

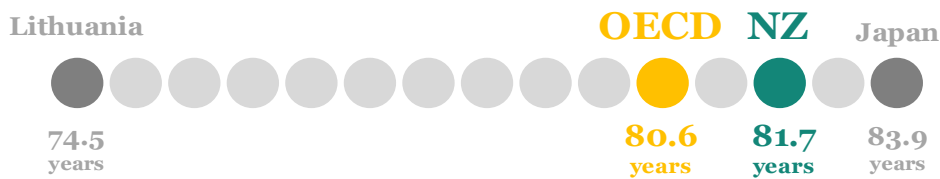
Section A:
Overview and context /
Tirohanga whānui
me te horopaki

1 Background / He whakamārama

Future-proofing our health and disability system

Aotearoa New Zealand’s health and disability system has many strengths. As a whole, New Zealanders are living longer and healthier lives, with high levels of self-rated health and wellbeing and good access to acute and emergency care. A dedicated health and disability workforce delivers support and services each day to thousands of individuals and their whānau across an extensive hospital, community, and home-based network. By international standards New Zealand’s expenditure on health as a proportion of gross domestic product is in the mid-range of OECD countries, and its outcomes on several key metrics, such as life expectancy at birth, are comparable (Figure 1.1).

FIGURE 1.1: LIFE EXPECTANCY AT BIRTH



SOURCE: OECD/WORLD HEALTH ORGANIZATION 2018.

The system, however, is under pressure and does not cater well for all. Despite progress, outcomes are not equitable across populations and life course, particularly for Māori, Pacific peoples, disabled people, and people experiencing poverty. Rural New Zealanders also look for sustainable and equitable access to health and disability services. As has been signalled in recent reviews and inquiries, New Zealanders’ mental

health outcomes are of particular concern, and the populations being underserved by the health and disability system are, in most instances, the same populations being underserved by other systems. Focusing on what New Zealanders value to improve their health and wellbeing remains critical including quality, diversity, transparency, and the timeliness of the system.

The current complex mix of governance, accountability, business arrangements, and workforce cannot deliver the responsive and smart system New Zealanders require for future health and wellbeing. A rapidly changing social, environmental, technological, and economic landscape, coupled with sizeable demographic shifts, severely threatens sustainability.

The New Zealand Health and Disability System Review / Hauora Manaaki ki Aotearoa Whānui (the Review) was established to respond to these and other challenges.

Terms of Reference

The Review's Terms of Reference encompass the overall health and disability system as set out in legislation. They require the Panel, by March 2020, to deliver to the Government final recommendations on a future health and disability system that is sustainable, is well placed to respond to future needs of all New Zealanders, and shifts the balance from treatment of illness towards health and wellbeing.

The Panel will recommend how the system could be designed to:

- ▶ achieve better health and wellbeing outcomes for all
- ▶ ensure improvements in health outcomes of Māori
- ▶ ensure improvements in health outcomes of other population groups
- ▶ reduce barriers to access to health and disability services to achieve equitable outcomes for all parts of the population
- ▶ improve the quality, effectiveness, and efficiency of the health and disability system, including institutional, funding, and governance arrangements.

In addition, the Panel's final report will include a framework for implementing its recommendations. The Review is not aiming to solve today's challenges theoretically; rather it is focused on identifying a clear and deliberately sequenced implementation path, so that, 10 years from now, those growing up with our new health and disability system can have equal expectations of achieving the same health and wellbeing outcomes.

Outside the scope of the Review are:

- ▶ the accident compensation scheme (although the relationship between the health and disability system and the compensation scheme is in scope)
- ▶ the Pharmaceutical Management Agency (PHARMAC) (although the relationship between the health and disability system and PHARMAC is in scope)
- ▶ private health insurance (although its interaction with demographic drivers of health care need is in scope)
- ▶ the MidCentral Prototype (for disability service delivery) that is under way (although lessons from this work will be considered when the Review's recommendations are developed).

The full Terms of Reference are in Appendix A online.

The Minister of Health appointed Heather Simpson to chair the Review and lead an Expert Panel to identify opportunities to improve the performance, structure, and sustainability of the system with a goal of achieving equity of outcomes and contributing to wellness for all, particularly Māori and Pacific peoples.

Expert Review Panel

- ▶ Heather Simpson (Chair)
- ▶ Dr Winfield Bennett
- ▶ Shelley Campbell
- ▶ Professor Peter Crampton
- ▶ Dr Lloyd McCann
- ▶ Sir Brian Roche
- ▶ Dr Margaret Southwick.

The Panel appointed a Māori Expert Advisory Group to support the Review and to help ensure that the advice it provides appropriately incorporates Māori views, including those relating to hauora (health and wellbeing) and mātauranga Māori (knowledge), in order to improve Māori health outcomes, equity, and broader wellbeing.

Māori Expert Advisory Group

- ▶ Sharon Shea (Chair)
- ▶ Dr Dale Bramley
- ▶ Associate Professor Terryann Clark
- ▶ Associate Professor Sue Crengle
- ▶ Takutai Moana Natasha Kemp
- ▶ Linda Ngata.

Meaningful implementation of te Tiriti o Waitangi / the Treaty of Waitangi

Te Tiriti o Waitangi / the Treaty of Waitangi places obligations on the Crown regarding the health of Māori communities. Both Māori and non-Māori are seeking meaningful implementation of te Tiriti/the Treaty. This was widely discussed at our wānanga and during wider stakeholder engagement. Submissions also discussed the role and importance of honouring te Tiriti/the Treaty as being essential to improving Māori health outcomes. Several submissions also argued that failure to achieve equity for Māori is a breach of articles 23 and 24 of the United Nations Declaration of the Rights of Indigenous People.

Currently, the Government is considering new provisions to strengthen the Crown–Māori relationship within an updated Public Service Act. The Waitangi Tribunal / Te Rōpū Whakamana i te Tiriti o Waitangi also recently published its initial report from stage 1 of the Health Services and Outcomes Kaupapa Inquiry. The findings from this inquiry echo many of the challenges and solutions we heard from Māori during Phase One.

A key focus for the final recommendations of this Review will be to consider how the system can embed rangatiratanga (authority, ownership, leadership), and mana motuhake (self-determination, autonomy) appropriately throughout the system.

Chapter 3: Hauora Māori raises issues, challenges and opportunities heard during Phase One – these are also threaded throughout this report.

Towards our final recommendations: Phase One and the interim report

In our journey towards final recommendations, the Review is structured into two phases.



Phase One has enabled the Panel to establish a clear view of current arrangements and inform its thinking about potential system-level changes. The interim report signals the culmination of Phase One and reflects what the Panel heard regarding key successes and challenges within the current system, and provides our own analysis of some of the issues and the Panel’s thinking on the direction of changes required.

Phase Two will focus on developing recommendations for the key changes that can best move the system towards more sustainable and fairer performance. Developing these recommendations will require us to answer specific questions in each of our focus areas. This will be done in conjunction with the sector and will include further consultation on specific proposals.

ENGAGEMENT DURING PHASE ONE

- ▶ *met with over 300 organisations, workforce representatives, boards, consumer and disabled people's representatives, government, professional and allied health bodies, and provider, business and private hospitals groups*
- ▶ *visited District Health Boards (DHBs) and met with representatives from their districts*
- ▶ *received over 650 written submissions (online, email and delivered) in response to the public request for feedback. Our survey was available in English, te reo Māori, NZ sign language and easy read.*
- ▶ *held wānanga with over 300 Māori leaders, specialists, researchers, and healthcare providers across four locations (Kaikohe, Rotorua, Wellington, and Dunedin)*
- ▶ *met with Pacific health leaders and organisations*
- ▶ *held workshops focusing on the provision of home and community health and disability services across four locations (Auckland, Hamilton, Palmerston North, and Christchurch)*
- ▶ *met with international healthcare organisations and service providers, including the NHS (United Kingdom), Norwegian Healthcare, Nuka System of Care (Alaska), First Nations Health Authority (Canada), Intermountain Healthcare (United States), and Kaiser Permanente (United States)*
- ▶ *commissioned reports from government departments and external agencies.*

2 People and communities / Ngā tāngata me ngā hapori

The health and disability system exists only to serve the needs of New Zealanders and their communities. Consideration of system changes to effectively address inequities requires us to have a good understanding of population characteristics both now and in the future. We need to understand what is driving inequity, what global trends are likely to impact the system, and what people think.

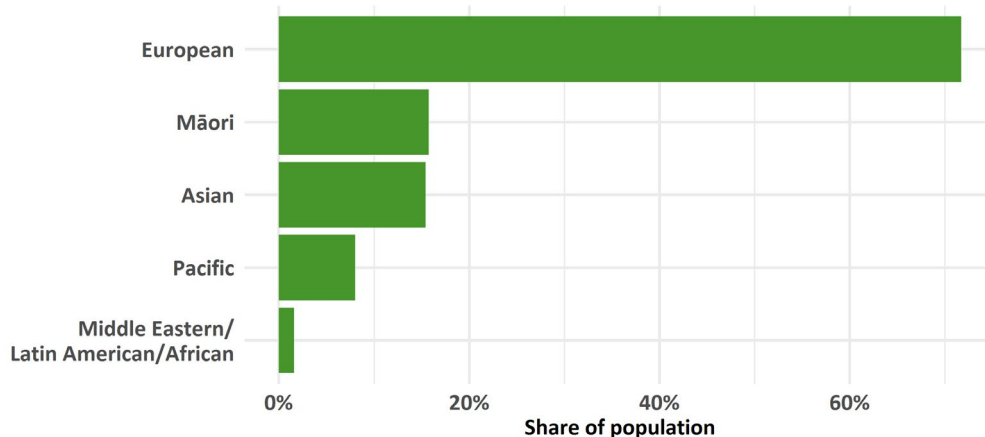
A diverse population

Aotearoa New Zealand is a diverse society with a large indigenous Māori population, and a range of other cultures, including significant Pacific and Asian populations, and a majority New Zealand European/Pākehā population. Around 10% of New Zealanders identify with more than one of these ethnic groups. There is also a small but growing Middle Eastern, Latin American, and African (MELAA) population (Figure 2.1).

New Zealand officially recognises three languages (English, te reo Māori and New Zealand Sign Language). Almost one-fifth of the population is multilingual (with one in five multilingual speakers having te reo as one of their languages).

As the indigenous population, Māori are highly connected through whakapapa (kinship ties), and the wellbeing of individuals is strongly associated with the wellbeing of the wider whānau (family). Irrespective of where they reside, most Māori hold strong connections and sense of belonging to their tūrangawaewae (ancestral lands) and marae, and their ability to access and participate in Te Ao Māori (Māori world view). These familial and cultural connections provide a strong and enduring sense of identity and are prerequisites to good health.¹

FIGURE 2.1: SHARE OF POPULATION BY ETHNIC GROUP, 2018



Note: Shares do not sum to 100% as people can identify with more than one ethnic group.

SOURCE: STATS NZ, POPULATION PROJECTIONS.

