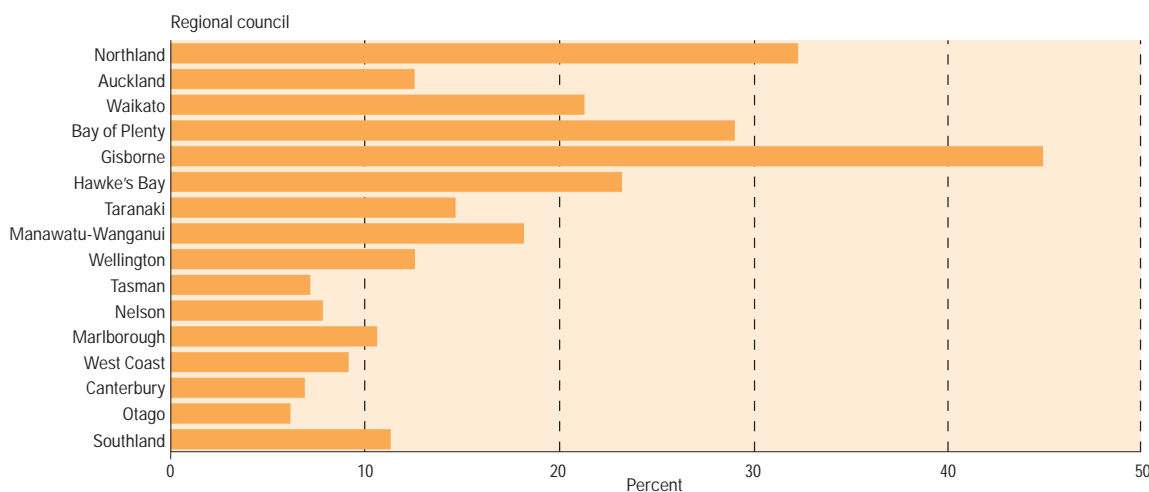
Mortality

Historically, the Māori population have had higher death rates than the non-Māori population, but the ethnic gap in life expectancy at birth has narrowed substantially in the last four decades. In the 1950–1952 period, the difference in life expectancy between Māori and non-Māori males was 14.2 years, and 16.5 years for females. In 1990–1992 the difference was 5.4 and 6.2 years respectively (Statistics New Zealand 1995).

Migration

While Māori made up 15 percent of the total New Zealand population in 1996, Figure 3 shows that they made up 45 percent of the Gisborne Regional Council population and 32 percent of the Northland Regional Council population (Statistics New Zealand 1997a).

Figure 3: Percent of regional population which is Māori, 1996



Source: Statistics New Zealand: 1996 Census of Population and Dwellings: Iwi

Of Māori affiliated to North Island-based iwi, most live in the North Island, although considerable numbers do not live in their tribal area. For example, just 22 percent of Ngati Porou, an East Coast-based iwi, live in the Gisborne Regional Council area. Ngati Porou is the second largest iwi nationally and one of only three with more than 40,000 affiliates. Two-thirds (67 percent) of Ngati Porou members live in a main urban area. Over the five years to 1996 Ngai Tahu experienced the greatest absolute increase in total membership of all iwi. This increase of 43.5 percent resulted in Ngai Tahu becoming the fourth largest iwi in 1996. Four out of every 10 Ngai Tahu affiliates do not live in the South Island and 60 percent live in a main urban area (Statistics New Zealand 1997b).

Māori migration overseas has placed further pressure on supportive extended whānau networks. Between 1980–1986 the total net loss of Māori overseas migration was 8,000. It is expected over the next forty years, 500 Māori will be lost per year in external migration, which will be a total of 20,000 by the year 2031. Most of those leaving New Zealand are likely to be young adults of childbearing age. By going overseas they reduce the fertility levels of the Māori population remaining in New Zealand, and if they have a family while away they increase the population of Māori resident overseas. The loss to external migration has both an immediate and long-term effect through a loss in the total Māori population (Wereta 1994).

Gender

Gender issues have implications for the health of whānau. Māori women, as health professionals, lawyers, workers, employers, leaders, nurturers, mothers, carers, partners/ wives, aunts, grandmothers, and as individuals, play a pivotal role in enhancing and maintaining whānau wellbeing. For many Māori women, their contribution to whānau stability is either underestimated or ignored (TPK 1994d). In most instances Māori women are the primary caregivers for whānau. Māori men are the single most vulnerable group, in New Zealand, in terms of health status. Little is known about the health needs of Māori men, except in the context of the health and wellbeing of Māori generally. However, there is already some evidence that Māori men are at particular risk in terms of their physical and mental health (TPK 1994g, North Health 1996a, North Health 1996b).

Education

Education impacts directly on whānau health and wellbeing as it determines the future life chances and life style of whānau. Forty-five percent of Māori aged 15 years and over held formal educational qualifications at the 1996 Census, the same proportion as the 1991 Census. Māori women (31 percent) were more likely than Māori men (27 percent) to have a higher qualification at the school level. Similar proportions of men (17 percent) and women (16 percent) held post-school qualifications (Statistics New Zealand 1997a). Education has a direct impact on the employment opportunities and future earning power of the individual. The low numbers of Māori attaining a tertiary education limits the income potential for many whānau, which will impact on health practices and outcomes.

Employment

Employment capacity contributes to the ability of whānau to meet their basic human needs (including adequate food and shelter). At the 1996 Census, 65 percent of Māori aged 15 years and over were in the labour force. Of this group, 83 percent worked in paid employment and 17 percent were unemployed and seeking work (Statistics New Zealand 1997a). Labour force participation among iwi varies within a range of 59 percent (Ngati Paoa) and 70 percent (Ngai Tahu and Te Atiawa) for those with more than 1,000 affiliates (Statistics New Zealand 1997b).

Rates of unemployment recorded in the 1996 Census show considerable variation by iwi. The lowest unemployment rate among the larger iwi was 10.4 percent while the highest was 23.5 percent. Unemployment levels for the larger iwi generally lie between 16 and 19 percent. For example, Ngati Porou had an unemployment rate of 18.3 percent in 1996 and Ngapuhi 18.1 percent. People of Māori descent who did not know the name of their iwi had a lower than average rate of unemployment at 12.4 percent (Statistics New Zealand 1997b).

Income

The importance of income and social class as a determinant of health status is now widely accepted (Ministry of Health 1997c). The median annual income for Māori men aged 15 years and over at the 1996 Census was \$16,000 (compared to \$22,000 for all New Zealand men). Māori women had a median annual income of \$11,200 (compared to \$12,600 for all New Zealand women). These median income levels varied according to people's labour force status and occupation (Statistics New Zealand 1997a). The median income of men affiliated to Ngai Tahu in 1996 was \$20,208. No other iwi with more than 5,000 members showed median incomes for men in excess of \$17,500. Median incomes for iwi with more than 1,000 members fell between \$11,800 and \$20,200 for men and \$10,200 to \$13,000 for women (Statistics New Zealand 1997a).

Unpaid work

A total of 179,436 people, or 55 percent of Māori aged 15 and over, said they had been involved in unpaid work outside the home during the four weeks leading up to the 1996 Census. Women (59 percent) were more likely than men (50 percent) to report participation. Among those involved in unpaid work outside the home, caring for children was the most common form of work undertaken by women (55 percent) and household work the most common form for men (41 percent) (Statistics New Zealand 1997a).

The submission received from Te Ohu Whakatupu on this issue noted that 'unpaid work occurs primarily in the family setting. However, the invisibility of unpaid work helps to perpetuate

inequalities between men and women in both the family and paid work settings'. The impact of this reality for Māori women has health outcome implications for whānau.

Determinants of health

Durie's *Whare Tapa Whā* (1994a), Pere's *Te Wheke* (Pere 1984), and the Royal Commission on Social Policy *Ngā Pou Mana* (Royal Commission on Social Policy 1988) Māori models of health have identified the various individual and broader social, economic and cultural influences that impact on Māori health status. More recently research developments in the area of the determinants of health model have adopted the holistic approach evident in these early Māori models. A focus on the determinants of health is important to address the root of many health issues, produce the most long-term gains and move beyond a narrow lifestyle focus. The relationship between the determinants of health and health status is complex and involves many sectors of society.

Of the 21 submissions received on this issue, there was general agreement regarding the need to address the various social factors that impact on the health of whānau both individually and collectively.

The Ministry of Health supported Dahlgren and Whitehead's (1991) model, which describes the complex relationship between the following determinants of health:

- individual lifestyle factors
- social and community influences
- living and working conditions
- general socioeconomic, cultural and environmental conditions (Ministry of Health 1997).

The following sections will use the above determinants of health as a framework to examine a number of public health priorities and associated issues that impact on whānau members *collectively*. The first heading combines individual lifestyle factors and social and community influences as determinants of health because of the close interaction and interdependence between these aspects. Separation of these components would create artificial boundaries and unnecessary compartmentalisation.

Individual lifestyle factors/social and community influences

The ideal whānau provides an optimal environment for the healthy development of all its members. In reality for many family members the family itself is a risk to good health. The transition from a healthy to an unhealthy environment is seldom sudden nor is it associated with only one type of family. All whānau are capable of creating health hazards within the family context (Durie 1994a). The following section updates information on the various whānau issues identified in *He Matariki* which have individual lifestyle factors, social and community implications for the health of whānau in the follows areas:

- nutrition
- food safety
- physical activity
- disability
- sexual and reproductive health

- oral health
- tobacco
- alcohol
- cannabis
- violence
- mental health and illness
- diabetes.

Nutrition

Nutrition impacts equally on the individual, social and community determinants of health. The 1989–1990 Life in New Zealand (LINZ) Survey looked at the 24-hour dietary recall of 1702 adult New Zealanders, of whom 120 were Māori. This survey showed that there were less Māori (over 15 years of age) than non-Māori consuming the recommended amounts of breads, cereals, fruits and vegetables. Also it noted that the intake of both total fat and saturated fat was higher in Māori than non-Māori (Wilson et al 1993). There is a need to focus on increasing awareness among whānau about healthy foods and engaging their individual and collective whānau, hapū and iwi support for and action on eating foods and feeding children with high nutritional value (PHC 1994b, PHC 1995d, PHC 1995f, PHC 1995g, PHC 1995h, PHC 1995i, Ministry of Health 1997m).

Food safety

The effect of food safety on the individual, social and community determinants of health is of particular importance to whānau health. Whānau frequently gather in large numbers on marae to share food. Marae are private dwellings, regardless of the number of people they cater for. Hence, food safety issues for whānau on the marae can be effectively dealt with by education and consultation, not by regulation (PHC 1994e). Of particular importance to whānau is the issue of the safety of seafood. Public health attention on the contamination of shellfish by toxic algal blooms has specific health implications for whānau who have kaitiaki and commercial interests in the protection and conservation of seabed safety (PHC 1995j).

Physical activity

Physical activity has particular application to the individual determinants of health and is well documented in the literature. There is now widespread agreement that physical activity of moderate intensity is beneficial for health. The amount of activity is more important than the manner in which it is performed (that is, the mode, intensity or duration of activity). Physical activity is closely related to but distinct from exercise or physical fitness.

The Physical Activity Taskforce was convened by the Hillary Commission to review and report on Māori sport, fitness and active leisure. The Taskforce includes various stakeholders including the Hillary Commission, TPK, HFA, Internal Affairs, Ministry of Health, Local Government of New Zealand, Otago University, Heart Foundation, Sport Bay of Plenty and the National Health Committee. Their report *More People, More Active, More Often: Recommendations from the Physical Activity Taskforce to the Minister of Sport, Fitness and Leisure* is expected by the end of May 1998. Other initiatives include promoting health through the marae setting through the use of tikanga Māori and the marae setting to deliver health messages for Māori. The Health Through The Marae initiative seeks to promote attitude change to adopt healthy lifestyles (TPK 1995b, TPK 1995d). Other initiatives to address this issue include amongst others programmes like the Whare Oranga programme described later in this document.

Disability

There are individual, social and community determinants that influence health outcomes for whānau living with disability. At the 1996 Census, of the 20 percent of the total population that reported living with disability, 19 percent were Māori. Non-Māori dominate the numbers in residential facilities, with Māori accounting for just 4 percent of the total adult population living in such facilities. The fact that disability increases with age may help to explain this because of the relatively younger age groups in the Māori population. Additionally in recent times there has been a trend away from admitting children to residential facilities (Statistics New Zealand 1998).

There are particular issues for whānau caring for others who are living with disability. The submission from the Disabilities Resource Centre on this issue stated that 'one of the barriers within Māori health issues is the problem of employing whānau members as principal caregivers. The system believes that whānau support is expected to be provided without any cost. For paid care, the client is forced to look outside the whānau and may set up the possibility of care being culturally unsafe. It is felt that this attitude towards whānau members actually reduces the whānau wellbeing and does nothing for a holistic approach to Māori wellness'.

Sexual and reproductive health

In the area of sexual and reproductive health there are implications for the individual, social and community determinants of health. Whānau sexual and reproductive health is important to ensure the continuity of whakapapa (Ministry of Health 1997a). There are various health challenges that impact on individual members of a whānau which have individual and collective implications. These issues have been described in various issues-based publications (PHC 1994g, TPK 1994i, TPK 1995f, TPK 1995h, TPK 1995i, Ministry of Health 1997a, Ministry of Health 1997h). The development and delivery of appropriate maternity programmes and services is important to ensure healthy childbearing and maternity outcomes and to prevent whānau representation in negative health outcomes in this area (Ministry of Health 1997a). This focus is important to achieve a strong healthy start for new whānau members. In 1996/97 the then Southern RHA contracted HIV/AIDS and STD prevention programmes from Māori providers, and Midland RHA contracted Ngati Porou providers to deliver primary maternity services to whānau in their regions (Ministry of Health 1998b).