Pacific peoples are a youthful and diverse population made up of more over 16 distinct ethnic groups with different, languages and cultures. The five largest groups in New Zealand are Samoan (49%), Cook Island Māori (21%), Tongan (20%), Niuean (8%), and Fijian (5%). Samoan is the third most common language spoken in New Zealand. One in four Pacific people (and 40% of Pacific children aged 0-4) identify with more than one ethnic group (compared with 7% of non-Pacific people).²

Although from many different countries, Pacific peoples share cultural values such as:

- ▶ the central place of family (which contributes to identity and feelings of belonging)
- ▶ collectivism and communitarianism (everyone working together to achieve common goals)
- ▶ the importance of spirituality (attributing life events to a higher power)
- ▶ reciprocity (mutual help and interdependence)
- ▶ respect (particularly towards elders, parents, women, and people in positions of authority).

The Asian population is very broad, comprising ethnic groups from Afghanistan to Japan. Despite this diversity, Asian New Zealanders share common values, such as those based on family, education, and community ties.³ They also share the experience of negotiating between traditional values and those of the dominant Pākehā culture.⁴ Although 77% of the Asian population is overseas-born, Asian communities have been present in New Zealand since the 1800s. The largest groups are Chinese (35%), Indian (30%), Filipino (9%), and South Korean (6%). Only 1% of the total New Zealand population identify with at least one MELAA ethnicity.

European New Zealanders are people of European descent, including British and Irish, and people indirectly of European descent, including North Americans, South Africans, Canadians, and Australians. In the 2013 census, at least 74% of the New Zealand population identified with one or more European ethnicities.

New Zealand accepts around 1,000 refugees and 150 asylum seekers from diverse backgrounds annually.

New Zealand is also becoming more religiously diverse. Other than Christians groups, the large religious groups include Hindu (90,000), Buddhist (60,000), Muslim (50,000), Sikh (20,000) and Jewish (7,000). Non-Christian religious groups have grown from 4% of the population in 2001 to around 6% (2013). Around 40% of those in Asian ethnic groups affiliate with a religion other than Christianity. Given that Asian populations are projected to increase by over half a million over the next two decades, New Zealand is likely to become more religiously diverse.

One in four New Zealanders identifies as disabled

A quarter of New Zealanders live with one or more disabilities – 11% of children (14% of Māori children), 21% of young and working age people (32% of Māori young and working age), and 59% of seniors (62% of Māori seniors).

There is no precise definition of disability, rather, similar to ethnicity, it is self-identified, and the term broadly encompasses wide variations of physical, mental, sensory, communication, and other impairments, and their effects on people’s lives. Definitions in use uniformly include two broad aspects: impairment, and social and environmental impacts (such as discrimination and limits to accessibility).

Māori have significantly higher rates of disability across all age groups, and Pacific peoples have slightly higher rates. Higher rates of disability are also found in families with low incomes and people living in communities experiencing high socioeconomic deprivation. For example, in 2013, disabled people had an 80% higher rate of living in a low-income household than all people.

Ethnic populations have different age distributions

FIGURE 2.2: DISTRIBUTION OF NEW ZEALAND’S POPULATION, 2018

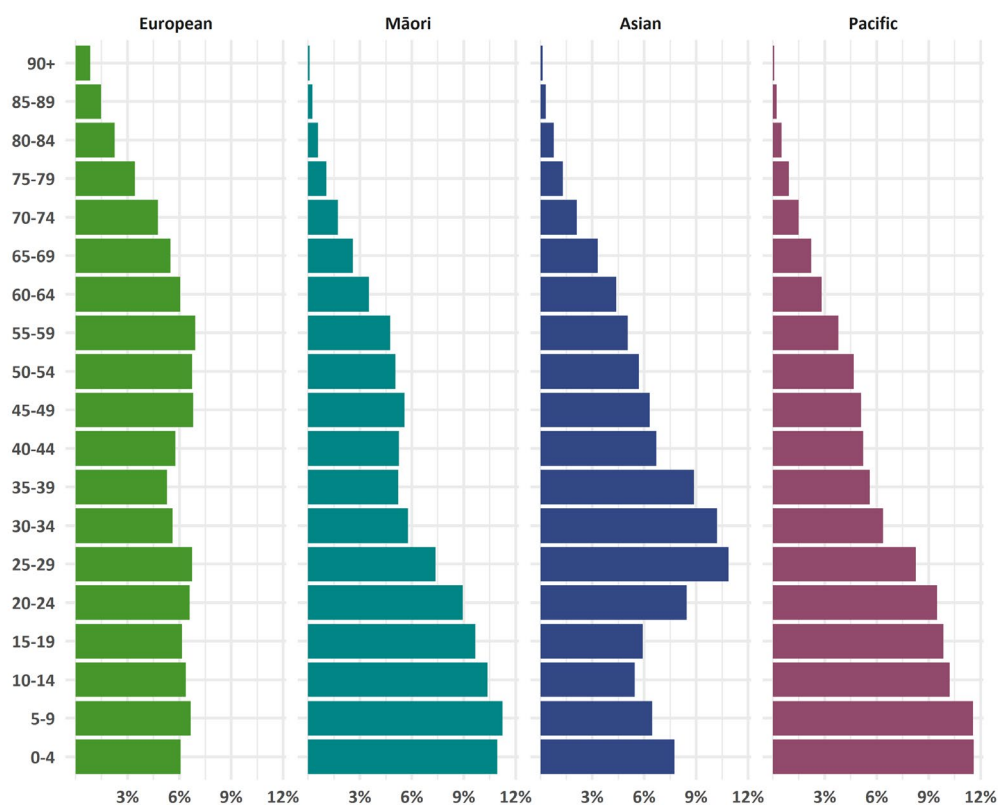
	European	Māori	Asian	Pacific	MELAA
Population total	3,489,000	766,000	750,000	390,000	78,000
Median age	40.5 years	24.3 years	30.6 years	22.3 years	28.5 years
Share under 20 years	25%	42%	26%	43%	32%
Share above 85 years	2.3%	0.4%	0.5%	0.3%	0.4%
Share in high socioeconomic deprivation	13%	40%	18%	54%	23%

Note: MELAA = Middle Eastern, Latin American, and African.

SOURCE: STATS NZ, POPULATION PROJECTIONS.

Age distribution differs greatly between ethnic groups. Māori and Pacific peoples are significantly younger on average than the European population, with over half being under 25 years. The European population is older on average, and this difference becomes more pronounced with age. The Asian population has a higher proportion of people aged 20–39, reflecting large inward migration in these age groups. (See Figure 2.3).

FIGURE 2.3: AGE DISTRIBUTION OF EUROPEAN, MĀORI, PACIFIC, AND ASIAN POPULATIONS, 2018



SOURCE: STATS NZ, POPULATION PROJECTIONS.

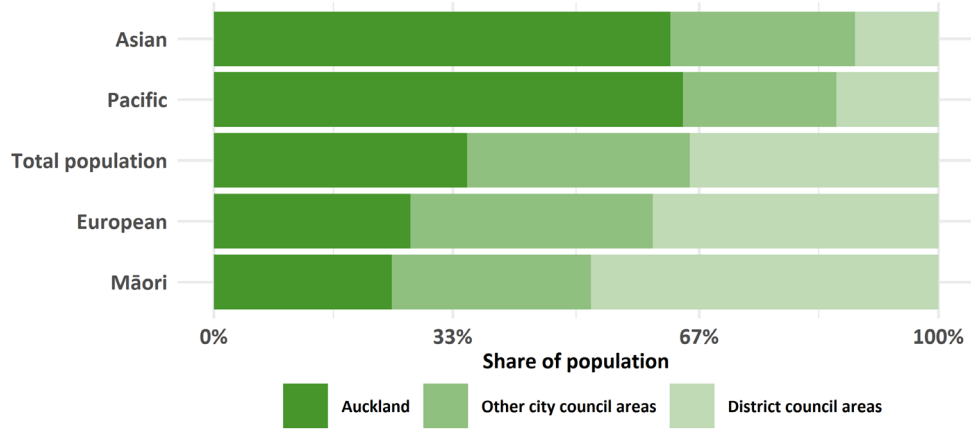
Urban and rural living arrangements vary by ethnicity

Roughly a third of New Zealand’s population lives in the Auckland council area, a third in other city council areas, and a third in district council areas (non-city areas). However, this split of population masks significant differences across ethnic groups.

Over 60% of the Pacific and Asian populations live in Auckland, compared with only one-third of the total population (see Figure 2.4). Auckland’s Pacific population is also highly concentrated with almost one-third in just three of 21 Auckland local board areas: Māngere-Ōtāhuhu, Ōtara–Papatoetoe, and Manurewa.

Only 12% of the Asian population and 14% of the Pacific population live in district council areas (non-city areas). In contrast, Māori are less likely to live in main urban areas, with just under half living in district council areas.

FIGURE 2.4: SHARE OF POPULATION BY ETHNICITY AND DISTRICT AREA, 2018

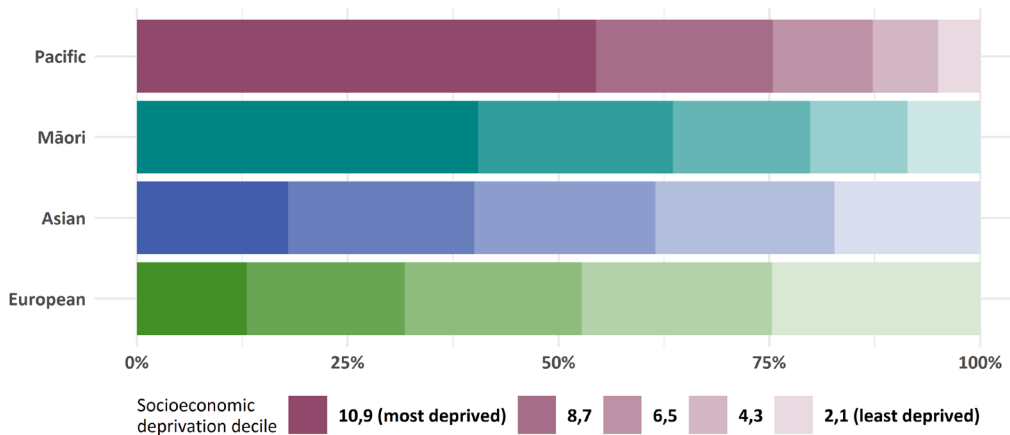


SOURCE: STATS NZ, POPULATION PROJECTIONS.