Oral health

The impact of oral health has particular application to the individual determinants of health (PHC 1995e). Māori have relatively poor dental health compared to non-Māori (Broughton and Kopu 1996). Thirty-four percent of Māori five-year-olds are caries-free compared to 62 percent of non-Māori five-year-olds. Māori Form Two children have on average 60 percent more missing or filled teeth than non-Māori children (Ministry of Health 1997c). At age five years and at Form Two, Māori children experience more severe tooth decay, and Māori preschool children are less likely to have been seen by the School Dental Service (PHC 1995e).

Factors contributing to the relatively poor state of Māori dental health include the appropriateness, affordability, acceptability and accessibility of dental services. Despite the School Dental Service being free to both Māori and non-Māori children, Māori do not fully utilise the service (Broughton and Kopu 1996). In 1996/97, dental programmes were funded for Māori children in the Far North and in Rotorua through Tipu Ora for whānau in those regions (Ministry of Health 1998b).

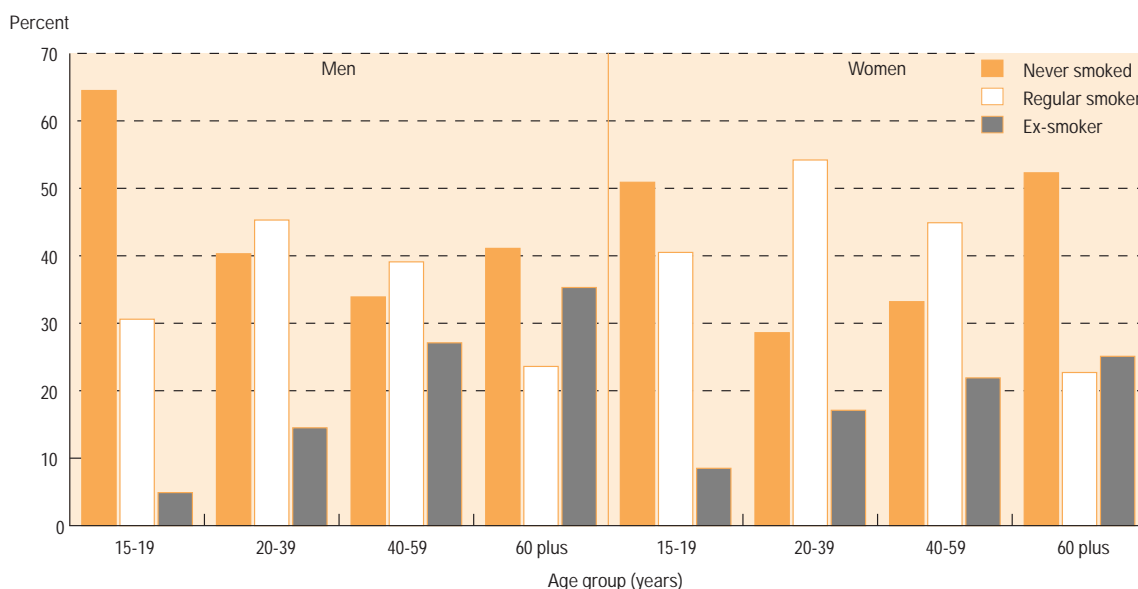
Cost barriers of dental care present particular problems for whānau health. Given the early school leaving and reduced income patterns demonstrated, it is unlikely that many will fully benefit

from the subsidised school programme or be able to afford the costs of dental care having left school. Cost barriers will continue to present prohibitive barriers to all whānau members beyond the subsidised school programme target population. Initiatives to address this issue include amongst others programmes like the Oranga Niho programme described later in this document.

Tobacco

Tobacco impacts equally on the individual, social and community determinants of health (PHC 1994c, PHC 1994d, Reid 1996). At the 1996 Census 44 percent of Māori aged 15 years and over said that they smoked one or more cigarettes per day and 18 percent said that they used to smoke regularly but no longer did. A higher proportion of women (47 percent) were regular smokers than men (40 percent). Figure 4 shows how smoking characteristics vary according to age and sex. Amongst women, those aged 20 to 39 were most likely to be regular smokers (54 percent), while for men those aged between 25 and 39 had the highest smoking rate (46 percent).

Figure 4: Cigarette Smoking Characteristics of Māori 1996 aged 15 years and over



Source: Statistics New Zealand: 1996 Census of Population and Dwellings: Māori

Smoking among Māori pregnant women continues to be a concern (Ministry of Health 1996b). Strategies to address tobacco consumption concerns include amongst many:

- National Co-ordinator Smokefree Māori position in Te Hotu Manawa Māori located in the National Heart Foundation which co-ordinates smokefree programmes nationwide
- Māori Women's Welfare League's Healthy Lifestyle Programme, which uses netball as the medium to promote smokefree behaviours
- Ministry of Health 'Why Start' programme targeting groups including rangatahi and Māori tobacco consumption during pregnancy.

Other initiatives include programmes like the Tihei Mauriora programme described later in this document.

Alcohol

The impact of alcohol affects on the individual, social and community determinants of health is well documented in the literature (PHC 1994f, PHC 1994k, Ministry of Health 1996b, TPK 1995g). Heavy drinking over a long period has been linked to a number of health problems, particularly liver and heart damage, hypertension and diseases of the digestive system. In addition, high alcohol consumption is linked to mental disorders such as alcoholism, and during pregnancy can lead to birth defects, including the fetal alcohol syndrome (Ministry of Health 1996b, Ministry of Health 1997c).

There is overwhelming evidence of a strong association between excessive alcohol consumption and motor vehicle crashes. Traditional strategies have aimed at separating drinking from driving by the use of legislation and penalties as a deterrent. There is a trend to combine these methods with community action aimed at changing attitudes and drinking behaviours to promote a safety culture (PHC 1994f). Programmes to reduce alcohol consumption include the Manaaki Tangata programme, which recognises that both tangata whenua and manuhiri have equal responsibility in promoting safer drinking practices (Ministry of Health 1997c). In 1996/97 the then Midland RHA contracted Māori providers to deliver alcohol and drug services to whānau in the Midland region (Ministry of Health 1998b).

The submission from the Land Transport Safety Authority on this issue stated that 'improving the quality and amount of data available on the state of Māori health in relation to road safety would enable better targeted road safety projects and improve road safety outcomes. To this end we would support a joint approach to resolving this problem'. An intersectoral approach would benefit whānau by ensuring co-ordination in dealing with the health effects of alcohol-related road accidents. This would enable maximum benefit from government funding invested in reducing negative health outcomes in this area.

Cannabis

The effect of cannabis on the individual, social and community determinants of health is of particular importance to whānau health (Ministry of Health 1996c). In 1995, TPK reported that cannabis use appeared to be endemic in some Māori communities, and cannabis consumption had become the norm for some whānau. The potential for this norm to be passed on to succeeding generations of whānau causes concern. TPK noted that Māori suffer from high rates of cannabis-related psychosis. Kaumātua have expressed their concern that growers of the plant do not know the location of local wāhi tapu and may have plantations near or on urupā (burial sites). TPK reports some kaumātua believe this to be a significant factor in the high levels of cannabis-induced psychoses in Māori (TPK 1995a).

Violence

Physical and sexual abuse have been linked to dysfunctional families, fragmentation of families, alcohol and drug abuse and mental illness. As such these issues have implications for the individual, social and community determinants of health. Young et al's (1997) study found the prevalence rate of partner abuse for Māori to be generally much higher than for non-Māori, and the rate for Māori women to be much higher than non-Māori women. For whānau, psychological and emotional forms of abuse can result in the breakdown of relationships and of the whānau structure itself. Furthermore, the abuse of the weak by the powerful has been identified as a clear breach of tikanga which cannot be sustained (TPK 1994d). The Ministry of Health has completed consultation on draft family violence protocols for the health sector. These protocols are part of the Government

Strategy to reduce family violence. Whānau experiencing family violence will benefit from an improved and effective response from the health sector to address needs in this area (Ministry of Health 1996a, Ministry of Health 1997b). Initiatives to address this issue include programmes like the Kokona Whānau programme described later in this document.

Mental health and illness

In the area of mental health and illness there are implications for the individual, social and community determinants of health (Ministry of Health 1996d, Ministry of Health 1997k, Ellis and Collings 1997). Whānau mental health and wellbeing is influenced by a range of social, economic, cultural and political variables and the diverse realities that shape whānau experiences. Dyall (1997) argued in her paper on Māori mental health issues, that whānau wellbeing cannot be sustained unless members have strong connections with each other, to their cultural heritage, to their environment and land, and have control over their destiny and economic security.

In 1995, in the 20–29 year age group, Māori men were at greatest risk of mental illness (Ministry of Youth Affairs et al 1998). Their first admission rates to a psychiatric inpatient unit were more than three times the overall rate. The inadequacy of services for Māori was identified in the Ministerial Inquiry into Mental Health Services conducted in 1996 (Ministerial Inquiry to the Minister of Health, Hon Jenny Shipley 1996). Concern has been expressed that Māori mental health problems might be being misdiagnosed and that stress as a result of unemployment and low socioeconomic status also needed to be addressed (TPK 1993, PHC 1995a). Potential misdiagnosis of whānau members' mental illness will be minimised by establishing effective partnerships between kaumātua who have cultural expertise and health professionals with mental health expertise.

In 1996/97 the then Midland RHA contracted Māori providers to deliver mental health services (including a focus on youth, community housing, rehabilitation, education and prevention) to whānau in the Midland region (Ministry of Health 1998b). Other initiatives to address this issue include programmes like the Rapua te Oranga Hinengaro programme described later in this document.

Suicide

In 1996, the rate of Māori youth suicide (44.6 per 100,000) slightly exceeded the non-Māori rate (38.4 per 100,000) for males aged 15–24 years. In 1995, Māori females aged 15–19 years had the highest rate of intentional self-injury / attempted suicide (489.6 per 100,000) of hospitalisations for all population groups (Ministry of Youth Affairs et al 1998). Ongoing concerns regarding the quality of ethnicity data relating to mortality is likely to prevent an accurate estimation of the suicide rate among Māori (Ministry of Health 1997c). A National Youth Suicide Prevention Strategy has been released to promote a co-ordinated approach to youth suicide prevention. Within this strategy there is a distinct youth suicide prevention strategy for Māori rangatahi and whānau (Ministry of Youth Affairs et al 1998).

Diabetes

At least one in three whānau members who survive to 60 years of age will develop diabetes. Diabetes affects Māori whānau at an earlier age than non-Māori. Whānau are particularly susceptible to renal complications and blindness. They suffer at least twice the prevalence of diabetes and have four to six times higher mortality than non-Māori (Ministry of Health 1997i, Ministry of Health 1997l). In 1996/97 the then Midland RHA contracted Māori providers to deliver diabetes services to whānau in the Midland region (Ministry of Health 1998b). Initiatives to address this

issue include amongst other programmes, like the Te Roopu Matehuka programme described later in this document.

Living and working conditions

Whānau is a Māori social and cultural structure. Whānau as a primary source of identity, confidence and pride, has the ability to assume responsibilities on behalf of its members, and to assign responsibilities to them. At the same time, whānau has the potential to be an environment for nurturing, support, protection and safety on the one hand, and a source of censure, discipline, organisation and strength on the other. The whānau structure has retained its integrity as a source of support, protection and safety for Māori despite adverse factors, including socioeconomic influences.

This section focuses on the various living and working determinants of health that impact on whānau health. Issues include:

- housing
- households
- parenting.

Housing

Housing adequacy has direct implications for the living and working conditions of whānau. Low income levels, higher levels of unemployment, and reliance on income support are social factors which contribute to whānau ability to access adequate housing. For some Māori housing choices are limited. In some rural areas where whānau are turangawaewae-based, housing availability may be particularly limited.

Of Māori living in private dwellings at the 1996 Census, just over half (52 percent) lived in dwellings which were owned either with or without a mortgage. Forty-one percent lived in permanent private dwellings which were rented. A total of 2,145 or 0.4 percent of the Māori population occupying private dwellings lived in temporary dwellings such as caravans, cabins, tents and mobile homes. This number represented 19 percent of the total New Zealand population living in temporary private dwellings in 1996 (Statistics New Zealand 1997a).

The submission from Western Bay Health Limited on this issue acknowledged the value of 'local government surveying their districts so that there would be a database of housing inadequacy measured against a standard such as the Housing Improvement Regulations 1947'. This type of data would enable the identification of trends to ensure evidence-based policy development on housing priorities for whānau.

Households

Household composition has implications for the living and working determinants of health of whānau. At the 1996 Census, 33 percent of all Māori whānau households were headed by sole parents. Of these sole parent households 77 percent had dependent children. Also, one in five Māori (19 percent) lived in extended family households, the majority of which were households containing three or more generations of the same family (57 percent). Only nine percent of the total New Zealand population lived in households containing extended families in 1996 (Statistics New Zealand 1997a). For people of Māori descent living in private households, by far the majority live in a household comprised of a single family. For example, 77 percent of Waikato and 84 percent of Ngai Tahu were living in single family households in 1996. In general, iwi in the upper

half of the North Island (Northland/Auckland, Hauraki and Waikato) are more likely to live in an extended family than iwi in other areas of New Zealand (Statistics New Zealand 1997a).

Parenting

Socioeconomic and cultural factors influence whānau understanding and parenting skills. Selection of parenting style will be affected by these factors and the diverse realities of whānau. The loss of accessible whānau, hapū and iwi structures to support parenting and child rearing has significant implications for whānau living and working determinants of health. Work-subsidised childcare provisions are rare and of particular importance to sole parents seeking employment.