Socioeconomic deprivation varies by ethnicity and location

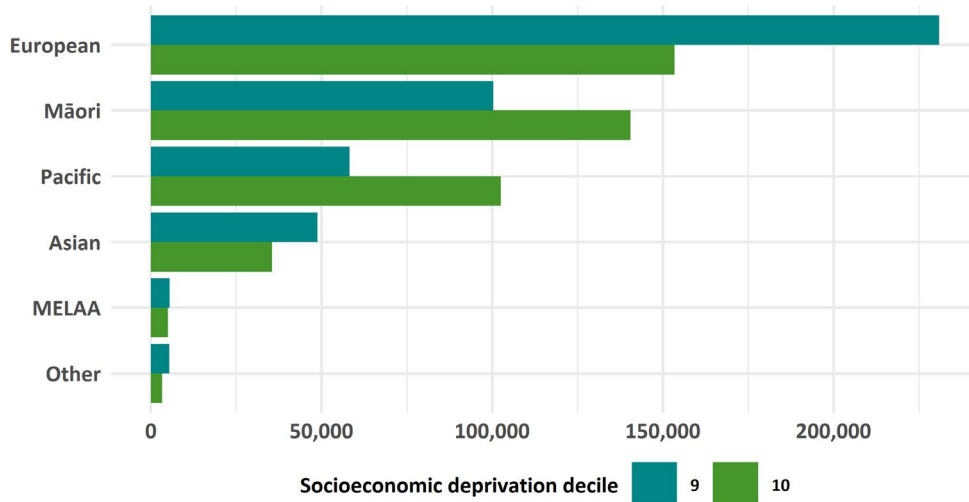
Māori and Pacific peoples are significantly more likely to live in areas of high socioeconomic deprivation than are other populations. Forty percent of Māori and over half of the Pacific population live in the two most deprived areas (deciles 9 and 10). Although by population size, the largest ethnic group to live in deciles 9 and 10 is New Zealand European, by proportion this group tends to live in less deprived areas. New Zealand’s Asian population is relatively evenly distribution across socioeconomic deprivation deciles. (See Figure 2.5)

FIGURE 2.5: SOCIOECONOMIC DEPRIVATION DECILE – ETHNICITY DISTRIBUTION, 2013



SOURCE: STATS NZ, CENSUS DATA.

FIGURE 2.6: SOCIOECONOMIC DEPRIVATION, DECILES 9 AND 10 , BY ETHNICITY, 2013



Note: MELAA = Middle Eastern, Latin American, and African.

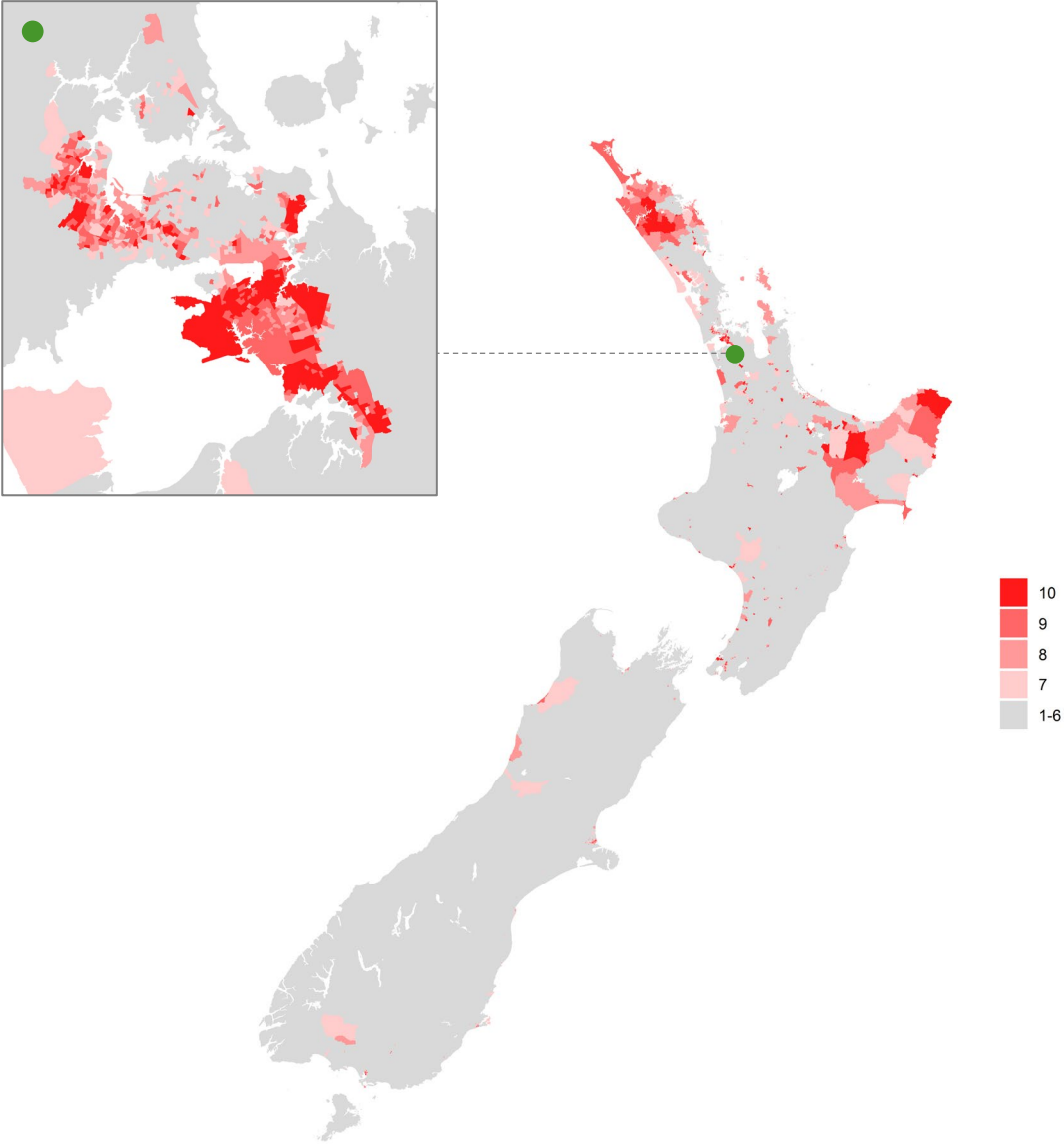
SOURCE: STATS NZ, CENSUS 2013.

Some regions of New Zealand have significantly higher rates of socioeconomic deprivation than others. In general, the North Island has more areas of high socioeconomic deprivation. Over a third of the population in Northland and nearly half of the population in Gisborne live in the highest socioeconomic deprivation quintile (10). Large populations also live in deprived urban areas that are less prominent in Figure 2.7.

Figure 2.7 also shows areas of socioeconomic deprivation in Auckland. Almost all of south Auckland is in the four highest deciles of socioeconomic deprivation (7–10), with large areas in the highest decile of deprivation (10). Significant parts of west Auckland also have high socioeconomic deprivation. Small pockets of high deprivation occur in central Auckland and the North Shore.

Other population-based characteristics intersect with demographics and can influence health behaviours and outcomes. These characteristics include family composition, living arrangements, sexual and gender identity, religious affiliation, life course, and occupation.

FIGURE 2.7: AREAS BY DEPRIVATION DECILE, 2013



SOURCE: UNIVERSITY OF AUCKLAND, INDEX OF MULTIPLE DEPRIVATION.

Changes to population and communities

The next 20 years will bring sizeable shifts to New Zealand's population in terms of age, ethnicity, and geographic spread. In addition to demographic shifts, environmental, social, technological, and cultural changes will provide both opportunities and pressures on the sustainability and efficiency of the health and disability system.

FIGURE 2.8: DISTRIBUTION OF NEW ZEALAND'S POPULATION, 2038

	European	Māori	Asian	Pacific	MELAA
Median age	42.8 years	27.9 years	40.4 years	27.3 years	33.8 years
Increase in population	292,000	294,000	522,000	201,000	94,000
Increase in under 20s	17,000	70,000	94,000	57,000	27,000
Increase in over 85s	92,000	10,000	25,000	4,000	2,000

Note: MELAA = Middle Eastern, Latin American, and African.

SOURCE: STATS NZ, POPULATION PROJECTIONS.

TABLE 2.1: POPULATION CHANGE BY AGE AND ETHNICITY, 2018–2038

	2018		2038		Change	
	Population	%	Population	%	Population	%
European	3,489,100	72%	3,781,400	66%	292,300	8%
Māori	765,900	16%	1,059,400	18%	293,500	38%
Asian	749,900	15%	1,272,200	22%	522,300	70%
Pacific	389,700	8%	590,200	10%	200,500	51%
MELAA	77,500	2%	171,400	3%	93,900	121%
0-24	1,613,100	33%	1,669,500	29%	56,400	3%
25-44	1,284,600	26%	1,467,400	25%	182,800	14%
45-64	1,219,200	25%	1,329,300	23%	110,100	9%
65-84	661,000	14%	1,089,300	19%	428,300	65%
85+	86,800	2%	214,100	4%	127,300	147%
Total	4,864,700		5,769,600		904,900	19%

Note: MELAA = Middle Eastern, Latin American, and African.

Ethnicity does not sum to 100% as people can identify with more than one ethnic group.

SOURCE: STATS NZ, POPULATION PROJECTIONS.

New Zealand’s population is getting older and more ethnically diverse

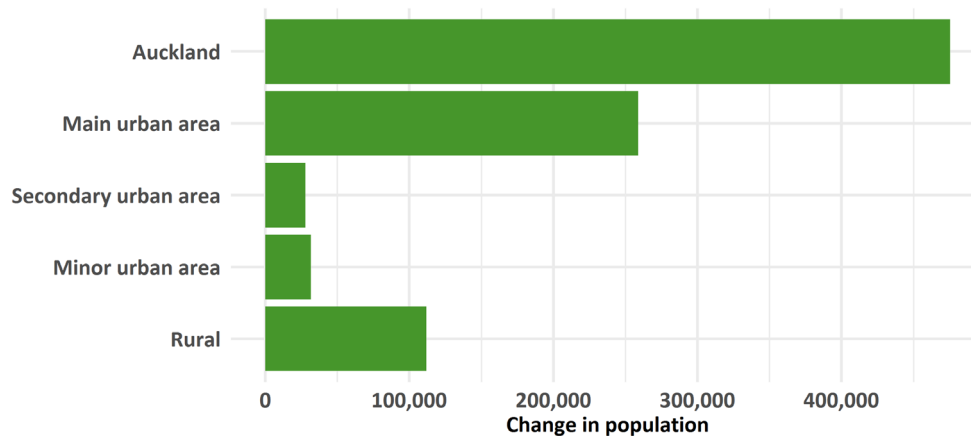
New Zealand’s population is projected to grow by almost 1 million people over the next two decades. Over half of this increase will identify with an Asian ethnicity.

Table 2.1 shows how the age distribution of New Zealand is projected to change over 20 years. In 2038, a larger share of the population will be aged over 64, and a smaller share of the population will be aged under 30. This trend is seen across all ethnic groups, but is most pronounced for the Asian population. Although Māori and Pacific populations are projected to be older, they will still be younger on average and make up a smaller share of the older population. For example, by 2038, the Māori and Pacific populations are projected to make up 6% and 3%, respectively, of the population aged 85 and over.

New Zealand will still have a significant rural population in 20 years

Although around half of the population growth over the next 20 years will be in Auckland (increasing Auckland’s population by 23%), rural areas are projected to grow slightly faster than other main urban areas at 14% (an increase of 100,000 people on current numbers). (Figure 2.9).

FIGURE 2.9: PROJECTED INCREASE IN POPULATION BY AREA, 2018 TO 2038



SOURCE: STATS NZ, POPULATION PROJECTIONS.

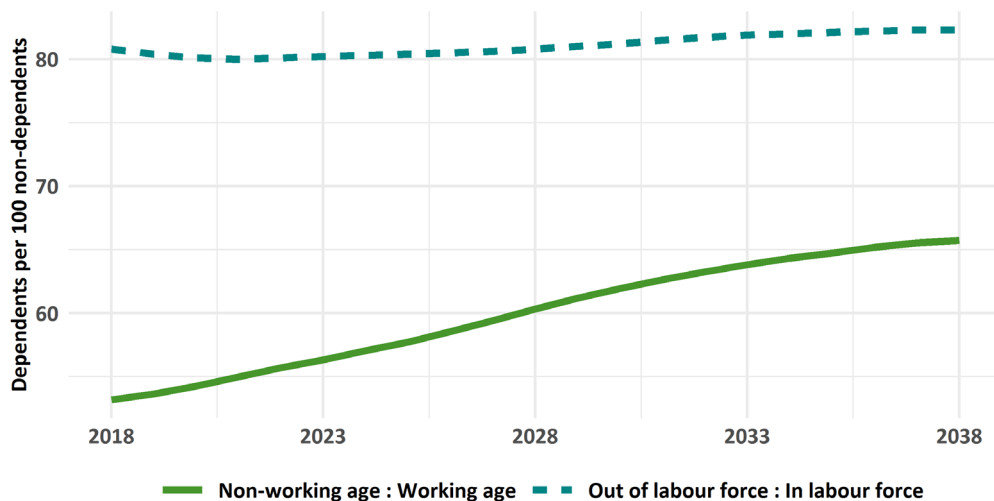
Future workforce a smaller share

With the population as a whole ageing, a smaller share of the population will be available for the workforce. However, the extent of this change depends on labour force participation rates.

Comparing the working age population (15–64 years) with the non-working age population (0–14, and 65 and over) shows a significant increase in the ‘dependency ratio’, from 55 dependents to 100 workers in 2018, to 65 dependents to 100 workers in 2038 (see Figure 2.10). However, projections from Stats NZ assume more people will stay in paid work past the age of 65, making the increase in the dependency ratio smaller.

Regardless of which projection is more accurate, the health and disability system will need to do a better job of attracting new workers and ensuring the existing workforce is effective even as they age.

FIGURE 2.10: NUMBER OF DEPENDENTS PER 100 NON-DEPENDENTS, 2018–2038



SOURCE: STATS NZ, POPULATION PROJECTIONS.

Global and regional shifts will provide challenges and opportunities

In addition to projected demographic shifts and increased rates of diseases and comorbidity, the near future brings challenges and opportunities that will shape New Zealanders’ health and wellbeing.

These challenges and opportunities include the impact of climate change, technological and research advances, significant shifts in consumer demand, and social and cultural changes. Many of these can have a positive impact on New Zealander’s health and wellbeing, including advances in technology and medicine, smart transport and housing options, expanded self-monitoring and consumer options for accessing health services, and strengthening of cultural aspirations.

However, others, such as climate change, could be far-reaching for health and wellbeing, as noted by the Royal Society of New Zealand / Te Apārangi:⁵

Climate change affects human health in a number of ways. The ideal healthy human has complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. Changes to the climate can impact on these:

- ▶ *Directly via air and sea temperature, flooding and storms;*
- ▶ *Indirectly due to changes to the environment and ecosystems; and*
- ▶ *Indirectly due to social and economic changes, such as migration stresses, health inequality and socioeconomic deprivation.*

Figure 2.11 overviews global and regionalised trends that may impact on the sustainability and delivery of health and wellbeing in New Zealand.

FIGURE 2.11: GLOBAL AND REGIONAL TRENDS



Current health behaviours, health loss, and outcomes

This Review focuses on developing a system in which equitable health outcomes for New Zealanders and their communities can be realised, and wellbeing and prevention become a significant focus of the health and disability system. This focus includes recognising the impact on health outcomes of access, integration, and treatment across services, as well as system levers and enablers that influence these.

Although 88% of New Zealand adults self-reported their health to be ‘good, very good or excellent’ and that of their children to be even higher,⁶ research demonstrates significant variation in health behaviour and health outcomes across populations and life course.

In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes. (Ministry of Health)

Insight into health loss

The most recent data (2013) shows that three categories of conditions account for over half (53%) of all health loss in the total New Zealand population with some variation across gender, age, ethnicity, and life course.⁷ These conditions are:

- ▶ neuropsychiatric disorder (number one health loss in 19% of the population), includes neurological disorders, mental disorders, and addiction disorders
- ▶ cancers (number two health loss, 17% of population), includes benign and malignant neoplasms
- ▶ cardiovascular disease and diabetes (number three health loss, 17% of population), includes cardiac and vascular diseases and diabetes mellitus (which is included in the definition because much diabetes-related health loss is vascular in nature).

Conditions causing health loss vary across the life course. For example, the number one health loss for:

- ▶ children (mainly under-fives) is from neonatal, nutritional deficiency, infectious disorders and birth defects (40% of health loss in children)
- ▶ young people and young adults is from neuropsychiatric disorders (35% and 31%, respectively)
- ▶ adults into middle age is from cancer (23%)
- ▶ older people is from cardiovascular disorders including diabetes (28%).

New Zealand's mental health challenges and suicide rates remain high, recognised by the Government's recent acceptance of many recommendations from the Government Inquiry into Mental Health and Addiction.⁸ Suicide rates remain higher for males than females, for Māori than non-Māori, and for people in rural areas than in urban areas.⁹ Patterns of use for both inpatient and community mental health specialist services show higher rates for Māori, Pacific peoples, recently released prisoners, young people (13–24 years), and people who identify as LGBTQIA+.¹⁰

The Global Burden of Disease study provides insights into health behaviours that have contributed most to ill health and mortality in New Zealand over the past 25 years and require population-level approaches to prevent. The five leading risk factors in 2016 were:

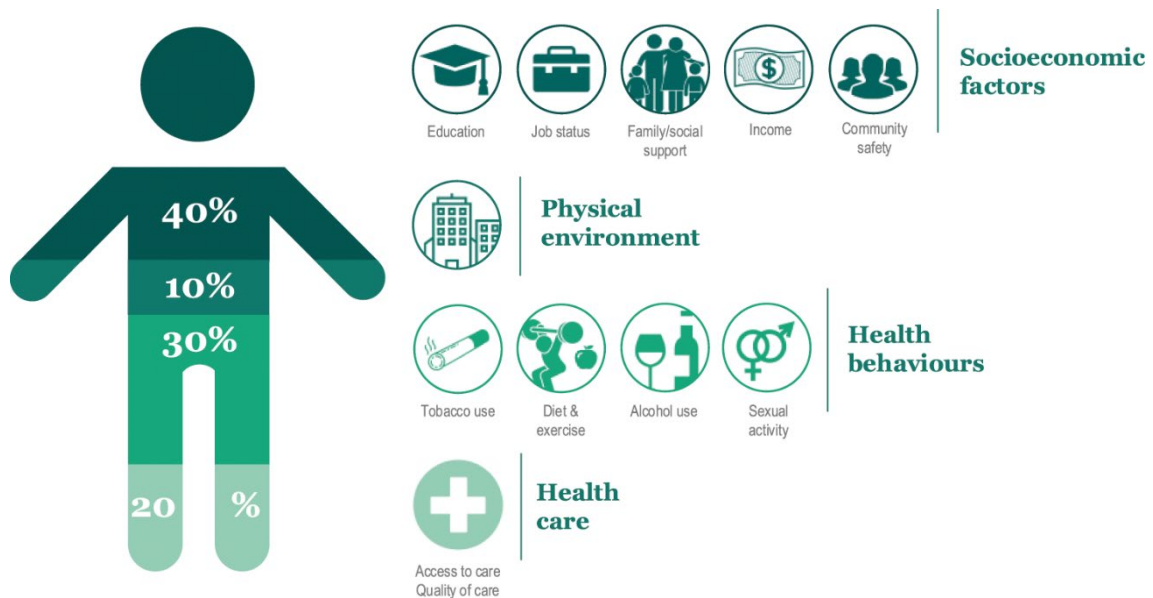
- ▶ *being overweight (a high body mass index)*
- ▶ *dietary risks*
- ▶ *tobacco use*
- ▶ *high blood pressure*
- ▶ *alcohol and other drug use.*

Socioeconomic deprivation and wider determinants of health

Although many people continue to consider health care in the context of clinical and medical care only, it is widely acknowledged that this accounts for only about 20% of a person’s health and wellbeing status. The other 80% arises from the conditions in which a person is born, grows, lives, works, and ages, including physical, cultural and natural environments, housing, education, the distribution of power and income, and health behaviours.¹¹ The impacts of these can accumulate over a life time.

A strong body of evidence shows that tackling the determinants of health and wellbeing will improve equity across a variety of societal outcomes.¹² In the New Zealand context, we also need to overlay cultural determinants (eg. cultural identity), and the negative impacts of racism and colonisation.

FIGURE 2.12: FACTORS THAT INFLUENCE OUR HEALTH AND WELLBEING



SOURCE: INSTITUTE FOR CLINICAL SYSTEMS IMPROVEMENT, 2014.

Socioeconomic deprivation, including poverty, income deprivation, and material deprivation, is a significant social determinant. One of the main determining factors of poverty and income is employment status.

Of all ethnic groups in New Zealand, Pacific peoples are amongst those most affected by inequities in the socioeconomic determinants of health, including living in areas of high socioeconomic deprivation, being unemployed, and having low weekly earnings (see Table 2.2). These factors can affect health directly (for example, through damp, cold, and overcrowded conditions, which increase the transmission of infectious diseases) and indirectly (for example, by limiting opportunities to engage in health-promoting behaviours).