There is a need to protect the continuity of whānau and whakapapa by providing adequate care for tamariki as they are the link between the past and the future. This will be achieved when tamariki are nurtured by supported parents and caregivers and strong healthy whānau. Ensuring optimal health for tamariki will be essential for improving whānau wellbeing (Ministry of Health 1998a). Strategies to achieve these objectives include the purchase of parenting programmes from a number of Māori organisations, including the Tipu Ora Trust, to assist Māori parents and caregivers. The Tipu Ora Trust will be discussed in more detail later in this document.

General socioeconomic, cultural and environmental conditions

Whānau have the potential to both create, and tap into, opportunities for their members to assume responsibility for their own health gain both as individuals and as part of a collective. Whānau operate in an environment in which they have to assume some responsibility for enhancing their members' economic, political, social and cultural participation in both the broad New Zealand and the Māori/iwi sectors.

This section addresses the general socioeconomic cultural and environmental determinants that impact on whānau health. It is acknowledged that a number of issues identified in the previous section could have equally been examined here (eg, food safety). The issues will focus on:

- whānau, hapū and iwi resources
- environmental factors.

Whānau, hapū and iwi resources

Whānau, hapū and iwi resources are likely to influence the general socioeconomic cultural and environmental determinants of health. Any government return of Māori confiscated land resources and/or financial settlements for Waitangi Tribunal claims is likely to have an impact on the health status of whānau hapū and iwi in the long term. The relationship between the cultural and spiritual significance of tribal land and the health and wellbeing of whānau has been consistently recognised throughout Māori history and continues to be supported in contemporary Māori society. An improved iwi economic resource base is likely to in part contribute to addressing poverty issues for the whānau that directly benefit from such settlements. The flow-on effects from this will include better access to the determinants of health and thereby improved health outcomes. Whānau hapū and iwi development and provision of health programmes and services is another possible outcome from an improved economic base. These economic benefits are likely to indirectly advantage other iwi who are not currently pursuing Treaty of Waitangi (Te Tiriti o Waitangi) settlements and whānau who have lost touch with their iwi links through the provision of such services. In the medium and long term, these developments will enhance existing Government

strategies to improve Māori health status. However, such initiatives do not remove Government's responsibility to adequately resource effective strategies to address the disparities between Māori and non-Māori health outcomes.

Environmental factors

There are a number of environmental issues-based papers which identify the general socioeconomic and cultural determinants of health relevant to whānau (PHC 1994l, PHC 1994m, PHC 1994n, Ministry of Health 1997n, Ministry of Health 1997o). The impact, of unsatisfactory environmental factors, such as poor water quality and safety, sanitation, air quality and hazardous substances on whānau health, is well recognised. The importance of the environment on whānau wellbeing is recognised in the various Māori models of health identified earlier in this document.

Māori interest in their kaitiaki environmental responsibilities have been consistent in the past and has continued to the present. This is evidenced by ongoing whānau, hapū and iwi efforts to promote, protect and conserve natural resources, and by the various Waitangi Tribunal claims focused on the environment. However, Māori representation in the professional roles responsible for monitoring and protecting the environment is low with few Māori trained in health protection and environmental health.

The Ministry of Health is developing new targets, and monitoring and reviewing targets as appropriate for environmental health.

The submission from ESR Health to the draft discussion document on this issue called for 'the development of a national strategy for aspects of the physical environment to frame approaches to food safety and water quality'. Such a strategy would provide a holistic approach to monitoring environmental health issues and concerns to enable an effective and co-ordinated response.

Public health priorities for individuals within whānau: a life cycle perspective

The determinants of health affect whānau lifestyle choices, health behaviours and outcomes. These processes and outcomes are influenced in part by the life cycle development phase of *individual* whānau members. *He Matariki* described the various public health issues and priorities for the four population groups (tamariki, rangatahi, pakeke/mātua and kaumātua) that comprise whānau (PHC 1995a). These four life cycle groupings continue to be classified primarily in age band terms in various policy papers (Ministry of Health 1997a, Ministry of Health 1997h).

The following section presents an update on the morbidity and mortality profiles for tamariki, rangatahi, pakeke/mātua and kaumātua which reflects the current public health priorities for individuals within whānau.

Tamariki (0–12 years)

Māori children are the link for whānau between the past and the future (Ministry of Health 1998a). Māori children are hospitalised at a higher rate than non-Māori children. In 1995, the hospitalisation rate for Māori children was 88 percent higher than the rate for non-Māori children. The largest disparity between Māori and non-Māori rates of hospitalisation are due to nervous system and respiratory conditions. For each of these groups of causes, Māori children are hospitalised at rates close to one-and-a-half times the non-Māori rates (Ministry of Health, in press).

Māori children are at higher risk of dying before the age of 15 years than non-Māori children. In 1994, Māori recorded a death rate 63 percent higher than non-Māori in this age group (114 and 70 per 100,000 for Māori and non-Māori respectively). Māori recorded particularly high disparities for sudden infant death syndrome (SIDS). Māori children recorded a rate 4.5 times the non-Māori rate for SIDS during that period (Ministry of Health, in press). A number of issues-based papers have been developed looking at the various public health priorities for tamariki (PHC 1994d, PHC 1994i, PHC 1994j, PHC 1995b, Ministry of Health 1994a, Ministry of Health 1996a, Ministry of Health 1996e, Ministry of Health 1997h).

Rangatahi (13–24 years)

Rangatahi are important for whānau wellbeing and health because the highest childbearing patterns in whānau occur between the ages of 15–24. In 1995, the major cause of hospitalisation for young Māori women in this age group was childbirth and associated conditions (Ministry of Health 1997e). For young Māori men, the major cause of hospitalisation was unintentional injury. Twenty-five percent of unintentional injuries requiring hospitalisation were motor vehicle traffic accidents.

In 1995, the main causes of death for Māori aged 15–24 years were motor crash accidents (18 actual deaths – 36 percent of all deaths) and suicide (16 actual deaths – 32 percent). A number of issues-based papers have been developed looking at the various public health priorities for rangatahi (PHC 1994k, PHC 1995c, PHC 1995h, PHC 1995i, Ministry of Health 1996b, Ministry of Health 1996d, Ministry of Health 1996e, Ministry of Health 1997a, Ministry of Health 1997h, Ministry of Health 1997k, Ministry of Youth Affairs et al 1998, TPK 1994g, TPK 1994i, TPK 1998).

Pakeke/mātua (25–54 years)

For many Māori whānau, pakeke represent the primary wage earners that commonly subsidise both their tamariki and rangatahi and also their kaumātua and kuia. In 1995, childbirth and associated conditions were the primary causes of hospitalisation for Māori women in the 25–44 year age group, and for Māori men in that age group, it was unintentional injury (Ministry of Health 1997e). For Māori men and women aged 45–54 years circulatory disease (mainly ischaemic heart disease) is the leading cause of hospitalisation, followed by genitourinary diseases.

In 1995, the major causes of death for the 25–54 year age group were diseases of the circulatory system (30 percent) and cancers (27 percent). A number of issues-based papers have been developed looking at the various public health priorities for pakeke (PHC 1994a, Ministry of Health 1995c, Ministry of Health 1996f, Ministry of Health 1997i, Ministry of Health 1997l). It is important to note that many of the health issues that affect pakeke (eg, heart disease) have been addressed in papers that focus on prevention strategies (eg, nutrition) rather than adopting an illness analysis approach.

Kaumātua (55 years and over)

In Māori society the leadership roles for kaumātua and kuia increase with age, knowledge and wisdom. In 1995, the leading causes of hospitalisation of kaumātua men and women were circulatory diseases (heart disease and strokes), followed by procedures (such as operations).

The two leading causes of death of kaumātua in 1994 were circulatory diseases, which accounted for 48 percent of deaths, and cancer (25 percent) (Ministry of Health 1997f). A number of issues-based papers have been developed looking at the public health priorities for kaumātua (Thomson

1997, Ministry of Health 1997p, Robertson and Gardner 1997, Bonita and Beaglehole 1998, PHC 1996).

Following consultation a small number of submissions were received on kaumātua issues. The submission from Age Concern New Zealand Ltd noted that kaumātua needs must be addressed and that 'it must not be assumed that whānau do not need assistance in caring for their older relatives'.

SUMMARY OF ISSUES

BACKGROUND ISSUES

Historical factors resulted in the breakdown of traditional supportive whānau, hapū and iwi structures and belief systems which impacted negatively on whānau health status and included:

- breakdown of pre-colonisation collective structures of whānau, hapū and iwi
- musket warfare, introduced diseases and Christianity
- alienation from Māori land
- urbanisation.

DEMOGRAPHY

Demographic trends show that:

- at the 1996 Census, 16 percent of New Zealand residents said they had Māori ancestry. 74 percent of those who said they had Māori ancestry reported belonging to at least one iwi
- 19 percent were unable to name an iwi
- at the 1996 Census, the median age for people belonging to the Māori ethnic group was 21.4 years (compared to 32.3 years for the total population)
- of the larger iwi, Tuwharetoa and Tuhoe had the youngest populations (ie, 40 percent and 42 percent respectively were under the age of 15 years)
- the *fertility* rate for whānau has declined dramatically
- Māori women started and finished early their childbearing experience
- *life expectancy* disparities between Māori and non-Māori has narrowed substantially
- considerable numbers of Māori do not live in their tribal areas – eg, only 22 percent of Ngati Porou live in the Gisborne Regional Council area
- Ngai Tahu experienced the greatest increase in total membership
- Māori *migration overseas* is expected to be 20,000 by the year 2031.

SUMMARY OF ISSUES

SOCIAL FACTORS

- Māori women play a pivotal role in enhancing and maintaining whānau wellbeing
- Māori men are at particular risk in terms of their physical and mental health
- there are low numbers of Māori attaining *tertiary education* qualifications
- at the 1996 Census, 65 percent of Māori aged 15 years and over were in the *labour force*
- the median average *annual income* for Māori men aged 15 years and over was \$16,000, compared to \$22,000 for all New Zealand men.

DETERMINANTS OF HEALTH

- focusing on the determinants of health is important to address the root of many health issues and produce the greatest long-term gain
- the *individual lifestyle factors and social and community influences* as determinants of health focuses on nutrition, food safety, physical activity, disability, sexual and reproductive health, oral health, tobacco, alcohol, cannabis, violence, mental health and illness, diabetes
- *living and working conditions* as determinants of health examine housing, households and parenting
- *socioeconomic, cultural and environments conditions* as determinants of health look at whānau, hapū and iwi resources, and environmental issues.

LIFE CYCLE PERSPECTIVE

- death and hospitalisation rates show large disparities for tamariki across a range of conditions
- for female rangatahi the major cause of hospitalisation in 1995 was childbirth, for males it was unintentional injuries – main cause of death was motor vehicle accidents
- the main causes for pakeke hospitalisations were the same as for rangatahi – main cause of death was diseases of the circulatory system
- leading causes of hospitalisations in 1995 and death in 1994 for kaumātua were circulatory diseases.

Ngā Kaupapahere Hauora Tūmatanui: Healthy public policy issues

*He moana pukepuke e ekengia e te waka.
A mountainous sea which will be ascended by the canoe.*

The health and disability sector

In contemporary New Zealand society there are many policies which influence, to a greater or lesser extent, the health and wellbeing of whānau. Following are a number of significant policies.

Coalition Agreement

The Coalition Agreement (1996) reflects Government's commitment to improved Māori and child health and, therefore, whānau health outcomes. This Agreement commits the Government to particular areas that influence whānau health gain, which include:

- increasing health sector resources
- removing financial barriers to people needing to access health and disability services
- piloting a community-based family health team approach for the delivery of some primary healthcare services
- development of Māori provider workforce
- establishment of four commissions including the Māori Health Commission
- Māori health
- child health
- mental health (Coalition Agreement 1996: 36–38).

Strategic Result Areas

The Strategic Result Areas (SRAs) for the Public Health Sector 1997–2000 identify the need by health and disability services for a particular emphasis on whānau wellbeing and health. This SRA focuses on Māori health and signals the need for 'achieving improvements in the health status of Māori; by increased responsiveness to their needs and the development of appropriate professional, administrative and organisational expertise' (Department of the Prime Minister and Cabinet 1997). Improvements in Māori health cannot be achieved without improvements in whānau wellbeing and health. This whānau wellbeing document will provide material to inform policy development to enable an effective response by the health sector to progress toward this SRA.

The other SRA of particular relevance to whānau health outcomes relates to the Treaty of Waitangi (te Tiriti o Waitangi) settlement and Māori development. This SRA includes a focus on 'enhancing

and improving the design, access to, delivery and monitoring of policies and programmes which impact on Māori economic opportunity and social outcomes' (Department of the Prime Minister and Cabinet 1997). This whānau wellbeing document has supported the relationship between the determinants of health and the ongoing health outcome disparities between Māori and non-Māori at a whānau level. Policy development which addresses both of these SRAs is likely to contribute to improved whānau health gains.

Strengthening Public Health Action

The Ministry of Health has reviewed the strategic direction for public health and has released the plan for the next five years in the document *Strengthening Public Health Action: A review of 'A Strategic Direction to Improve and Protect the Public Health'*. This document incorporates a number of cross-cutting themes that cut across existing public health goals. The themes are consistent with international as well as Māori experience. They are:

- focusing on the determinants of health
- building strategic alliances within and between sectors
- implementing comprehensive programmes
- strengthening the public health infrastructure (Ministry of Health 1997j).

These cross-cutting themes will be used as a framework to examine whānau health programme issues in the Public Health Programmes section of this paper.

National Child Health Strategy

Government is in the process of developing a National Child Health Strategy. The final Strategy will bring together into a coherent strategic direction the various initiatives which contribute to improving, promoting and protecting the health of New Zealand children. The Strategy will acknowledge the role of families and whānau as children's primary caregivers. The family and whānau are critical to improving health outcomes for children/tamariki (Ministry of Health 1998a).