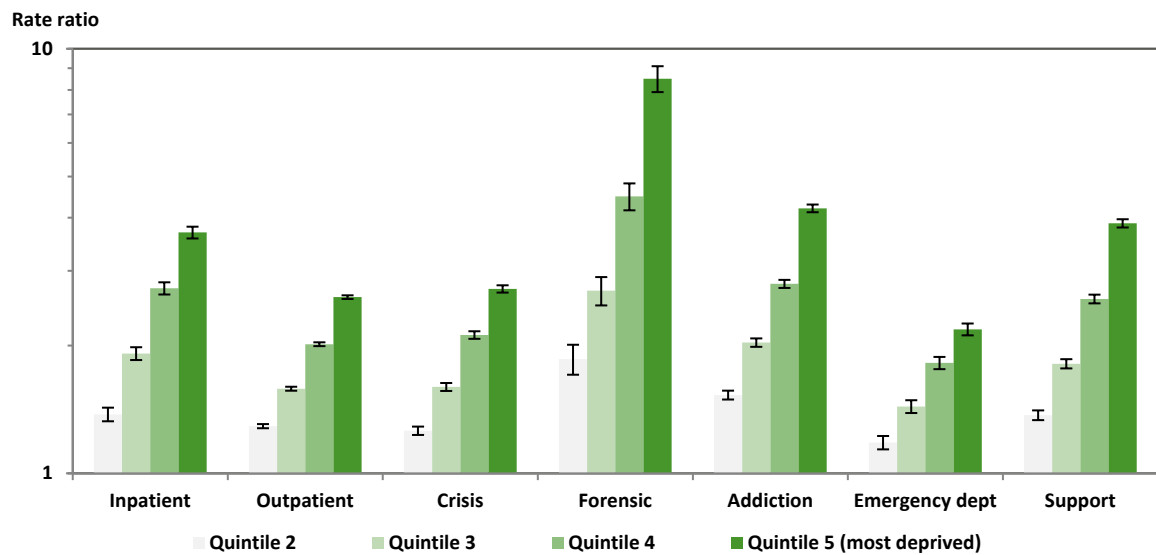
TABLE 2.2: SOCIAL DETERMINANTS OF HEALTH, PACIFIC COMPARED WITH TOTAL POPULATION

Population	Labour force participation rate ¹ (%)	Unemployment ¹ (%)	Living in areas of high deprivation ² (%)	Median weekly earnings ³	Home ownership ⁴ (%)	Over-crowding ⁴ (%)	English language speakers ⁵ (%)
Pacific	65.4	9.0	55.6	\$485	18.5	23.7	89.0
Total	70.4	4.2	20.0	\$670	50.2	2.7*	90.1

Notes : 1, 2, 4, 5 Stats NZ. 2019. Labour market statistics. Stats NZ census data. 3 Median weekly earnings and household overcrowding compared with New Zealand Europeans.

SOURCE: D RYAN, GREY, C, AND MISCHESKI, B. 2019. TOFA SAILI: A REVIEW OF EVIDENCE ABOUT HEALTH EQUITY FOR PACIFIC PEOPLES IN NEW ZEALAND. WELLINGTON: PACIFIC PERSPECTIVES.

FIGURE 2.13: RATE RATIO FOR MENTAL HEALTH SERVICE USE BY DEPRIVATION QUINTILE, 2018



SOURCE: S GIBB AND R CUNNINGHAM. 2018. MENTAL HEALTH AND ADDICTION IN AOTEAROA NEW ZEALAND: RECENT TRENDS IN SERVICE USE, UNMET NEED, AND INFORMATION GAPS. MENTAL HEALTH AND ADDICTION INQUIRY. <https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/Otago-mental-health.pdf>

Disabled New Zealanders report, on average, lower life satisfaction, being more likely to live in low-income households, and having poorer outcomes across health, economic, and social indicators.¹³ Disabled people have half the employment rate of non-disabled people, with younger disabled people (15–24 years) having only one-quarter of the employment rate as their non-disabled peers. Disabled children are more likely to be in households that are under low-household income thresholds, that report having not enough or just enough money, and having one parent.

The compounding effects of socioeconomic deprivation on health outcomes are well researched.¹⁴ For example, people living in more socioeconomically deprived areas are 2.5 times more likely to experience psychological distress than those in less deprived areas (adjusting for age, gender, and ethnicity).¹⁵ The rates of mental health service use is also significantly higher among those from high socioeconomic deprivation quintiles (Figure 2.13).¹⁶

Intersections between ethnicity, socioeconomic deprivation, age, disability, and geographic location exacerbate inequitable outcomes and access to healthcare.

Variations in access to primary care services

Timely access to primary services is important for reducing health inequities, preventing the development of health conditions, avoiding hospitalisation, and ensuring the system as a whole works for optimal health and wellbeing. Research notes barriers to access include cost, availability of appointments, and transport, but experience, health literacy, and cultural factors can often prevent people from seeking help until their condition worsens and requires urgent care.¹⁷ One-third of New Zealanders over the age of 15 experienced one or more types of unmet need for primary health care in the past 12 months.¹⁸

Cost barriers include not only the cost of the appointment but also the cost of transport or unpaid time taken off from work. Policies that have made GP visits free for children have positively improved access and attendance rates. However inequities remain for some groups, indicating challenges beside financial strain.

Pacific enrolment in primary care is high, and the Pacific GP utilisation rate is similar to that of non-Māori non-Pacific people. However, the New Zealand Health Survey also shows that Pacific peoples experience very high rates of unmet need for care compared with the total New Zealand population. About one-third (33%) of Pacific peoples report not seeing their primary care practitioner when needed, with most of this unmet need being related to cost. Similarly, 18% of Pacific peoples report not filling a prescription because of cost. Given the high rates of chronic conditions and multimorbidity among Pacific peoples, this data indicates that significant financial barriers to optimal medical management of long-term conditions remain.

Māori health outcomes

Clear disparities in health outcomes exist for Māori. Life expectancy remains one key indicator. On average, Māori live seven years less than non-Māori non-Pacific people (see Table 2.3). Māori life expectancy tends to be lower in DHB areas with higher levels of socioeconomic deprivation, ranging from 73 years in Lakes and Northland DHBs to 80 years in Waitemātā DHB. Similarly the gap in life expectancy between Māori and non-Māori non-Pacific is highest in DHB areas with higher levels of socioeconomic deprivation. Life expectancy of non-Māori and non-Pacific varies less across DHB areas.

For Māori, inequities of health span the life course.¹⁹ Examples include:

- ▶ childhood immunisation rates have fallen since 2014, with 15% lower rates among Māori than non-Māori
- ▶ Māori children with asthma are more likely to receive suboptimal asthma control with less preventative medication being prescribed, potentially contributing to the 30% higher hospitalisation rate for asthma in Māori children
- ▶ adult Māori are more likely than adult non-Māori to wait longer than three months for an appointment to see a specialist
- ▶ older Māori are more likely to be prescribed a combination of medications than older non-Māori, increasing their risk of acute kidney injury
- ▶ following a hip fracture, the proportion of Māori having an operation on the day of admission to hospital or the next day has decreased steadily since 2013, while the rate for non-Māori has steadily improved.²⁰

Health equity for Māori is substantially influenced by the unequal distribution of the social and economic determinants of health. However, healthcare services do have a significant role to play. For Māori, there is evidence that inadequate access to services, poorer quality of care, and a failure of improvements in health services to improve outcomes for Māori can and do lead to inequities in health outcomes.

Feedback from submissions and wānanga noted that improving equity for Māori requires the issues of racism and socioeconomic deprivation to be addressed alongside honouring te Tiriti o Waitangi / the Treaty of Waitangi and supporting community-led responses to Māori health needs.

Chapter 3: Hauora Māori more thoroughly explores the challenges and opportunities we heard from Māori during Phase One of the Review.

Pacific peoples' health outcomes

In the 2016/17 social wellbeing survey, Pacific peoples were just as likely as New Zealand Europeans to rate their overall life satisfaction as high (66%), their life as worthwhile (73%), and their health as very good or excellent (58%).²¹ However, research using a variety of data sources has shown long-standing inequities in health outcomes between Pacific and non-Māori non-Pacific peoples in New Zealand.^{22, 23, 24} Inequities include shorter life expectancy, a higher amenable mortality rate, multimorbidity, and a higher rate of death from cancer compared with non-Māori non-Pacific people (see Table 2.3).²⁵

Pacific childhood immunisation rates are among the highest of all ethnic groups.²⁶ However, persistent health inequities are seen in rates of hospitalisation, chronic respiratory and infectious diseases, and serious skin diseases. For example, the rate of hospitalisation for rheumatic fever, a potentially preventable condition with serious lifelong consequences, is 50 times higher in Pacific children than in New Zealand European children.²⁷

In 2015, the diabetes prevalence rate was 20% for Pacific adults (20–79 years) in New Zealand, the highest of all ethnic groups (Māori 10%, Asian 8%, and New Zealand European 6%) and far above the OECD average of 7%.²⁸ These percentages mask substantial disparities in the prevalence of diabetes by age: by the age of 65, more than half of all Pacific peoples are living with diabetes.

Evidence shows that the burden of risk factors for long-term conditions such as smoking, obesity, hypertension, and infectious diseases are prevalent in Pacific populations, but data is limited on how equitably interventions to address these risk factors and conditions are being provided by the health sector.

Some researchers have noted that Pacific peoples commonly associate health care with treating illness, not prevention or wellbeing, and often feel overwhelmed and disoriented when diagnosed with a health condition. Spirituality is closely related to health and wellbeing, and fatalism (the subjugation of events and actions to destiny) and denial are commonly reported.²⁹

Stakeholders and a significant number of submissions to the Review identified key issues relating to achieving equity of health outcomes for Pacific people, including the need to support and grow Pacific leadership, for partnership with Pacific populations in the design of services, for a people-centred approach to care in the community, to deliberately address access (for example, more accessible transport and more flexible booking practices), for culturally appropriate health promotion, and to strengthen the workforce.

In addition, many challenges exist with presenting a picture of the current state of Pacific health and, more importantly, identifying why disparities in outcomes, problems with access and quality of services, and unmet need persist.³⁰ These challenges are, in part, due to the disparate sources of information that are collected for different purposes, a lack of standardised data related to ethnicity, and the ability to access primary care data by ethnicity. Research has noted there appear to be no secondary care data governance requirements to support a national policy on equity for Pacific peoples.

TABLE 2.3: COMPARISON OF LIFE EXPECTANCY, MORTALITY, AND RISK FACTORS BY ETHNICITY

Notes	Category	Date	Māori	Pacific	Non-Māori non-Pacific	New Zealand
Life expectancy						
	Life expectancy	2015–17	75.6	76.5	82.8	81.7
	Life expectancy gap	2015–17	7.2	6.3	-	-
	Gap attributable to potentially avoidable causes of death (male)	2013–15	5.0	3.4	-	-
	Gap attributable to potentially avoidable causes of death (female)	2013–15	4.4	3.3	-	-
Mortality						
1, 3	Mortality rate per 100,000 population	2017	631.3	619.5	339.3	378.6
3	% of deaths potentially avoidable	2013–15	53.0%	47.3%	23.2%	27.3%
1, 3	Amenable mortality rate per 100,000 population*	2015	188.8	179.9	74.7	90.8
1, 3	Cardiovascular disease mortality rate per 100,000 population*	2015	200.8	185.6	99.5	111.1
1, 3	Cancer mortality rate per 100,000 population*	2015	200.9	168.5	113.9	123.5
1, 2	Infant mortality rate per 1,000 live births*	2018	4.7	-	3.3	3.7
1, 3	Suicide rate per 100,000 population*	2013–15	15.9	7.9	9.8	10.9
Hospitalisations						
1	Ambulatory sensitive hospitalisations (0–4 years) per 100,000 population*	2018	8,503	12,658	5,519	6,948
1	Ambulatory sensitive hospitalisations (45–64 years) per 100,000 population*	2018	7,794	8,966	3,101	3,916
1	Acute hospital bed days per 1,000 population*	2018	574.1	700.5	341.8	385
Risk factors						
4	% adults who are daily smokers	2017/18	31.2%	20.0%	11.7%	13.1%
5	% adults who are current smokers	2017/18	33.5%	22.9%	13.5%	14.9%
6	% adults obese	2017/18	47.5%	65.0%	30.7%	32.2%
7	% children obese	2017/18	16.9%	30.0%	9.8%	12.4%

Notes

- 1 Rate age standardised except for ambulatory sensitive hospitalisations and infant mortality.
- 2 Non-Māori non-Pacific includes Pacific in this instance.
- 3 Mortality rates use year death registered.
- 4 Non-Māori non-Pacific (excludes Asian) – Asian is 6.5%.
- 5 Non-Māori non-Pacific (excludes Asian) – Asian is 7.8%.
- 6 Non-Māori non-Pacific (excludes Asian) – Asian is 15.1%.
- 7 Non-Māori non-Pacific (excludes Asian) – Asian is 7.0%.