Strengthening Families Strategy

The Government's Strengthening Families Strategy involves a significant work programme intended to address problems of fragmentation and poor co-ordination of services for families with multiple social and economic disadvantage. This is an intersectoral initiative involving the health, education, welfare and other social sectors. The aim of the Strategy is to improve life outcomes for children at risk of poor outcomes, including improved health, better educational achievements, and a reduced incidence of persistent offending or abuse and neglect (Ministry of Health 1998a).

Towards a Code of Social and Family Responsibility

The *Towards a Code of Social and Family Responsibility* is a draft Government proposal on which the Government sought responses in February–April 1998 (New Zealand Government 1998). This document proposes a new social contract based on individual and family responsibility, which has important implications for the way in which whānau organise and structure their everyday lives.

Configuration of the health sector

The health sector is devolved, with the Health Funding Authority (HFA) as a single funder. The HFA is responsible for improving health outcomes and the population health status by funding health and disability support services and focusing on getting the best health outcomes from available resources. The Ministry of Health's role is to lead and have an overview of the health sector's performance, as well as acknowledging non-health factors contributing to health status.

Four principles underpin the operation of the health sector:

- services are organised around patients and communities, not health professionals
- local solutions to local problems
- ensuring better relationships between those who provide public health services
- decisions about resources need to be made as close to the need as possible.

These principles include the desire for a health sector which is devolved and responsive to the community. An increased focus on Māori whānau health needs and outcomes by policy makers and funders paper is consistent with the approach signalled by these principles.

Accountability arrangements

The Government has previously released its policy statements on improving Māori health status in various policy documents including *Whāia te Ora Mo te Iwi* (Department of Health 1992). Principles were identified for the health sector in this document which were: equity, effectiveness, efficiency, safety, acceptability and risk management. These principles have now been incorporated into new mechanisms identified in the Accountability Documents with the HFA (Ministry of Health 1997d). The HFA will be expected to fund and monitor programmes and services which promote and protect the public health of whānau.

Intersectoral policy approach

Intersectoral policy development will enable co-ordinated and consistent policy outcomes. This will require government agencies to work collaboratively and co-operatively across traditional barriers during the development, implementation and monitoring phases of policy work. Such an approach will ensure that Government investment in areas that impact on health is optimally located and effectively used.

Of the 17 submissions received on this issue, there was overwhelming support for an intersectoral approach to the development and implementation of public health policies that impact on whānau wellbeing. The submission from TPK stated that they 'would like to support the Ministry's work on whānau wellbeing at an intersectoral level'.

Other important themes that emerged from submissions included:

- supporting the document's position on the need for effective policy development that is holistic, reflects diverse realities and is underpinned by Māori values and beliefs (eg, whanaungatanga) as a basis for health gain
- supporting the need for policy that addresses both individual and collective whānau approaches
- agreeing that the development of a responsive policy framework needs to be aimed at reversing the disadvantage position of Māori
- acknowledging the role policy can have in nurturing the whānau structure as an informal mechanism for fostering Māori health development.

Māori strategic policy direction

The Treaty of Waitangi (Te Tiriti o Waitangi) and Māori health

In contemporary New Zealand society, The Treaty of Waitangi (Te Tiriti o Waitangi) has a particular whānau policy focus as New Zealand's founding document. It establishes the relationship between the Crown and Māori as tangata whenua and affirms Māori and thereby whānau rights. The Treaty of Waitangi (Te Tiriti o Waitangi) relationship has significance to the Ministry of Health as a Crown agency. Any discussion on Māori health should begin with the Treaty of Waitangi (te Tiriti o Waitangi).

As discussed earlier, Government has signalled its direction for 1997–2000 on the Treaty (te Tiriti) in an SRA. Policy development will be aimed at an effective health sector response which will advance health gain for Māori and thereby whānau. This policy development will be guided by each of the Treaty and Māori health SRAs, and in the Government's general policy direction for Māori health *Whāia te Ora Mo te Iwi* (Department of Health 1992). Government has accepted that there is a need to achieve parity for Māori, and therefore whānau, in terms of health outcomes (Ministry of Health 1998a).

Māori Health Commission

The Coalition Agreement made provision for the development of four Commissions to provide independent advice direct to the Minister of Māori Affairs on issues associated with health, education, economic development, and employment/ training. These four commissions have funding for three years. Māori representatives on the Health Commission come from a variety of provider, purchaser and health professional backgrounds. As new stakeholders in this area, the role and influence of the Health Commission cannot be gauged in the short term.

Measuring health gain in Māori health

Some authors have questioned the continued use of total population figures, vital statistics, life expectancy tables, mortality rates, hospital admissions and comparisons with non-Māori to measure health status in Māori (Pomare et al 1995, Durie 1994c). Although acknowledging the difficulty, Durie has promoted the need for health gain measurements that capture both 'quality' of life as well as 'quantity' of life measurements. Three alternative measures were:

- *whanaungatanga* – a measure of how whānau are able to carry out their various tasks including care, redistribution of goods and services, guardianship, empowerment and future planning (Durie 1994e)
- *kaumātua resources* – Māori estimates of the health or strength of a family or tribe are closely linked to the number and strength of its elderly population (Durie 1994c)
- *mauri* – which encompasses spiritual and physical dimensions, individual and group health, human and environmental forms (Durie 1994f).

Durie acknowledged that it would be premature to suggest that these three issues should be employed as the most desirable measures of health gain. However, he also noted that they represent possible alternative approaches which would have significance for Māori (Durie 1994c).

Policy development

Policy objectives concerning the relative roles between family and whānau and government in some instances appear confused. For example in the Mental Health (Compulsory Assessment and Treatment) Act 1992, family and whānau views are given consideration in applications for compulsory treatment. However, there is limited opportunity for families to participate in decisions to discharge patients to the care of relatives (Durie 1994b). A co-ordinated policy development approach is needed to ensure that this lack of clarity does not compound the barriers whānau already experience in accessing health programmes and services.

The policy development process may have the potential to alienate Māori and whānau from participating in the design, context and implementation of health and disability policy which ultimately affects their daily lives. There are potential risks for Māori and whānau in becoming involved in the policy development process directly, including:

- There are differing interpretations of the Treaty of Waitangi (Te Tiriti o Waitangi), and the interpretation by some Māori may be undervalued.
- The approach to Māori health and wellbeing programmes, policies and services may be fragmented.
- Consultative processes may not be regarded as sincere.
- The aspirations of diverse groups of Māori and whānau may be distorted.
- Health hui outcomes and recommendations may not be subsequently reflected in policy development.
- Cost barriers to accessing appropriate services may not be addressed consistently.
- Policy outcomes may contribute to the breakdown of whānau and other collective structures.

Policy makers need to be conscious of these risks, which may mitigate against whānau involvement in the policy development process.

Policy guidelines on whānau wellbeing

Social policies often directly or indirectly impact on whānau wellbeing and health. In developing such policies it is important that policy makers anticipate potential concerns in this area. This means the design of policy which enhances and/or affirms whānau wellbeing as a pivotal force in the lives of a diverse range of Māori people. It also means strengthening whānau in order that they might nurture, support, care for, encourage and protect their individual members. The following section presents a number of principles that policy makers need to consider in developing policy that has whānau health implications.

Principle 1

Whānau wellbeing is pivotal to the wellbeing of Māori people.

Principle 2

The recognition and upholding of the Treaty of Waitangi (Te Tiriti o Waitangi) is fundamental to the wellbeing of whānau.

Principle 3

Whānau wellbeing is affected by all aspects of the economic, political, social and cultural position of its members individually and collectively.

Principle 4

Whānau wellbeing is dependent on the social and cultural values and beliefs of the whānau being respected and valued.

Principle 5

Whānau is the most direct source of support and encouragement which contributes to the wellbeing of its members.

Principle 6

Whānau experience diverse realities and operate in a range of settings which must be recognised during policy, programme and service development processes.

SUMMARY OF ISSUES

HEALTH AND DISABILITY SECTOR

Policy issues which influence whānau health needs and outcomes within the health sector are:

- the Coalition Agreement, which reflects Government's commitment to improved Māori health status
- the Māori health and Treaty of Waitangi (Tiriti o Waitangi) SRAs signal increased responsiveness to achieve Māori health outcomes
- *Strengthening Public Health Action* provides a framework for public health direction
- *Strengthening Families* is an intersectoral government programme intended to address fragmentation and poor co-ordination of services with multiple social and economic disadvantages
- the *National Child Health Strategy* seeks to bring together a coherent strategic direction to programme and service focused on children
- *Towards a Code of Social and Family Responsibility* is a draft Government proposed social contract based on individual and family responsibility
- an increased focus on whānau health outcomes is consistent with the principles that underpin the health sector
- principles from *Whāia te Ora Mo te Iwi* have been incorporated into the accountability documents
- an intersectoral policy approach will ensure that Government investment in areas is optimally located and effectively used
- policy development need whānau input to policies that impact on whānau health outcomes
- policy principles to guide policy development are presented.

MĀORI STRATEGIC POLICY DIRECTION

There are specific issues to consider in developing strategic Māori policies to increase whānau health outcomes, which include:

- the Treaty of Waitangi (te Tiriti o Waitangi) outlines the relationship between Māori and the Crown
- Government has accepted that there is a need to achieve parity for Māori in terms of health outcomes
- two SRAs on Māori health and the Treaty (te Tiriti) have particular implications for related whānau health policy development
- the use of *measuring Māori health status* by comparing Māori with non-Māori has been questioned
- measuring Māori health status should capture both quality and quantity of life.
- policy design needs to affirm whānau wellbeing as a pivotal force in the lives of a diverse range of Māori people.

Ngā Kaupapa Hauora Tūmatanui: Public health programme issues

Nāu te rourou, nāku te rourou ka ora te iwi.

Your contribution and my contribution will assure the wellbeing of all the people.

Improving Māori health status

There are various ways in which Māori health status might be improved. For all health and disability support services, there is an increased emphasis on:

- health needs information as the basis for resource allocation decisions
- needs assessment, planning and evidence of effectiveness
- primary and preventive health
- role clarity, organisational focus and performance accountability
- inequities of access for population groups
- Māori participation in service delivery and purchasing decisions
- new arrangements for primary care funding
- new providers and innovative service delivery (Steering Group to Oversee Health and Disability Changes (SGOHDC) 1997: 21).

For Māori health, gains are evident in, for example:

- the increase in the number of Māori service providers (discussed in detail later in the text)
- Māori involvement in purchasing decisions
- the number and nature of contracts between the HFA and Māori/iwi/hapū groups
- the dissemination of information which addresses Māori as a distinct population group.

Nonetheless, although significant gains have been made in Māori health development in recent times, 'Māori continue to lag behind non-Māori in almost every indicator of health status' (SGOHDC 1997: 54). Therefore, the rationale for and basis of continued and systematic improvement of Māori health status still exists. Barriers have been identified which, if removed, could influence an effective Government response in this area.

Barriers to Māori access to health services

Māori under-utilise primary health care services (Pomare et al 1995, Malcolm 1995). Māori tend to access services later than non-Māori, treatable illnesses become severe, and as a result the ability for health services to intervene effectively is reduced (Pomare et al 1995). The reasons for these behaviours rest in part on whānau-perceived barriers to accessing health programmes and services.

This section will discuss the issues associated with cost, location, cultural and structural barriers and will describe some strategies and programmes that have developed to improve whānau access.

Health planners and providers must work to overcome these barriers in order to make health services more accessible and acceptable to whānau (Wellington School of Medicine, University of Otago 1993). In order to minimise barriers, integration, collaboration and co-operation between primary and secondary services is necessary (Ministry of Health, in press).

Cost barriers

Cost barriers associated with doctors' visits, dental services, pharmaceuticals, outpatient care, transport, loss of wages, and possible job loss, inhibit many Māori from seeking early health care for themselves and their families. However, free access to medical care (where it is available) for children under six years of age, and targeted subsidies including the community card scheme, partly address cost barriers for some whānau.

Of the small number of submissions received on this issue, all agreed on the negative impact of cost barriers preventing whānau from accessing services and programmes. The submission from the New Zealand General Practitioners Association on this issue noted that 'fully subsidised marae clinics resulted in increased attendance by Māori', and recommended that 'all direct and perceived cost barriers to general practice should be removed and other mechanisms for payment developed to remove the emphasis on direct payment for consultations'.

Some researchers have identified a relationship between poverty and the reduction of health care access for Māori whānau (Malcolm 1995, Pomare et al 1995). Although acknowledging that there is some truth in this argument, TPK (1998) argues the need to extend the analysis of Māori disadvantage beyond a purely economic framework. TPK states that the culture of poverty theory serves an explanation for the relative position of Māori within New Zealand but fails to recognise that the cause of Māori disadvantage is the impact of colonisation. Therefore, strategies designed to address barriers, without recognising the broader social and cultural barriers which compound the cost barrier effect, are unlikely to achieve optimal health outcomes for whānau.

Location barriers

Location of and transport to health programmes and services present barriers to whānau access. These issues are equally relevant for whānau in urban and rural areas. Cost of transport in urban areas presents barriers for some whānau who lack the resources to get to services. In isolated and rural areas cost and geographical distance present particular barriers that need to be addressed. Some providers have adopted a 'take programmes to the people' model through mobile services to overcome these location issues.

Cultural barriers

The cultural appropriateness of services has been the subject of considerable discussion both nationally and internationally. The World Health Organization acknowledged the issue formally in 1991, and expressed the view that 'Health services need to embrace an expanded mandate which is sensitive to and respects cultural needs' (WHO 1991). Pomare et al 1995 noted that cultural safety issues including attitudes of health professionals, acceptability of the provider, and cultural factors such as whakamā will represent barriers for whānau access to services (Pomare et al 1995).

With the exception of services designed specifically by, and for, Māori the health and disability services providing care to Māori tend to be owned, controlled, managed and staffed by non-Māori.

For the most part these programmes and services are not located in Māori communities, and some operate without due regard for the cultural values and beliefs of whānau service users.

Structural barriers

Although the structure of the health and disability sector does not affect Māori exclusively, it contributes to exacerbating the alienation of Māori from participating in the design, development, implementation, management and control of the systems intended to meet their health needs. The institutional processes of health agencies also act as structural barriers that require attention if optimal whānau health gains are to be realised.

The Steering Group to Oversee Health and Disability Changes to the Minister of Health and Associate Minister of Health (SGOHDC) produced a report in 1997. It was titled *Implementing the Coalition Agreement on Health – The Report of the Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health*. This report identified some themes necessary to ensure Māori needs are addressed. They include:

- *rangatiratanga* – as a way of recognising The Treaty of Waitangi (Te Tiriti o Waitangi), ‘Māori aspirations for autonomy and self-sufficiency and development of services managed by Māori’
- *access* to quality mainstream services – whereby services are ‘safe, equitable, culturally effective and appropriate’
- *new and existing Māori providers* – so that services are provided ‘by not-for-profit Māori providers’
- *gains and outcomes* – ‘keeping Māori health and independence a priority’
- *aukati – prevention/promotion* – recognising ‘disease prevention and health promotion give the best opportunities for significant long-term Māori health and independence gains’
- *tikanga Māori and kaupapa Māori* – including ‘traditional healing and other services rooted in Māori health and wellbeing philosophies’
- *integration – intrasectoral and intersectoral* – recognising ‘gains in health and independence stem as much from socioeconomic advancement as improved health and disability services’
- *resourcing Māori health and independence gains* – including ‘identifying specific Māori development funding, shifting resources from the margin to the Māori health and independence gain priority area, and ensuring the funder has strong partnership and participation strategies’
- *awatea – Māori development* – meaning ‘a holistic approach putting Māori health and independence improvement in the context of overall Māori development (SGOHDC 1997: 55–56).

In the context of structural issues, these themes have a significant bearing on the relationships, processes, strategies, values, preferences and participants involved in ensuring whānau needs are met by the health and disability sector as a whole.

During consultation there was overwhelming support for the need to address the various cost, structural, and entry barriers to enable effective programme and service delivery to whānau.

Overcoming programme barriers

Public health is a co-operative effort involving people working together to improve health. There are four important cross-cutting themes to consider in the development and delivery of health promotion programmes and the provision of public health services. They are:

- focusing on the determinants of health
- building strategic alliances within and between sectors
- implementing comprehensive programmes
- strengthening the public health infrastructure (Ministry of Health 1997j).

These cross-cutting themes will be used as a framework to describe how the following strategies and programmes minimise the cultural, cost and structural barriers described in the previous section. The cross-cutting themes and strategies will be examined in the following manner:

Focusing on the determinants of health

- cultural wellbeing
- whānau-focused approach
- culturally effective services

Building strategic alliances within and between sectors

- intersectoral approach
- co-ordinated programmes

Implementing comprehensive programmes

- settings issues

Strengthening the public health infrastructure

- resourcing issues
- workforce issues.

'Focusing on the determinants of health' cross-cutting theme

Given the breadth of factors that determine health, the challenge is to strategically focus on a manageable number of key determinants that can be changed and will result in health gain. In 1997, four *key* determinants were identified by the Ministry of Health which were the most important to address. They were: income inequalities, housing, employment, and education/ life skills (Ministry of Health 1997j). These key determinants are relevant to whānau health and addressing them will likely result in some improved health outcomes. However, an exclusive focus on socioeconomic factors as suggested will be inadequate and ineffective in achieving significant health gains for whānau in the long term. A focus is needed also on *cultural wellbeing* as a significant determinant of health for whānau. Analysis in the earlier background section of this paper has described the various historical and contemporary factors which have prevented whānau from achieving optimal health outcomes. Addition of the cultural wellbeing aspects will ensure a more relevant and holistic approach which acknowledges the importance of cultural identity and intactness to whānau health outcomes.

Cultural wellbeing

Determining the criteria which accurately measure the cultural wellbeing of whānau is fraught with difficulty. Such criteria will be dependent on the diverse realities of individuals within whānau and whānau as a collective, and will inevitably involve both objective and subjective measures. Knowledge of oneself (by implication cultural knowledge) is acknowledged in various Māori models as an important measure of health status. For many whānau, knowing themselves will include amongst other issues knowledge of iwi and te reo.

At the 1996 Census, Māori living in the South Island were less likely to know their iwi than those in the North Island. One in every three Māori in the Otago and West Coast regional council areas did not name an iwi to which they were affiliated, compared with just one in every 10 Māori living in the Gisborne Regional Council area. Living in a rural or urban setting made little difference to the proportion of Māori who could name at least one iwi to which they were affiliated. Twenty-one percent of South Island Māori who knew the name(s) of their iwi indicated that they were affiliated to more than one. For North Island Māori this figure was 29 percent (Statistics New Zealand 1997b).

Use of te reo at the 1996 Census indicated that the ability of people of Māori descent to converse in Māori varied considerably by iwi. Six iwi with 1,000 members or more reported over 40 percent of their members as being able to hold a conversation in Māori about everyday things. Of the larger iwi (those with a membership in excess of 20,000), 45 percent of people affiliated to Tuhoe said they could converse in Māori compared with 12 percent of those affiliated to Ngai Tahu. For people of Māori descent who did not know their iwi, seven percent could hold a conversation about everyday things in Māori (Statistics New Zealand 1997b).

Whānau-focused approach

Minimising barriers to access is likely to be achieved through a whānau-focused approach that addresses the historical and contemporary factors which have resulted in diverse realities for whānau. Diverse realities influence the way in which people develop their world view. These realities vary from iwi to iwi, hapū to hapū, and whānau to whānau. The most effective strategies for changing whānau health practices and behaviours best occur in the context of Māori development aspirations (SGHODC 1997). Māori development is synonymous with whānau development. Whānau focused programmes enable the inclusion and participation of both those Māori who have a close association with hapū and iwi and those that do not (PHC 1995a).

A whānau-focused approach which recognises diverse realities in the development and delivery of public health programmes will be effective in addressing the cultural barriers to whānau accessing health services. Whānau are the best guides through their own world, and they are the key to promoting health messages and accessing the full range of Māori networks, alliances, communities and social structures. Programmes which are identifiably Māori, and which validate whānau and their values and beliefs, are likely to minimise many of the structural barriers that some whānau experience in the delivery of programmes and services (Ministry of Health 1995b).

The Health and Disability Commissioner's submission on this issue stated that according to 'Right 7(4) of The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, the views of suitable persons may be taken into account by the provider before providing a service'. This means that when deciding what service to provide, the provider is able to take into account the views of whānau.

Such strategies will enable progress toward quality of life outcomes for whānau members identified at Te Ara Ahu Whakamua Hui, which included having a strong sense of identity, high self-esteem, confidence, pride, independence, a strong voice, intellectual alertness, physical fitness, spiritual awareness, personal responsibility, co-operation, respect, knowledge of te reo Māori and tikanga Māori, economic security and strong whānau support (TPK 1994e).

Of the small number of submissions received on this issue, the majority agreed on the whānau focused approach promoted in this document. However, the submission from Te Ohu Whakatupu although 'fully agreeing to the need for services to work with a person's family' also noted they 'were not convinced that this meant there is a need for a whānau policy'.

Culturally effective services

The need for culturally effective services is predicated on the importance of cultural wellbeing on whānau health outcomes. Further, it recognises the influence of the cultural baggage that both providers and whānau bring when interfacing in the health sector. The provision of culturally effective services that recognises diverse whānau realities means that providers will be sufficiently familiar with Māori cultural values, beliefs and norms that impact on health practices and lifestyle choices and behaviour. This is necessary to eliminate the risk of inappropriate practices which cause offence, create barriers of access and marginalise participation on cultural grounds. Also, it necessitates providers being aware of the different power relationships between providers and consumers in the health sector, and the potential for providers to impose their cultural beliefs on whānau service users.

There are significant gains to be made from the various micro and macro approaches to the provision of culturally effective programme development and delivery in the health sector. Attention to minimising cultural barriers at the programme interface and the institutional level is likely to improve whānau access to and use of programmes and services. Appropriately targeted culturally effective health promotion programmes and services and increased whānau access to primary health care are likely to result in improved cost benefits in the long term. It is expected that the HFA will purchase culturally effective programmes and services (Ministry of Health 1997d). This requirement has particular implications to both mainstream primary health care providers and 'by Māori for Māori' organisations and initiatives to ensure services are accessible and acceptable to the actual and intended users of those services (Ministry of Health 1997g, Ministry of Health 1998b).

'Building strategic alliances within and between sectors' cross-cutting theme

Intersectoral approach

Building strategic alliances to advance health gains for whānau requires a climate of professional collaboration between the Ministry of Health and other central, regional, and local government agencies. This will help prevent duplication of effort and fill the gaps (Ministry of Health 1997j). Such an approach will improve cost effectiveness gains through improved returns for health dollars invested. Whānau will benefit from this approach by avoiding overlaps through co-ordinated and targeted programme expenditure.

Co-ordinated programmes

Programme issues associated with building strategic alliances require public health, personal health and other social agency providers to work in a co-operative and collaborative manner. Effective programmes and services need to include whānau and the broader community in their development, and to be holistic in their approach and co-ordinated in their delivery. This is particularly important for isolated and rural communities.

There are various barriers that impact on co-operation between providers. These include conflicting philosophies and agendas, the lack of appropriate mechanisms to facilitate co-operation, the competition for scarce resources, and the competitive contracting model in the health sector (Ministry of Health 1997j). Co-ordinated approaches that include mechanisms to promote the sharing of expertise and resources will benefit whānau through planned, sequenced and consistent strategies.

Of the 19 submissions received on this issue, there was overwhelming support for a co-ordinated approach to holistic programme and service development and implementation both across government agencies (where there are health implications) and within the health sector. The Hokitika Consultation Hui Report's submission on this issue acknowledged the particular importance of this approach for isolated and rural Māori communities in the South Island.

Effective co-ordination of programmes and services will by definition require effective and seamless referral systems. This will prevent whānau from 'falling through the cracks' and will provide a 'safety net' to ensure those requiring alternative services receive their required follow-up care. The Tamaki Makaurau Marae Consultation Hui Report submission on this issue endorsed the need for 'a stable and seamless referral system'.

Family health teams

The Government is committed to a greater emphasis on health gain and the co-ordination of programmes and services. The Coalition Agreement identified the need for a Family Health Teams pilot. This strategy signalled the need for better co-ordination and integration between secondary and public health services (Coalition Agreement 1996). Therefore, it is anticipated that the Family Health Teams pilot will address the needs of Māori whānau and demonstrate how whānau health gains will be advanced through this strategy.

'Implementing comprehensive programmes' cross-cutting theme

Settings issues

Attention to working in settings requires the recognition that settings will influence the manner in which programmes are delivered by providers and received by whānau. The delivery of services in areas that whānau live, work and play is likely to contribute to optimal health outcomes. However, it has acknowledged that a settings approach may not meet whānau most in need because these people often do not, or cannot, participate in settings such as schools and workplaces (Ministry of Health 1997j).

A settings approach also requires attention to the effect of and interaction between the various components involved in the delivery of effective health promotion programmes. These comprise the messenger (eg, Māori health promoters), the message (eg, minimising the use of jargon), the

medium (eg, use of appropriate health education resources) and the environment (eg, community, marae or home-based). A settings approach will address some cultural and structural barriers and is likely to increase and improve programme outcomes for whānau.

‘Strengthening the public health infrastructure’ cross-cutting theme

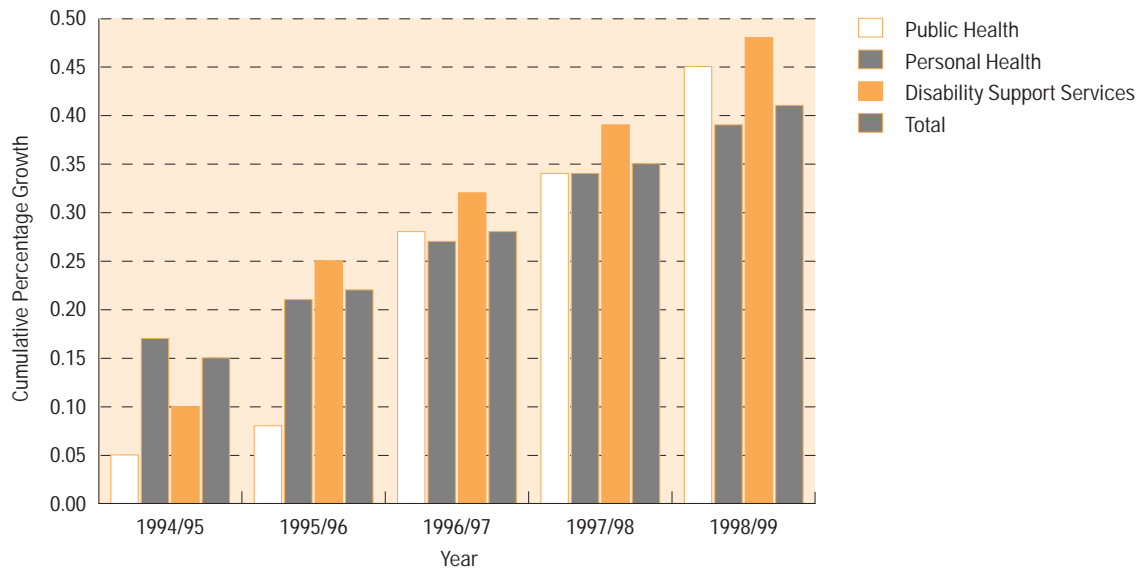
Resourcing issues

Public health resourcing issues

Programme issues associated with strengthening the public health infrastructure includes the need for adequate resourcing. Public health needs to be adequately resourced in order to ensure effective action. Investment in public health has the potential to improve health and reduce costs in the personal health and disability sector (Ministry of Health 1997j). Since the 1993 health reforms, public health funding has been ring-fenced from personal health care funding in order to protect the current investment. This was in response to the perceived diversion of funds which occurred in the past in area health boards. Funding for public health is less than 2 percent of Vote Health on the definition that was first used in 1992 in the Public Health Resource Identification Project (NIPB 1992).