Source: New Zealand Mortality Collection; M Walsh and Grey, C. 2019. The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand: A decomposition analysis. *New Zealand Medical Journal* 132(1,492): 46–60; Statistics NZ (Infoshare); Ministry of Health (National Minimum Dataset and New Zealand Health Survey).

Health outcomes for disabled people

As noted, a quarter of New Zealanders live with disability, and the overall prevalence of disability is rising – both through population growth in older age groups and, more importantly, through increases in disability in adulthood from the effects of long-term conditions such as diabetes and dementia. During Phase One, we heard from organisations that inequities are well documented, yet little progress has been made to address them.

Many health information collections do not collect information about disability, so information about disabled people's health is limited. However, at an overall population level, research indicates:

- ▶ 50 percent of disabled adults aged 15 and over rate their health as good (excellent, very good or good) compared with 89 percent of non-disabled adults³¹
- ▶ people with intellectual disabilities have a life expectancy 18 years shorter for males and nearly 23 years shorter for females than the same sex in the total population, and they have much higher rates of several chronic conditions (from 1.5 times the rate of chronic respiratory disease and cancer to 15 times the rate of dental care in a public hospital).³²

Disabled people are more likely to feel the impacts of the social determinants of health. These are lower employment, having sufficient income, having secure and warm housing, and experiencing higher rates of discrimination.

Rural health outcomes

Rural New Zealand is a diverse population, and access to health services varies significantly across New Zealand. Rural populations continue to be resilient and innovative in solutions to health care. However, while data is limited, indications are that people living in rural towns can have poorer health outcomes, including lower life expectancy, than people living in cities or surrounding rural areas, an effect that is accentuated for rural Māori and disabled people.³³ As noted, mental health challenges and access to health and support services in rural areas remain a priority.

One challenge when considering equity of health outcomes in rural populations is in the use of rural and urban categorisation, which does not accurately account for the populations that access rural or urban health services. As a result, significant numbers of the population designated as 'rural' live near to large urban centres and can access urban health services. Conversely, some small rural communities are grouped with larger centres and defined as 'independent urban', despite some communities having fewer than 1,000 residents and accessing rural health services.³⁴

Much of the analysis is, therefore, research based.

- ▶ A rural health report by the National Health Committee in 2010 concluded that life expectancy and other measures of health status were similar for rural and urban populations. Life expectancy for rural Māori was slightly lower than for urban Māori. Factors identified as contributing to poorer access to health services in rural communities were socioeconomic deprivation, geographical and distance barriers, transport, telecommunications, cost of access to service, and service acceptability.³⁵
- ▶ Research in 2016 identified disparity in disease rates, access to services, and outcomes when comparing rural and urban communities.³⁶

Recognising experiences of racism in the health system

Racism is a social system based on historical and political inequalities that results in systematic privileging some groups over others.^{37, 38} Racism can be manifest in three ways: institutional (systemic), interpersonal (personally mediated), and internalised.³⁹ While all three manifestations impact on health, the effects of institutional and personally mediated racism are particularly important.

New Zealand research shows that self-reported experience of racism, including by health professionals, is higher for Māori, Pacific peoples, and Asian peoples than for European/Other people.^{40, 41, 42, 43, 44}

National and international literature consistently highlights a clear link between experiences of racism and negative health outcomes for adults, youth, and children.⁴⁵ A dose-response relationship between exposure to racism and adverse outcomes has been reported among adults⁴⁶ and children.⁴⁷ That is, the adverse effects of exposure to racism increase as the amount of racism experienced increases.

What New Zealanders told us during Phase One

During Phase One of the Review we heard from New Zealanders across ethnicities, age groups, geographical locations, and occupations. We asked about values, equity, and future improvements to the health and disability system. Unsurprisingly, there was a degree of consistency across themes. Many of the responses we heard during this consultation also reflected those from extensive public engagements of recently completed or ongoing initiatives across other domains including mental health, education, social security, and child wellbeing (see Appendix B online).

New Zealanders told us that their health and wellbeing is important and need to be prioritised and protected, and that it should be everyone's right to live well with equal opportunities. This includes being empowered to make choices, with respect and without discrimination, and recognising good health requires more than a biomedical response to illness.

We heard that consistency of service access, integration, and treatment across services in the community, home, and hospital were important for all, no matter where a person lives, and that new and innovative ways of delivering services need to cater for modern consumer demands and expectations. This includes access to services that valued a person's time and were fit for modern society: opening hours that suited consumers, access to information via digital health technology, and using data to enhance health outcomes and provide an integrated experience so people don't have to repeat their story at each step of their health journey. People understood the value of quality data to improving healthcare, but wanted confidence that their information and privacy were secure.

We were assured that many had good experiences in the health system or with individual staff, but changes were needed to ensure equitable outcomes particularly for Māori, Pacific peoples, and disabled people. Changes included services and a workforce that reflect New Zealand's diverse population and expansion of whānau-centred care. Some had experienced discrimination and racism within the system and were aware of the need to combat these at personal and institutional levels.

Many wanted the system to be more accountable and transparent, and to be heard, seen, listened to, and treated fairly.

3 Hauora Māori / Māori health

Tuia a Ranginui e tū iho nei, tuia a Papatuanuku e takoto nei

Tuia te here tangata, ka rongo te pō ka rongo te ao ki te Whei Ao, ki te Ao

Mārama Tihei mauriora!

Māori as tangata whenua are Treaty partners with the Crown. The health and disability system has not served Māori well. It has not properly recognised different world views, different knowledge bases, or different cultural norms. This section aims to help better understand mātauranga Māori, and to learn from what has and has not worked well in the current system for Māori. We reflect on the voices from the wānanga to understand the aspirations of whānau and communities so future changes can be based in a strong and effective partnership.

Whānau and culture are important to Māori wellbeing. Connectedness through whakapapa, the ability to speak te reo and participate in tikanga Māori, as well as being able to access Māori cultural domains, such as marae, are fundamental to a secure cultural identity so that Māori might live as Māori^{48, 49}

Since the early 1970s, Māori have been experiencing a cultural and economic renaissance that reaffirms Māori tangata whenua status and enduring indigenous rights for Māori in Aotearoa. During this time there was also a reclaiming and reinvigorating of cultural practices and te reo Māori. This in turn has contributed to the burgeoning of Māori-centred development, including establishment of kōhanga reo (preschool), kura kaupapa and whare kura (primary and secondary education), and whare wānanga (tertiary education), which provide education opportunities deeply grounded in Māori tikanga (values and customs), and, importantly, centred on the revitalisation of te reo Māori (Māori language).⁵⁰

In health too, growth in kaupapa Māori health services has been strong and positive with increasing acceptance that Māori health models and practitioners are critical to improving Māori health outcomes.⁵¹ The resurgence and acknowledgement of mātauranga Māori (Māori knowledge) in the health system (discussed later in this chapter) has contributed to a growing awareness in the health system of the different values, beliefs, and approaches Māori apply in their pursuit of health and wellbeing.

Mātauranga Māori is intrinsically linked to people and the human experience. A critical defining characteristic of mātauranga is its connection to tikanga and te reo Māori, the language in which it is intended to be expressed and conveyed.⁵²

As with other indigenous populations, Māori hold a view of health that is holistic and recognises the relationships between people's physical wellbeing, their whānau and social connections, spirituality, and the wider physical and social environment as important determinants of wellbeing. This is further supported by being able to lead healthy lifestyles, participate effectively in the economy and wider society, and be able to express self-determination and leadership.⁵³

Whānau has been recognised as the foundational basis of Māori society and communities and a source of strength, support, identity, and wellbeing for Māori individually and collectively.⁵⁴

Whanaungatanga (kinship relationships) are one of the determinants for Māori life satisfaction. The interdependence of strong relationships between whānau members is an essential element of Māori culture and these relationships have been shown to be important in maintaining both collective and individual wellbeing.⁵⁵

Cultural identity has also been positively associated with improved health and wellbeing outcomes for Māori. Data collected in 2013 showed that 83% of Māori felt their whānau was doing well, 89% knew their iwi, 55% had some ability to speak te reo Māori (compared with 42% in 2001), and 70% reported that it was at least somewhat important for them to be involved in Māori culture (Figure 3 1). Between 2001 and 2013, there was a large increase in the number of rangatahi (young people) who reported some ability to speak te reo Māori.⁵⁶

For rangatahi Māori, a strong sense of cultural identity was associated with wellbeing and reduced depression, whereas experiences of racism were associated with poor wellbeing outcomes, increased depression, and higher suicide attempts.⁵⁷ Similar findings have been identified for Māori adults, where connectedness to whānau and a strong sense of cultural identity are consistently correlated to mental wellbeing.⁵⁸

FIGURE 3 1: MĀORI CULTURAL WELLBEING IN 2013 – POSTER



SOURCE: STATISTICS NEW ZEALAND. 2014.
MĀORI CULTURAL WELL-BEING IN 2013 – POSTER.

Mātauranga Māori / Māori knowledge systems

All indigenous peoples have their own knowledge systems, reflected to a large extent in their unique languages. But their knowledge systems also reflect longstanding relationships with the environment, with the human life cycle, with social and economic interactions, and with inevitable challenges that arise over time. Together, those dimensions constitute a distinctive heritage and continue to remain foundations for societal change and evolving cultures.

In effect, indigenous knowledge:

- ▶ reflects indigenous ways of thinking, relating, and discovering
- ▶ links indigenous peoples with their environments and is often inspired by environmental encounters
- ▶ is conveyed within the distinctiveness of indigenous languages and cultural practices.⁵⁹

Like other indigenous knowledge systems, mātauranga Māori draws on past knowledge so it can be applied to current contexts and realities to support flourishing Māori communities. Like all forms of knowledge, mātauranga Māori is adaptive and represents interconnected and interwoven bodies of knowledge. Māori often assign equal value to mātauranga Māori as to Western knowledge, and when it is applied in settings that are inconsistent with Māori values and guiding principles there is a greater risk for the use of mātauranga to breach the tapu (protections) for the person, the process, or the knowledge itself. Māori assert that it is for this reason Māori leadership and control over the use and application of mātauranga in contemporary health settings is critical to ensure the appropriate protections and processes are in place to protect the integrity of mātauranga in health.⁶⁰

Mātauranga Māori and kaupapa Māori approaches are synonymous and closely interlinked. Over the decades, leaders in domains such as education, health, and research have explained the principles that underpin kaupapa Māori as being:

- ▶ tino rangatiratanga – self-determination – independence and control over destiny
- ▶ taonga tuku iho – aspirations and validity of cultural beliefs and practices
- ▶ Ako Māori – culturally preferred pedagogy or Māori ways of knowing, valuing, and doing
- ▶ kia piki ake i ngā raruraru i te kainga – socioeconomic mediation of disadvantages experienced by Māori
- ▶ whānau – recognising the importance of strong and connected extended family structures
- ▶ kaupapa – collective aspirations and philosophy
- ▶ ata – growing respectful relationships and notions of equality and reciprocity
- ▶ Te Tiriti o Waitangi – affirmation of the rights and status of Māori as tangata whenua and the importance of building effective relationships between Māori and the Crown.⁶¹

Te Mātauranga i roto i ngā mahi hora o nāiane / Mātauranga in current health delivery

Over the last four decades there has been a strong and positive new era in which mātauranga Māori has been incorporated into health care. There has also been an increase in Māori health services offering kaupapa Māori services or mātauranga approaches as alternative or complementary care options in the health system.⁶²

MAHI A ATUA (TE KŪWATAWATA)

Established in 2017 in Tairāwhiti (Gisborne), Te Kūwatawata was a service designed as a single point of entry into the services available to people experiencing mental distress to those based in Gisborne and the wider Tūranga-nui-ā Kiwa area. It is provided to Māori and non-Māori alike.

As a Te Ao Māori approach inside a mainstream mental health service, Te Kūwatawata uses pūrakau (Māori creation stories) and Mahi a Atua (footsteps of the ancestor-gods) as a 'Māori-resonate portal' into a therapeutic treatment pathway. All staff, whether administrative staff or cultural, artistic, or clinical experts, are referred to as Mataora (workers trained in Mahi a Atua) and work in teams to meet the needs of the particular person or whānau.

An evaluation review of Te Kūwatawata, conducted in 2018⁶³ suggests that deliberately making the clinical process secondary to a more meaningful process encourages Māori to readily engage with clinical professionals. Importantly, the rate of referral of Māori to the Te Tai Rāwhiti DHB child and adolescent psychiatric team had reduced significantly, from 80 people monthly to somewhere between 5-10 per month. While few non-Māori patients and their families were referred to the service the evaluation reported increased access rates for both Māori and non-Māori via self-referrals.

The evaluation of Te Kūwatawata highlighted institutional racism as a threat to both the viability and sustainability of the Mahi a Atua model and Te Kūwatawata itself. The report describes and defines institutional racism in this context and within the broader use of the term itself, as 'inaction in the face of need'⁶⁴.

Examples of the role of mātauranga Māori with wide acceptance and common usage in health include:

- ▶ models of Māori health such as Te Whare Tapa Whā and Te Pae Mahutonga, Te Wheke, and Maramataka
- ▶ Māori health and healing practices such as rongoā (traditional Māori medicine), mirimiri (massage), karakia (prayer), whānau awhi (whānau support), whānau pēpi (birthing practices), oriori (whakapapa lullabies), and tangihanga (funerals)
- ▶ tikanga Māori (values and concepts) in the delivery of health care (for example, the removal, retention, disposal, and return of body parts, tissues, and substances and organ donations)⁶⁵
- ▶ initiatives and interventions such as Te Kūwatawata (see the case study below), wahakura (see the case study below), rongoā, whitiwhiti kōrero (cultural support), and karakia (pastoral support)
- ▶ data management and protection such as the National Kaitiaki Group (which ensures protection of Māori women's cervical screening data⁶⁶) and Te Mana Raraunga (the Māori Data Sovereignty Network)⁶⁷
- ▶ leadership and governance mechanisms such as Te Kāhui Tāwharautanga o ngā Rongoā (established in response to the Waitangi Tribunal / Te Rōpū Whakamana i te Tiriti o Waitangi claim for the protection of indigenous flora and fauna, including in relation to traditional Māori healing practices)⁶⁸
- ▶ Māori workforce development and leadership strategies e.g. Te Rau Ora (formerly Te rau Matatini) and Ngā Manukura o Āpōpō (Māori nursing leadership).

WAHAKURA – APPLICATION OF MĀTAURANGA MĀORI AT THE BEGINNING OF LIFE

Wahakura involves the application of mātauranga Māori at the beginning of life for newborn tamariki but also their whāea (mothers). Wahakura are woven pods made from an indigenous fibre known as harakeke (a native flax) that safely protect newborn babies from the risks associated with parental bed sharing and the associated the risk of SUDI (sudden unexplained death of an infant), providing a safe, separate sleeping for the infant. The processes and tikanga of weaving wahakura represent a reaffirmation of Māori cultural identity and whakapapa.⁶⁹

A randomised trial of wahakura, compared with bassinets, for safe infant sleep confirmed the safety of wahakura and identified additional benefits such as a higher rate of sustained breastfeeding in the wahakura group⁷⁰ and a higher level of maternal and infant bonding.⁷¹

Iwi are increasingly supporting provision of wahakura for new mothers and whānau in the knowledge that a wider mātauranga or curriculum accompanies the process of weaving wahakura. Beyond their role as a safe infant sleeping device, wahakura have a much deeper and more culturally profound distinction and significance.⁷² Wahakura wānanga have been established across New Zealand to support pregnant women and their whānau to learn how to weave their own wahakura. The process of weaving creates an opportunity for whānau to not only learn about tikanga Māori and weaving, but also to prepare them for welcoming their baby into their world and to discuss infant safety and child-rearing practices.⁷³

Ngā take nunui mō āpōpō / Future considerations for mātauranga Māori

An important driving aspect of mātauranga is that health services should have the appropriate level of competency to engage with Māori in ways that are meaningful to them, but also that Māori providers delivering kaupapa Māori approaches need to have the appropriate proficiencies to ensure Māori are accessing high-quality clinical care. The relationship between cultural and clinical excellence is key to improving Māori health care and outcomes.⁷⁴

Submitters to the Review noted that hauora is broader than the Western concept of health, encompassing the dynamic and interconnected nature of health in Aotearoa New Zealand and embracing social, physical, environmental, and spiritual dimensions.

Submitters also conveyed the view that tikanga Māori should be normalised within the health system, and the health system should be configured in a way that reflects Māori culture, theories of health, wellbeing, and aspirations. It was also noted that the development and adoption of a wairua-centred approach would ground Māori ways of working in cultural strengths and beliefs, which would benefit all New Zealanders

There was a call for support and funding for mātauranga Māori and kaupapa Māori services which were seen as lacking in the health system, and that investing in research on rongoā Māori would provide an evidence base in relation to traditional Māori medicines.

The Panel agrees that mātauranga Māori must be an integral part of all tiers of the health and disability system.

Te noho mārama ki ngā take hauora Māori / Understanding Māori health issues

Mā te rongo, ka mohio, Mā te mohio, ka mārama,

Mā te mārama, ka matatau, Mā te matatau, ka whai te oranga.

From listening comes knowledge, from knowledge comes understanding,

From understanding comes wisdom, from wisdom comes well-being.

The Māori Expert Advisory Group (MEAG) identified the key issues that affect Māori health outcomes. In developing these issues, their advice to the Review was informed by many sources, including:

- ▶ the Health Services and Outcomes Kaupapa Inquiry (Wai 2575)
- ▶ the Government Inquiry into Mental Health and Addiction
- ▶ the Whānau Ora Review, Ministry of Health reports, and other published material
- ▶ tier 1 workshops held with funders, planners, providers, and academics who work in the primary health care sector
- ▶ wānanga held across the country.

The key issues raised were discussed as part of a series of four wānanga with Māori leaders and stakeholders and were reiterated in submissions.

The wānanga were an opportunity for the Review to hear whakaaro Māori about the issues impacting on Māori within the system, as well as ideas and inspiration about a future system designed to prioritise Māori health equity, outcomes, and aspirations. Participants were asked to think about the system-level changes that might be needed to drive improved Māori wellbeing for the benefits to be realised within the next 5–10 years.

The wānanga discussed the need for the system to respond to Māori whānau needs rather than expecting individuals to simply conform to system requirements. So for example, continually measuring ‘*did not attend rates*’ implies this is somehow the fault of the service user. Turning this around would have us focusing on rates of where the system ‘*did not adequately respond*’ instead. Discussion also highlighted the ‘monocultural design bias⁷⁵’ that has contributed to Māori inequities in health, and in particular considered how we can create a system that responds to diversity and how we might measure the impact of this for Māori health outcomes.

Te Tiriti o Waitangi / the Treaty of Waitangi was referenced frequently by most participants to highlight the political position of Māori. They felt the position of te Tiriti / the Treaty had mainly been rhetoric, and that the relationship between Māori and the Crown continued to be challenging. Wānanga participants were strong in their belief that te Tiriti / the Treaty is the enduring foundation on which Māori and the Crown are obliged to establish a trustworthy relationship to reduce inequities in Māori health.

When presented with a summary of issues the MEAG and the Panel had heard, most wānanga participants could relate to the key issues outlined and used their understandings and work experiences to contrast, support, discuss, and extend their views towards an ideal future health system for Māori. Many of the issues raised in this chapter were reiterated and supported by wānanga participants. Participants also contributed to developing a vision of what the system would look like in 5-10 years time if it was designed to better meet Māori needs. An executive summary of wānanga feedback is included as Appendix C online.

Te Tiriti o Waitangi / The Treaty of Waitangi

Mā pango mā whero, ka oti te mahi

With black and with red the work is completed

In relation to te Tiriti o Waitangi / the Treaty of Waitangi, a significant number of responses were received from Māori and non-Māori organisations. The main theme that sums up many these submissions is that honouring te Tiriti o Waitangi / the Treaty of Waitangi is essential to improving Māori health outcomes and is the most important value that needs to underpin the health system.

It was noted that not only does te Tiriti /the Treaty describe Crown obligations and Māori rights, but it is also a “key improvement tool for achieving health equity for Māori and improving the health system” and “the principles and the detail of the articles of te Tiriti o Waitangi / the Treaty of Waitangi provide useful guidance for effective partnering with Māori”.⁷⁶

Several submissions strongly emphasised the role of te Tiriti / the Treaty in providing a framework for meaningful and substantive relationships between iwi, Māori and the Crown. It was also discussed as a mechanism to reaffirm Crown obligations to enable Māori to participate in health leadership, workforce, and governance and exercise tino rangatiratanga and to reaffirm accountability for ensuring Māori achieve equitable health outcomes.

Submissions also raised issues of culturally competent services, racism, the rights and wellbeing of Māori children, Māori health leadership and advice, poor service performance, government policy, and the protection of Māori cultural concepts, values, and practices in relation to te Tiriti / the Treaty.