From 1993/94 to 1995/96, growth in funding was based on funding bids which were prioritised against all other bids. In 1996/97 the public health funding formula was introduced for the first time and this was further developed in 1997/98 (Ministry of Health 1996g). The population-based system uses demographic adjusters to calculate how much extra money needs to go to providing public health services just to keep up with the growth of New Zealand’s population. The population-based funding formula is based on existing patterns of service utilisation across age and ethnic groups. As a result of the application of this formula, catch-up and other one-off programmes, the cumulative percentage growth in public health funding was significant between 1995/96 and 1996/97 and since then has kept up with the growth in personal health funding (Durham 1998). This pattern is illustrated in Figure 5.

Figure 5: Vote Health Growth Comparison 1994-1998



Source: Durham 1998

The Ministry of Health has noted that the nature and effectiveness of public health funding needs to be examined (Ministry of Health 1997j). Further work needs to be done to determine how to address the ‘ring-fence’ issues relating to Māori health. The current definitions used for funding and accountability within the two Non-Departmental Output Class (NDOCs) for health (both public and personal) are inappropriate for Māori who wish to provide holistic services.

Equitable resourcing

Issues associated with strengthening the public health infrastructure also include the need for equitable resourcing. There is a need for equitable funding of providers, as Māori appear to have been traditionally under funded in primary health care services. In 1994, budgets in general practitioner (GP) fund holding had been based upon historical expenditure. As a result, per capita budgets had varied widely between practices by a factor of at least three times, which is unexplained by the needs of the population served (TPK 1994a).

Equitable resourcing includes the desirability of additional funding for new Māori programmes and initiatives to enable the establishment of an effective infrastructure. Such a strategy would contribute to Government’s desire to increase Māori providers in the health sector.

Of the 12 submissions received on this issue, the majority supported the need for resourcing to ensure accessible long-term health promotion programmes for whānau that are not set up to fail. Other issues raised include:

- every dollar allocated to Māori health must be a ‘working dollar’
- resourcing programmes in organisations that have an established infrastructure.

Māori funding models

Strategies associated with strengthening the public health infrastructure have resulted in increased Māori involvement in the funding and provision of health and disability services for Māori. Recommendations from the Te Ara Whakamua Hui stated the need for increased emphasis on Māori control over Māori health development and a greater role for Māori in the purchasing and provision of health services (TPK 1994e). Some of the following Māori funding models address the early aspirations and direction identified at the Te Ara Whakamua Hui in terms of active Māori participation in decision-making in the health sector.

The Northern Office of the HFA has established three Māori Co-purchasing Organisations (MAPOs), comprising:

- Ngati Whatua (sub-region north of the Manukau Harbour including Dargaville, but excluding Whangarei)
- Tainui (sub-region south of the Manukau Harbour)
- Te Taitokerau (Whangarei and rest of Northland).

These MAPO have individual and collective responsibility for the planning and purchasing of health and disability services for Māori in the Northern region (Ministry of Health 1998b).

The Midland Office of the HFA has four Joint Venture Boards responsible for driving the development and implementation of Māori health policy in its regions. The Joint Venture Boards represent iwi as follows:

- Piki Te Ora (representing five iwi of the Waikato and King Country)
- Te Tahuhu Hauora o te Tairāwhiti (representing four iwi of the East Coast)
- Te Ara Tuhono (representing eight iwi of Taranaki)
- Te Taātau Pounamu (representing eighteen iwi from the Bay of Plenty) (Ministry of Health 1998b).

In other regions providers have elected to have a direct relationship with the funding authority, rather than work through an intermediary body. The Central Office of the HFA has delegated functions as part of its move towards establishing Māori Integrated Care Organisations – six of which have been identified (Ministry of Health 1998b).

The Southern Office of the HFA has focused attention on building on the work done by Māori units within CHEs and on encouraging CHE providers to provide culturally appropriate environments within CHEs. In 1997, Te Runanga o Ngai Tahu was contracted to undertake consultation with Māori in its region on health issues (Ministry of Health 1997g, Ministry of Health 1998b).

Some submissions received on this issue supported the need to fund Māori programmes through Māori organisations in order to minimise the barriers between the funder and Māori programme providers.

Workforce Issues

Māori provider issues

Addressing Māori provider workforce issues will have a significant impact on improved whānau access to programmes and services as well as strengthening the public health infrastructure. Following the 1993 health reforms the participation of Māori in the health sector has increased. In

1997, there were over 200 Māori providers, as compared with 30 in 1993 (Ministry of Health 1998b). The Steering Group to Oversee Health and Disability Changes (1997) expressed the view that: 'Positive Māori development is a key issue. In the health and disability sector, this will include increased attention to encouraging development of Māori providers and workforce, and delivery of mainstream health and disability services culturally appropriate to Māori' (SGOHDC 1997). The Coalition Agreement signalled the Government's intention that this issue be addressed (Coalition Agreement 1996). To achieve this end \$8 million was allocated for the first year and tagged funding for a further two years was provided to accelerate the development of the Māori health and disability workforce, as well as Māori providers. It is anticipated that whānau will benefit from increased Māori provider presence and increased choice of provider, programmes and services which address whānau diverse realities.

Māori participation in the health sector

Programme issues associated with strengthening the public health infrastructure requires increased Māori participation in decision-making at all levels of the health sector. Areas include management, policy development, direct service, across the preventive, primary, secondary and tertiary service levels. Māori participation in the health professions must be increased. Factors that contribute to low participation in this area include recruitment and retention barriers (Ministry of Health 1997j).

Results of the 1996 New Zealand Health Workforce Survey indicate that in 1996 there were a total of 31,199 Registered Nurses, of which 5.5 percent (1,727) were Māori Registered Nurses. In the same year there were a total of 5,827 Enrolled Nurses, of which 11.1 percent (652) were Māori Enrolled Nurses. In 1997, the results of the New Zealand Health Workforce Survey showed there were 201 out of a total of 8,224 Medical Practitioners² who reported themselves as Māori. It is important to note that in both these examples the figures use the mixed ethnicity classification (personal communication, Paul Easton NZHIS, April 1998).

Currently there are no Medical Officers of Health and there are very few Health Protection Officers who identify as Māori. Low educational attainment among Māori and high academic entry criteria and performance have in some instances compromised Māori participation as qualified health professionals. Bridging programmes are a positive strategy that will increase the Māori recruitment and presence in this area. Retention of Māori will be achieved through policy and curriculum development that addresses the structural and cultural barriers. Increased Māori participation in these areas will address in part some of the cultural and structural barriers for whānau through increased choice of health professional providers that can effectively meet whānau expectations.

Of the submissions received on this issue, there was unanimous support for the need to increase Māori representation at all levels of the health sector, particularly in the health professions. Other submissions registered strong support for Māori control over decision-making, health structures, organisations, policies and procedures that provide services to whānau. Another issue that was highlighted in this area was the need for training for community health workers to enable them to develop transportable and optimal competencies to contribute to whānau health care delivery.

² Medical Practitioner includes the following categories: House Officers, Registrars, Medical Officers, General Practitioners, 'Other' Primary Care Practitioners and Specialists.

What programmes and services exist?

'By Māori for Māori' issues associated with strengthening the public health infrastructure include the development of programmes that use Māori health and wellbeing philosophies and practices in the delivery of their programmes and services. Examples include the revival of traditional cultural healing practices such as mirimiri and the increasingly explicit use of Māori herbal remedies (rongoa Māori). This revival reflects the diverse health needs of whānau. Also it indicates that whānau will access various configurations of traditional and mainstream providers to meet the full range of their health and disability needs.

The scope for addressing the barriers whānau encounter in seeking to access information, advice, resources and services has improved with the increase in the number of Māori providers. 'By Māori for Māori' providers have achieved a balance between the treatment of illness, and health promotion activities that are whānau, hapū and iwi focused. Resourcing of these providers is necessary to ensure that Māori aspirations for Māori control of services by and for Māori can be realised.

A number of health services which have tikanga Māori as an integral part of their service have been developed by Māori. They include primary health care, child health services, healthy lifestyle programmes, and combinations of these aspects into comprehensive social and economic development programmes. The following examples describe some of those programmes and services. 'By Māori for Māori' reflects the diverse realities of whānau, and the examples are potential models for whānau to develop their own approach to resolving their own issues. However, the economic, political, social, cultural and community conditions which characterise the history of these examples may be vastly different from those of whānau in other locations. Therefore, whānau need to evaluate the examples for differences and/or similarities before adopting a particular example as a model for dealing with their situation.

Many 'by Māori for Māori' groups, organisations and initiatives have reshaped their business focus to a 'by Māori for all' approach. This approach benefits whānau in that all families and whānau have their needs met through a Māori delivery approach which promotes Māori norms, values and beliefs. In order for whānau health gains to continue and improve, it is important that existing 'by Māori for Māori' programmes be adequately resourced and monitored for performance.

Tihei Mauriora (Smokefree Marae)

Tikanga Māori is central to the Tihei Mauriora Smokefree Marae programme, because smoking constitutes a breach of the tikanga which treats breath as tapu. This tikanga originates from the creation of the first human being, Hine-ahu-one, who was given life through Tane Mahuta breathing life into her and reciting an ancient karakia:

Tihei mauri ora, ki te whai ao, ki te Ao Marama

Behold the breath of life, strive for the new world, the world of light.

Respect for tikanga and whakapapa has provided strong motivation for many whānau who have succeeded in giving up smoking through this programme (LTPK 1995b).

Kokona Whānau

This programme is a marae-based programme which addresses sexual abuse within whānau and focuses on both the victim and the perpetrator. Kokona Whānau facilitates the treatment and rehabilitation of the victim and engages them and their whānau in a positive process. The programme affirms the centrality of whakapapa in determining the victim's identity and re-establishes their place in the whānau. It also acknowledges the marae as the spiritual centre of whānau, and draws on the rituals of kawa as part of the healing process. When focusing on the perpetrator, Kokona Whānau seeks to resolve all aspects of the incident(s). As a result, the perpetrator can be stripped of mana and be ordered to make reparations to the victim and their whānau.

Rapua te Oranga Hinengaro

Rapua te Oranga Hinengaro is a community-based, iwi-controlled service for Māori who suffer from psychiatric illness. This service uses tikanga Māori as its guiding principle. It was developed under the guidance of kaumātua concerned about the substantial increase in psychiatric illness among whānau, and the apparent inability of mainstream mental health services to address this problem (TPK 1993). The Rapua te Oranga Hinengaro service is an extension of the bicultural mental health services in the Auckland region. The service focuses on the needs of the client and their whānau and is delivered in the places where the clients feel most comfortable (eg, marae or home). Rapua te Oranga Hinengaro recognises the impact of cultural alienation and the breakdown of cultural traditions on the mental wellbeing of their clients. As part of their work, kaumātua seek to assist clients to rediscover their ancestry and reconnect them with whānau, hapū and iwi. This reclamation of their cultural heritage, whakapapa and tikanga, has enabled some clients to map out a path to recovery based on their cultural heritage (Huakina Development Trust 1994).

Tipu Ora

Tipu Ora currently operates in the Te Arawa, Mataatua and some parts of the Ngai Tahu areas. Tipu Ora is a holistic well-child care programme which focuses on delivering health care programmes for parents, caregivers and tamariki (TPK 1994c). A lack of access to care, a poor knowledge of good health measures and isolation are common problems faced by young Māori parents. Tipu Ora has responded to these problems by using kaitiaki (guardians) who are experienced in child care, are well-versed in tikanga and who are able to guide young parents in raising their children. The kaitiaki visit the homes of new parents to provide support, education and instruction in parenting skills. The Tipu Ora programme has led to a dramatic reduction in the Māori SIDS rate and has increased immunisation and breastfeeding in the areas covered by this service. The programme has succeeded in reducing the smoking of pregnant mothers and there are positive early indications that they have achieved increased birth weights (Ropiha 1993, TPK 1994c).

Te Roopu Matehuka

Te Roopu Matehuka is the national organisation of Māori diabetes workers. It is developing a whānau approach to diabetes care and ensures that diabetes services are appropriate and safe for Māori. To successfully deal with the disease and the changes it involves, the person needs the support of their whānau. Strategies to address diabetes include developing a national strategy for diabetes that recognises the health needs of Māori. The direct threat of this kind of illness can lead to behaviour changes for the whānau as well as the individual concerned. Healthy food, smoking cessation, exercise and drug-free lives can become the reality for the whānau. In this way, a personal health issue generates a public health whānau response.

Whare Oranga

Whare Oranga – marae-based gymnasiums – are the centre of Tahuna Minhinnick’s vision of excellence for Māori health. As the marae is the central cultural enforcer of Māori tikanga, it is logical that it be the place to introduce healthy lifestyles.

We need to create and re-introduce tikanga which facilitate exercise and good kai. In this way we are in a position to positively influence Māori people’s attitude to good health (TPK 1995b).

Oranga Niho

There are significant cost and cultural barriers that Māori currently face in accessing good dental care. Te Whare Kaitiaki in Dunedin is a Māori-focused dental service that operates on whānau principles. There has been an overwhelming demand for its services (TPK 1995e). There is a particular need for greater emphasis to be placed on health education in this area of dental health issues. There is also potential for an expanded role for dental therapists. There are resource problems for dental health promotion. Organisations that currently include dental health promotion among their services are finding that this is not part of their contracted work (TPK 1995e).

Evaluation frameworks

The evaluation of programmes and services is important to ensure that whānau needs are effectively addressed. Appropriate frameworks to assist this process include *The CHI Model: A culturally appropriate auditing model* (PHC 1994h). This model provides a framework within which provider contracts can be audited with respect to cultural appropriateness and health gains for Māori. The model adopts a holistic framework and seeks to be interactive. Another potential model which adopts a similar approach for providers is *He Taura Tieke: Measuring effective health services for Māori* (Ministry of Health 1995b).

Culturally effective service delivery should be assessed for the quality of service being delivered at the organisational level. Strategies to achieve this have varied in regions nationwide. In the Northern region, a Hauora Māori Schedule was negotiated with each CHE as part of the CHE contracts. A cultural audit and review was conducted for the disability support services against the requirements of the schedule. In the Midland region three of the Joint Venture Boards have introduced cultural frameworks to improve cultural appropriateness. The framework encourages a cultural change throughout CHEs, with the Joint Ventures having responsibility for monitoring the framework (Ministry of Health 1997g). *He Anga Whakamana* (Ratima and Allan 1996, Ratima et al 1996) is another tool used to evaluate the effectiveness of service delivery for whānau who are living with disability. The benefits of these types of evaluation tools, for whānau as end users, include the use of specific cultural audit tools to monitor and evaluate the quality of service provisions according to purchase agreement and contracting requirements.

Following consultation some of the submissions received on this issue identified the need for developing criteria and frameworks which can monitor and evaluate if services are effective for whānau. The Health and Disability Commissioner’s submission acknowledged ‘the importance of establishing qualitative measures which can be utilised as recognised standards for providers in Māori health care’. This approach is consistent with the early work undertaken by Māori researchers on this issue (Pomare et al 1995, Durie 1994c).

The Commissioner also stated that she ‘would welcome further research and discussion in the area of establishing recognised standards relevant to the delivery of health and disability services appropriate to Māori’. The development of such standards would enable Government to gather both qualitative and quantitative data to effectively measure the value of Government funded service delivery.

Key features of effective health programmes and services for whānau

Active support for whānau wellbeing requires a comprehensive approach, which includes the following:

Co-ordination

- interagency and intra-agency co-ordination and co-operation
- minimising duplication and wastage
- increased ability to provide appropriate and accessible programmes and services.

Resources

- adequate resourcing that matches need
- resolution of inequitable resource allocation
- resource allocation/rationing according to community information and priorities.

Effective strategies

- owned and evaluated by the community they serve
- enable local solutions to local problems
- increase focus on health promotion and illness prevention
- develop, monitor and evaluate effective systems, services and strategies which will improve whānau access
- set and uphold standards of care to which whānau aspire
- ensure services are medically and physically safe and are culturally effective
- contribute to the development of the community served
- reduce the barriers for Māori in accessing effective health care services
- foster an approach which incorporates holistic Māori models including *Whare Tapa Whā* .

Accurate information

- accurate and reliable Māori health data, so that policy and programmes to address Māori health needs are evidence-based
- setting goals and targets to improve Māori health status
- sound and accurate Māori cultural information from the population group itself.

Workforce issues

- Māori workforce and provider development strategies, as a basis for improving the full participation of whānau to improve their own health and wellbeing.

Where to from here?

The potential of integrated/co-ordinated care

The 'integrated/co-ordinated care' model of health service provision has the potential to fit well with a holistic, whānau-centred approach to health care. At present there are limited systems of integrated/co-ordinated care operating in New Zealand. However, some Māori groups and organisations are seeking to build on their existing infrastructure to establish integrated/co-ordinated care arrangements to meet the needs of whānau in their area. This type of care offers opportunities for Māori to address many of the barriers whānau experience in accessing appropriate programmes and services. Further, it will enable whānau to meet many of their aspirations for more appropriate and effective health and disability services.

Integrated/co-ordinated initiatives

The Ministry of Health has identified the following arrangements as encompassing the spectrum of approaches which in New Zealand comprise an integrated/co-ordinated framework.

Collaborative purchasing (or co-purchasing) – Service providers or consumer representatives are involved in making purchasing decisions.

Budget holding – In the United Kingdom, this model typically involves controlled spending. Budget holding also ensures that communities, purchasers, providers and regulators are involved in shaping services to meet needs. In New Zealand, budget holding contracts give providers access to a specific pool of funds from which they must meet the costs of some of the services that their patients receive, or to which they are referred. Services may include pharmaceuticals, laboratory tests and elective surgery. In 1996/97 the then Central RHA signed a budget holding contract with Te Oranganui Trust in Wanganui for General Medical Subsidy (GMS), pharmaceuticals, laboratory tests, and maternity services to whānau in that region (Ministry of Health 1998b).

Capitation – Funding authorities are increasingly contracting with GPs for their services on the basis of the population they serve. In this model GPs are paid according to the number of people enrolled with their practice, rather than a fee for each service they provide (Ministry of Health 1998b). Budgets for capitation tend to be formula-based, which is important for reasons of equity.

Following consultation, the submission from the Royal New Zealand College of General Practitioners on this issue stated that 'Māori health initiatives should not be capitation-based as Māori health is worse – they will use up the fund quicker'. TPK has supported this position and has argued that historically Māori have under-utilised primary health care services. It was noted that any funding formula that is based on historical patterns is likely to be inadequate to meet the actual health care needs of Māori communities (TPK 1994a, TPK 1995c). The Ministry of Health agrees that capitation formulae must reflect the needs of the population.

Managed care – This model (which originated in the United States) is primarily seen as a tool for cost containment (Ministry of Health 1995a: 12). Managed care involves the co-ordinated provision of health care services that are designed to meet the particular needs of enrolled consumers. This model involves primary health care being responsible for the overall management and care in all phases – primary, secondary and tertiary. This may involve a shift in power from hospital system to the community (TPK 1994a).

Developing Māori integrated/co-ordinated care arrangements

There are essentially two avenues through which iwi and Māori organisations are currently developing integrated/co-ordinated care organisations, the provider route and the purchaser route.

The provider approach involves community-controlled models which include iwi and Māori organisations seeking funding to establish a range of primary and/or community care services, for an enrolled population (Ministry of Health 1995a: 17). One example amongst many is Te Whānau o Waipareira Trust, which is in the West Auckland area. This organisation is an example of a 'by Māori for all' approach which addresses the needs of the entire population that this organisation serves, with a particular focus on Māori whānau.

The other approach involves setting up new funding organisations which enable Māori to exert influence or control over purchasing decisions (Ministry of Health 1995a: 17). Examples of this includes the MAPO and the Joint Venture Board arrangements which have been discussed earlier in this document.

Essentially, whether the route be provider or purchaser, it is evident that there are many iwi and Māori groups and organisations that have established the infrastructure on which integrated/co-ordinated care configurations can be built.

Health care plans – This model is the most ambitious approach to integrated/co-ordinated care for Māori and would represent a move towards the United States managed-care model. The model represents an opportunity for the future in which iwi and Māori groups and organisations are directly funded from government (rather than through the HFA structure). Such an organisation would have a high degree of autonomy to shape the services for the people served and would also take on many of the current roles of the funder. This responsibility would cover all aspects of health and disability support and social services (eg, housing) for a specific population (Ministry of Health 1995a). This model will effectively achieve Māori aspirations for autonomy and self-sufficiency and the development of services managed by Māori (SGOHDC 1997).

At a whānau level, the benefits of this model would include removing most of the access barriers described earlier in this publication. A particular registration issue that requires careful attention is the need for a flexible system which recognises the current reality for many Māori who are living outside their iwi regions. In such a model, iwi/Māori registered consumers must be able to access services from providers outside their identified integrated/co-ordinated care organisation in times of emergency. Whānau (particularly those who are highly mobile) are likely to need this type of flexibility from a model of this kind. A proposal would require the development of a reciprocation system between integrated/co-ordinated organisations to ensure equitable funding mechanisms. It is essential that this model be managed as one in which barriers are removed, rather than created, to enable effective health care delivery which will facilitate whānau health gain.

Risk management

For Māori, the aim of an integrated/co-ordinated care approach is to increase access to and co-ordination of services delivered to whānau. In most models of integrated/co-ordinated care, the organisation carries or shares the financial risk with the government. An important question is what extent of the risk should Māori integrated/co-ordinated care providers carry? Given the absence of accurate data on the real level of health need among Māori, this question is yet to be answered. If the risk they were to carry was too high, the services might simply be set up to fail (TPK 1994a, TPK 1995c).

SUMMARY OF ISSUES

There are a number of issues to consider when developing programmes to advance health gain at a whānau level, and these include:

BARRIERS TO ACCESS

- barriers have been identified which if addressed would influence a more effective Government response for Māori health improvement
- *cost barriers* prevent whānau from accessing services and programmes
- *location barriers* and transport to services present barriers in both urban and rural areas
- *cultural barriers* including attitudes of health professionals, acceptability of the providers and whakamā present barriers
- *structural barriers* of the health and disability sector alienate Māori from participating in the design, development, implementation, management and control of systems intended to meet their health needs
- SGOHDC identified themes to ensure Māori needs are addressed.

OVERCOMING BARRIERS

Minimising barriers to access is likely to be achieved through cross-cutting themes strategies which include:

- working from a basis of the *key determinants of health cross-cutting theme* as including socioeconomic components: income inequalities, housing, employment and education/ life skills and cultural wellbeing issues
- a *whānau-focused* approach that addresses the historical and contemporary factors which have resulted in diverse realities
- the provision of *culturally effective* services will address whānau programme issues and concerns associated with cultural and structural barriers
- *building strategic alliances within and between sectors* to advance health gains for whānau will require an *intersectoral approach* and include whānau and the broader community, be holistic, and *co-ordinated*
- *implementing comprehensive programmes* by working in settings requires delivering services in areas that whānau live, work and play to be effective
- *strengthening the public health infrastructure* requires a focus on *resourcing* issues including public health funding issues (eg, ring-fenced public health budget), and equitable funding of providers
- attention to Māori provider *workforce* issues will have a significant impact on whānau access to services as well as strengthening the public health infrastructure
- Māori *participation in decision-making* is required at all levels of the health sector
- programmes which use Māori health and wellbeing philosophies and practices are needed
- *integrated/co-ordinated care models* offer further frameworks for Māori providers to develop programmes which will optimise effective access of whānau to programmes and services
- the *evaluation* of programmes and services is important to ensure that whānau needs are effectively addressed.

Rangahau, Whakamōhiotanga: Research and information

*I kune mai i Hawaiki ki te kune kai ki te kune tangata.
It sprang up in Hawaiki, the growth of food, the growth of people.*

This section discusses research issues that would normally be addressed by research funding agencies. The Crown's attainment of its own objectives depends on the collection, analysis and use of accurate and comprehensive health information. Accurate information is a key ingredient in, for example, quality assurance methodologies, testing the adequacy of systems, evaluating the performance of policy makers, funders and providers, and maintaining a balance between rationing on the one hand, and needs on the other. Therefore, the collection, analysis and use of health information continues to be a priority. In the research area, there is an ongoing need to improve the availability of quality research. The discussion below provides information for policy makers and researchers to consider in developing proposals in the area of whānau wellbeing and health.

Māori intellectual property rights

Understanding Māori culture, values, norms and perspectives is vital in the collection, collation, storage and access to information relating to Māori (and by implication whānau) health. Past experiences have shown that whānau have had little control or opportunity to manage information once it is collected. The result of incorrect information makes it difficult to measure the success of policies or programmes targeted to whānau. In the case of individuals, information may be withheld in an attempt to retain control over that information. In order to remedy past errors and to support development initiatives, systems and processes must be developed that allow Māori whānau to manage their own information (TPK 1994j).

Māori have claimed that New Zealand's intellectual property laws provide inadequate protection for their cultural and intellectual property (Ministry of Commerce 1994). Intellectual property usually refers to intangible things such as knowledge, ideas, secrets, which are protected by the laws relating to intellectual property. Cultural property usually refers to evidence of a certain stage in development of a culture's heritage and includes works of art, archaeological and historical objects. These western traditions of cultural and intellectual property are not widely accepted by Māori whānau, whose concepts do not fit well with this paradigm (Ministry of Commerce 1996).

Any collection of information on Māori whānau health issues must address the protection of cultural and intellectual property rights, and steps must be taken to protect this taonga. As whānau take a holistic approach to health, all collected data should be regarded as intellectual as well as cultural property. Any information collected regarding Māori health, belongs to the whānau and is both cultural and intellectual property.

The Mataatua Declaration

The Mataatua Declaration on Cultural and Intellectual Property Rights of Indigenous Peoples, June 1993, declared 'that Indigenous Peoples of the world have the right to self determination, and in exercising that right must be recognised as the exclusive owners of their culture and property'. The Mataatua Declaration also suggests that Māori (and thereby whānau), as an Indigenous People should, amongst other things:

- define their own intellectual and cultural property
- develop a Code of Ethics which external users must observe
- develop and maintain their traditional practices and sanctions for the protection, preservation and revitalisation of their traditional intellectual and cultural properties (TPK 1994j).

Health Information Privacy Code

This Code was established under the Privacy Act 1993 and incorporates many of the concerns that Māori whānau have expressed about how their personal information has been used in the past. The Code applies only to personal data and not aggregated data or information collated to form national or regional statistics. Personal information cannot be collected without the individual's informed consent. The Code places responsibility on health providers, both Māori and non-Māori, who must recognise the sensitive situation that arises in the provision of health care to whānau (TPK 1994k).

The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996

This Code has provisions for whānau as consumers, which include the right to respect of culture, values and beliefs, and the right to personal privacy in consultation and treatment and also in the collection of any information. Whānau must be kept fully informed regarding all aspects of information collection, collation and distribution. There is also provision for whānau to have support people or advocates if needed, which is of particular relevance when sensitive information is requested (Health and Disability Commissioner's Office 1996).

Health sector issues

There is apparent tension between Māori whānau and the sector in terms of intellectual property issues. This tension exists at the point at which the rights of individuals supersede those of collective Māori such as whānau, hapū and iwi. Both the Privacy Act 1993 and the Code of Rights promote individual rights and priorities. This approach is consistent with the fundamental basis of the health and disability sector. However, such an approach does not address some of the fundamental values and beliefs for whānau as a collective. It ignores the extent to which whānau and hapū act as support systems for individuals in managing the effects of ill health. It also fails to acknowledge whānau contributions to health and attainment and maintenance of wellbeing for each of their members.

The approach is based on the assumption that the rights of the individual to decide how their personal information will be used overrides the rights of access of whānau and hapū to their

information, even when they wish to use the information for the wellbeing of individual members. This approach has the potential to create conflict where none existed, and to add confusion to an environment which is already strained because the wellbeing of one or more of its members is in jeopardy. Clearly, there are bound to be exceptions to the rule, some of which will be based on sound cultural grounds and some of which will be based on ill-founded assumptions made by agencies and individuals alike.

Data collection

There are ongoing concerns about the comparability of existing Māori health data as a basis for Māori research. This is due to the inconsistency between government agencies in terms of collecting and recording ethnicity data (where it is collected at all). Due to this variance, it is very difficult to determine an accurate picture of the social and economic factors which impact on Māori health status generally and whānau wellbeing in particular.

As a result, there are information gaps about whānau access to services. While it is clear, for example, that whānau under-utilise services, the extent of that under-utilisation is not known. At present, the evidence suggests that in the national data, Māori hospital admissions are likely to be understated by at least 30 percent (Kilgour and Keefe 1992). Existing data raise many questions, and although health risks for whānau have been identified, the data do not accurately indicate whether whānau access appropriate health services to reduce those risks. Therefore, it is difficult to determine the level of resourcing required for health services to be as fully effective in addressing whānau health needs. The New Zealand Health Survey 1996/97 is likely to address many of the information gaps, and the Māori sample is sufficiently large to provide much of the information required. Improved data will enable evidence-based and informed policy development to advance whānau health gains.

Māori health data

During 1996/97 the then RHAs were asked to improve the accuracy and quality of Māori health data in both hospital and primary care settings. Activity in this area focused on changes to ethnicity coding in the National Minimum Data Set to a self-identified ethnic origin basis consistent with the way ethnicity is recorded in the Census of Population and Dwellings. Other activity included audits of CHEs. Independent research in the Central region found errors in CHE coding of ethnicity of up to 30 percent. In the primary care setting the then Midland and Southern RHAs inserted clauses with GPs to improve the accuracy of ethnicity data (Ministry of Health 1998b). These measures are essential to ensure that an accurate profile of Māori whānau health status is established to inform policy, funding, and programme decision making to advance whānau health gains.

There were 18 submissions on various research issues. In these submissions there was general agreement of the need for more research on Māori. Two main themes emerge of particular relevance to the HFA which included:

- support for needs analysis to enable effective planning and decision-making
- the development of tools to measure the effectiveness of programme and service delivery to whānau.

Other issues raised in submissions for consideration include:

- exploring ways to measure the health of the whānau as a collective
- workplace research

- the experience of older Māori with personal care and carer support
- depression among older Māori
- sexual abuse
- the lack of investment at the community level in developing young Māori as researchers.

SUMMARY OF ISSUES

MĀORI INTELLECTUAL PROPERTY ISSUES

The Crown's attainment of its own objectives depends on the collection, analysis and use of accurate and comprehensive whānau health information. Issues to consider include:

- Māori intellectual and cultural property rights are viewed as taonga
- the *Mataatua Declaration* supports the intellectual and cultural property rights of Māori whānau as indigenous people
- the *Health Information Privacy Code* and the *The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996* identify individual and collective whānau rights
- there is tension between the cultural and intellectual property rights of individuals and those of collective Māori at the whānau, hapū and iwi levels
- ethnicity data collection is important to accurately assess needs and gaps in programme and service delivery for whānau.

Whakamutunga: Conclusion

The wellbeing of whānau is vital to improving Māori health outcomes. Recent years have seen the development of innovative health initiatives, programmes and services that have made significant progress in achieving improvements in Māori health. Many of these initiatives operate on a Māori kaupapa that developed from the past and present Māori diverse reality. These initiatives are the foundations of a Māori health sector that will have a significant role in contributing to the improvement of Māori health outcomes and will be on the cutting edge of public health development. The Government has identified the benefits of developing the Māori health sector as central to improving Māori health status (Ministerial Planning Group 1991). For this sector to grow there will need to be an effective partnership established between the Crown, the health sector, culturally effective and Māori providers, and Māori communities. This will assist the Crown to achieve its objective in improving Māori health and remove the disparity in health status between the tangata whenua and the rest of the community. It will give the health sector innovative models and programmes for reducing the various barriers whānau perceive in accessing health programmes and services, and thereby advance the health of all communities. Most importantly it will return to Māori whānau and communities the responsibility and resource to protect their wellbeing.

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Rārangi Kupu: Glossary

Ao tūroa	The outside world or environment.
Budget holding	A system where providers have a fixed budget for a defined population of clients and must meet the costs of an agreed set of services used by that population (these may include services provided by other providers). Budget holding may or may not involve the provider bearing financial risk of costs being above or under the agreed budget. Budget holding is often associated with managed care organisations in New Zealand.
Capitation	A system of paying providers a defined price for each consumer who is registered with a provider. The price may be adjusted for different characteristics of consumers such as age, gender and socioeconomic status.
Co-ordinated care	‘Co-ordinated care’ is not a single model of how services are funded and delivered; rather, the term encompasses a number of approaches that give the health purchaser greater influence over the providers’ actions (Ministry of Health 1995a).
Hapū	A social and political unit made up of several whānau.
Ihi	Power.
Iwi	A social and political unit made up of several hapū.
Kaitiaki	Guardian.
Karakia	Prayer.
Kaupapa	Purpose.
Kawa	Protocol.
Kāwanatanga	Governance.
Mana	Status, authority, prestige or power.
Managed care organisation	An organisation or service provider which is given responsibility for ensuring that a defined population receives a defined set of services in a co-ordinated way.
Mauri	Life force.
Mirimiri	Massage.
Pakeke/mātua	Māori adults aged 25–54 years.
Rangatahi	Māori youths and young adults aged 13–24 years.
Rangatira	Tribal leader.

Tamariki	Māori children aged 12 years and under.
Tangata whenua	Indigenous people.
Taonga	Treasures.
Tapu	Sacred, set apart.
Tikanga	Traditional beliefs and practices.
Urupā	Burial site.
Whāngai	Adopted children.
Whakapapa	Genealogy.
Whare	House.
Whenua	Ground and the placenta.

Appendix 1:

Consultation hui participants

Nukuhau Marae, Taupo, 9 April 1997

Angela Hindmarsh	Annette Collier
Cindy Warbrick	Lena Adams
Lianne Karaitiana	Maata McManus
Marcia Williams	Marie Maddox
Mauhaere Nathan	Natalie Kini
Ngaronoa Kimura	Noaria Wallace
Pip Henderson	Priscilla Puata
Riripeti Paine	Sandra Thompson
Trina Marsh	

Parawhenua Marae, Ohaeawai, 11 April 1997

Candy Cassidy	Chris Diamond
Heather Hallmond	Heeni Taukeiaho
Keir Volkerling	Lana Toia
Louie Katene	Luana Murray
Mabel Houston	Materangatira Campbell Cross
Michael Raimona	Nan Neho
Nellie Para	Ngaire Tango
Ngarimu Dobney	Noelle Curry
Patu Sigley	Pauline Hopa
Pepi Fifield	Ruth Curry
Shirley Anne Brown	Teina Kaka
Tere Gravenor	Tui Martin

Multi Cultural Centre Hokitika and Coast CHE Greymouth, 16 April 1997

Audrey McLaren	Barbara Greer
Christine Oakden	Christine Robinson
Debra Beard	Elizabeth Cunningham
Jocelyn Curtin	June Robinson
Karen Davies	Laura Hartley
Marie Forsyth	Moirra Geer
Paula Day	Shelley Mills
Stephanie Wade	Violet Bradley

**Tamaki Makaurau Marae, Auckland,
17–18 April 1997**

Angela Crichton	Annette Peri-Collier
Ataroa Brampton	Doreen Scully
Eru Thompson	Idiana Day
Karla Armstrong	Mavis Roberts
Nelle Kirkwood	Rev Hemi Rauwhero
Rongo Curry	Sisi Thompson
Steve Tipene Kirkwood	Tangiwaitua and Bill Hieatt
Tom Theodore	Tuki Rehua

**Kokohinau Marae, Te Teko,
20–21 April 1997**

Adelaide Waaka	Alf Bidois
Alison Collier	Avy Gardiner
Bev Tawhara	Carin Wilson
Dee Edwardson	Elsa Kupa
Hana Harawira	Hemana Eruera
Hineiromia Whaanga	Jo Barnaby
Joanne Aoake	Kanui Hunia
Kanui Hunia	Karilyn Teriini
Makarita Tahere-Te Huia	Marcus Woodland
Mary Ann Rua	Mary Ann Rua
Molly Pardoe	Owen Lloyd
Pam Greenway	Parena Walters
Pearl Haereroa	Puti Puti OBrien
Ruahine Lou Te Are	Sarah Eruera
Tamati Mangu Clarke	Tea Paul
Therese Voegeli Soerensen	Waina Araroa

**Te Puūtahi-ā-Toi Marae,
Massey University,
1–2 May 1997**

Barbara Simons	Bella Rooney
Bella Rooney	Bobby Atkin
Cheryl Maru	Dan Cook
Dawson Birch	Fleur K Rogers
Fran Somervell	Harawaitai Rowland
Herb Emery	Hono Lord
Huia Emery	Jean Kipa
Joanne Nikorima-Maxwell	Joanne Waldon
Maikara Tapuke	Margaret Winter
Maria Robinson	Mary McCulloch
Mary Sanson	Mary Smallman
Mathew Zijlstra	Miriama Hammond
Moe Milne	Nancy Harrison

Neta Grace
Paddy Jacobs
Pat Bodget
Pearl Lawton
Queenie Gripp
Ripeka Green
Rongo WiRepa
Sandi Kereopa
Tau Aroha Fraser
Von Hura

Ngarini Irene Williams
Parewaho Rudolph
Pearl Lawtana
Petikuia Wainui
Ripeka Edwards
Ripeka Wills
Rowena Gotty
Sharlene Te Whaiti
Vanessa Sidney
Wendy O'Carroll

**Rehua Marae, Christchurch,
8–9 May 1997**

Anaru Paul
Barbara Greer
Huia Kipa
June Robinson
Kathleen Mason
Maera Couch
Mekura Taiaroa Briggs
Patricia Hetariki
Paul Tau
Richard Tankersley
Russell Empson
Te Opewhakahukau

August Harding
Bernice Tainui
Jan McFarlane
Kate Smith
Kathy Peri
Maurice Gray
Nellie Neligan
Paul Hiroti
R Arahanga
Roberta Burt
Suzanne Edmonds
Tina Flecto

Appendix 2:

Submissions received on the draft discussion document

Whāia te Whanaukataka Oraka Whānau

Martha Rowbotham	Occupational Safety and Health Service, Department of Labour
Becky Fox	National Body of Māori Midwives: Ngā Maio o Aotearoa me te Wai Pounamu
Dawn Grey	Southern Public Health Services
Bryan Le Compte	Disabilities Resource Centre, Whakatane
Rebecca Harper	Martinborough
Carol McIntosh	Public Health Service, Nelson
Andrea Pettett	New Zealand General Practitioners Association
Craig Batchelar	Tauranga District Council
Rodney Giddens	Toi te Ora, Public Health Eastbay Health, Tauranga
Sue Crengle	Māori and Pacific Health, University of Auckland
Peter Fraser	The Treasury
Janet Mclean	Public Health Service, Hutt Valley Health
Colleen Pringle	The NZ Dental Council
Bill Swallow	ESR
Julie Wade	Māori and Pacific Health, University of Auckland
Professor Colin Mantell	Māori and Pacific Health, University of Auckland
Robyn Stent	Health and Disability Commissioner
Bev James	Te Puni Kōkiri
Robyn Blue	Turanganui a Kiwa Hauora
Richard Hoskins and Maree Pierce	Midland Health

Grant McLean	Age Concern
D Gilgen, T Ruakere, P Woolford, Rawiri Durie	College of General Practitioners
Sarah Thomson	Asthma and Respiratory Foundation
Idiana Day	Auckland Sexual Health Service, Auckland Hospital
Andrew Hearn	Land Transport Safety Authority
Paula Snowden	Te Ohu Whakatupu, Ministry of Women's Affairs
Sue Ineson	Family Planning Association
Irihapeti Ramsden	Te Pawai Tapu
Charles Olson	Palmerston North City Council
John Waldon	Te Pūmanawa Hauora
	Report from hui in Palmerston North 1–2 May 1997
	Report from hui in Whangarei 11 April 1997
	Report from hui in Hokitika 16 April 1997
	Report from hui in Taupo 9 April 1997
	Report from hui at Tamaki Makaurau Marae 17–18 April 1997
	Report from hui at Kokohinau Marae 20–21 April 1997
	Report from hui in Christchurch 8–9 May 1997

Address to Send Comments

The Public Health Group, Ministry of Health, would like your comments on the implementation of issues discussed in this document. They should be addressed to:

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