He ngoikore kē atu ngā putanga hauora mō ngāi Māori / Māori experience poorer health outcomes

Despite the significant progress noted above, evidence is clear that non-Māori still live longer, healthier lives than Māori. On average, Māori live seven years less than non-Māori and are 2.5 times more likely to die from diseases that can be addressed through health care.⁷⁷

Recognition is increasing that Māori health inequity requires a more determined focus on equity as a te Tiriti / the Treaty and indigenous right⁷⁸ as well as a basic human right.⁷⁹

Achieving equity for Māori requires multifaceted solutions that address intergenerational and intersectoral system failures, Treaty breaches, racism, and language, culture, and identity.^{80, 81, 82, 83} Academics conclude that normalisation and acceptance of inequalities in health for Māori are demonstrated by the health system's failure to respond, despite overwhelming and consistent inequities in Māori health outcomes, higher exposure to determinants of ill health and disease, and continued under-representation of Māori in the health workforce.⁸⁴

The evidence clearly shows that Māori experience inequities in health outcomes across the life course.^{85, 86, 87} Examples include:

- ▶ Nearly 50% of Māori women do not have a lead maternity caregiver in the first trimester of their pregnancy (17% less likely than non-Māori),⁸⁸ and perinatal-related death rates for Māori are significantly higher than for New Zealand Europeans.⁸⁹
- ▶ There is a nearly 20% difference between Māori and non-Māori preschool oral health enrolment (one-third of Māori preschool children receive no oral care), and more than half of 5-year-old Māori children have dental caries (33% higher than for non-Māori children).⁹⁰
- ▶ Data about 27,000 young people, including nearly 5,800 Māori, from the Youth2000 surveys (2001, 2007, 2012) shows despite improved wellbeing outcomes for rangatahi over the last 12 years, significant gaps in outcomes between Māori and non-Māori young people persist. These include poorer general physical and mental health, weight, substance use, and higher exposure to violence.⁹¹
- ▶ Hospital admissions for self-harm are higher for Māori aged 15–24 and have been increasing since 2016, and suicide rates among Māori aged 15–24 is more than twofold than that for non-Māori in the same age group.⁹²
- ▶ Māori develop diabetes up to 10 years younger and progress earlier to more serious disease, yet are less likely to receive appropriate HbA1 monitoring and appropriate diabetes-related renal-screening tests than non-Māori. The rate of admission to hospital with diabetic ketoacidosis is higher for Māori, and, while still rare, the rate of lower limb amputation linked to poor diabetes management is a third higher for Māori.⁹³
- ▶ Despite being significantly more likely to report multiple disabilities, Māori aged 65 and over are much more likely to have unmet need for a disability aid than non-Māori.⁹⁴

Participants at the wānanga and submitters noted that improving Māori health outcomes would require deliberate and concerted efforts to address the unequal distribution of the social and economic determinants that influence the levels of health advantage and disadvantage between individuals and population groups in New Zealand. They also noted the need to embed a lifecourse approach to social investment and funding in health and social support systems, including a call for a focus on the health of children, in particular, of Māori children, to reduce life-long and avoidable inequities in health.

Te pānga o ngā manaakitanga hauora ki te whiwhinga ōrite / Health care impacts on equity

In addition to the socioeconomic determinants of health, equity of outcomes is influenced by three factors in the delivery of health care:

- ▶ inequity in access – services are less accessible for some population groups
- ▶ inequity in quality – services are not providing the same benefits to everyone
- ▶ improvement – efforts to improve the quality of healthcare services do not always improve equity.⁹⁵

Te taurite o te wātea mai o ngā ratonga / Equity of access to services

Access to comprehensive, quality health care services is important for promoting and maintaining health, but Māori and some of New Zealand’s other vulnerable population groups continue to experience issues of access to services.

The ability to access appropriate health services can be affected by various factors, including the cost of care, geographical location (rural compared with urban), and the level of an individual’s health literacy and ability to navigate the system across the continuum of care. For example, the cost of general practitioner visits is a barrier to accessing primary care. One in seven (15%) adults reported not accessing primary care due to cost in the 2016/17 Health Survey, with Māori being 1.4 times more likely to report cost as barrier than non-Māori.⁹⁶

Māori were also less likely than non-Māori to report being offered a choice of appointment times, to be seen on time, or to be seen within their preferred timeframes in general practice. Māori adults and children are more than twice as likely not to have collected prescription medications because of cost than non-Māori adults and children.⁹⁷ Approximately 22% of rangatahi Māori were unable to access the care they needed in the previous year and were significantly less likely than Pākehā youth to be able to access the care they needed⁹⁸.

Te taurite me te kounga ratonga / Equity and quality of care

Evidence shows that engagement with the health system increases advantages for non-Māori and disadvantages for Māori across the life course. Where Māori are accessing health services, they do not always receive optimal quality of care, and this negatively affects outcomes for Māori. Lower quality of care includes suboptimal prescribing and over-prescribing to Māori, poor communication between professionals and Māori patients, delays in treatment and surgical interventions, and longer hospital bed stays after acute admissions.⁹⁹

The pattern of inequities shown suggests engagement with health services does not reduce inequity. In fact, results suggest a further accumulation of advantages for non-Māori and disadvantages for Māori through engagement with the health system across the life course. (Organisation submission)

The recent Government Inquiry into Mental Health and Addiction heard similar accounts.¹⁰⁰

Ngā pikinga ake o te kounga o ngā ratonga / Improvements in service quality

Efforts to improve quality of services have seen a significant impact on health outcomes, including for Māori. One example is in improving surgical site infection rates following orthopaedic surgery, which has seen a rapid reversal of high infection rates and achieved equity for Māori in four years of implementation. The key success factors were standardisation of clinical practice and guidelines, monitoring and reporting of implementation of best practice, and monitoring and reporting of outcomes.

Another example is a pilot screening programme for abdominal aortic aneurism in Waitematā DHB among nearly 2,500 Māori. The study confirmed a high burden of undetected abdominal aortic aneurism among Māori adults; culturally-robust, person-centred processes contributed to high levels of participation; and robust clinical processes led to a high follow up and intervention rate in those with identified aneurisms. These two examples relate to conditions that are relatively simple and able to be resolved primarily through improvements in clinical practice.¹⁰¹

However, evidence also exists that often general improvements in service quality do not achieve equity for Māori, particularly in areas that are more complex and require improvements at multiple levels of the system. Examples include failure to achieve and/or maintain equity in Māori childhood immunisation rates, the management and treatment of diabetes in Māori adults, and screening for renal failure in Māori adults despite higher risk factors.¹⁰²

There was a call from participants at the wānanga and submitters to enable more Māori and community-led services, and for this to sit at the centre of the system. It was noted that there was tension between universal and/or national approaches and community-led and driven approaches in health care services that constrained local flexibility and innovation to meet the unique and diverse needs of Māori. It was also expressed by many that central to the pursuit of health equity is recognition and honouring of te Tiriti o Waitangi and tackling racism in the system.

Ngā mamae whakatoihara / Impacts of racism

Kaua e takahia te mana o te tāngata

Do not trample on the dignity of people

The Review heard that Māori experiences of colonisation and intergenerational trauma are closely linked to experiences of racism and have had a significant impact on Māori health and wellbeing.¹⁰³ Māori are almost 10 times more likely to experience multiple forms of discrimination than the New Zealand European population.¹⁰⁴

A cross-sectional study of secondary students showed that students who experienced ethnic discrimination were less likely to report excellent or good health and to feel safe in their neighbourhood and were more likely to report an episode of binge drinking in the previous four weeks.¹⁰⁵

racism doesn't have to be deliberate. It can be the unintended ... outcome of well-intentioned people ... But ... it's a failure in imagination, it's a failure in monitoring, it's a failure in reporting and it's a failure for consequences for poor performance. (Came-Friar. H. p152).¹⁰⁶

In addition to racial discrimination, Māori report institutional racism, including differential access to the health care services and opportunities.

non-Māori are more advantaged than Māori across all socio-economic indicators including personal income, education level and living circumstances (including household crowding, rented accommodation and access to motor vehicles). There is compelling, and growing, evidence of the role of racism as a determinant of health. (Organisation submission)

Submitters noted that there is evidence of implicit bias by professionals in the health system, which perpetuates and maintains power imbalances in the system, and impacts on the quality of care Māori receive. One submission noted that a core goal for the health system must be to prevent people from enacting approaches that perpetuate power imbalances and inequity, whether these are due to personal unconscious or conscious bias or institutional racism. But it was also noted that in order to be effective, eliminating racism needed to also be a goal for wider social service agencies whose services contributed to poorer Māori health outcomes.

It was noted that eliminating racism in the system is everyone's responsibility from those working in administration to service delivery and leadership and governance, and that this needs to be in both personal and organisational performance plans. Further, submitters noted that this should be monitored, and reported on in accountability documents.

There was a call for a stronger research evidence base identifying and assessing programmes and interventions that are effective in addressing the frequency and impact of racism on health outcomes for Māori.

Ngā whakaritenga o te pūnaha / System settings

Ngā kaupapa here hauora me ngā takohanga / Health policy implementation and accountability

During this phase of the Review, concerns were raised around the strength of the accountability mechanisms available to ensure the implementation of health policies is appropriate, but also flexible enough to allow for tailored approaches to addressing Māori health needs at a local level. It was noted that in particular that there has been a failure to adequately address Māori equity needs as part of the recent New Zealand Health Strategy and that Māori-specific policy development and implementation is lacking. One submission referred to a study of 10 years of public health policies to understand how te Tiriti / the Treaty was represented in health policy frameworks. The study found that there were inconsistencies in policy engagement. Over the 49 policies reviewed for that period, only 12 mentioned te Tiriti o Waitangi / the Treaty of Waitangi.¹⁰⁷

Ngā tikanga pūtea / Funding mechanisms

Chapter 4: governance and funding, sets out and describes the current funding arrangements for the system. A number of issues and concerns were raised by Māori about funding during the wānanga, in submissions and during the Wai 2575 Inquiry. A common theme raised by Māori was related to the belief that funding formulas, such as primary care capitation, failed to meet the high, and diverse needs of Māori communities and whānau. It was also suggested that funding was largely driven by political electoral cycles and ideology, rather than need, and did not adequately allow for Māori-specific responses. In particular, it was noted that the lack of a specific national Māori investment plan for health services meant that health funding is not invested where it's most needed, particularly in relation to achieving health equity for Māori and the provision of rural health services. Submitters also raised concerns about insufficient investment in preventive care approaches.

There were also significant concerns raised about contracting models and underfunding of Māori providers and services. It was noted that Māori health providers were not funded to a level that allowed delivery of holistic services consistent with Māori models of practice and recognising the complexity of the circumstances of their client base. It was also raised that contracting arrangements lacked the flexibility to allow for innovation in service delivery. Submitters also noted that contracts awarded to Māori providers did not allow for pay equity and did not recognise the dual clinical/technical and cultural competencies of Māori practitioners and health workers. This is discussed further in chapter 4: governance and funding.

There was a strong call from a number of submitters, phase one claimants to the Wai 2575, and during wānanga for a dedicated Māori funding entity that focuses on Māori health needs and responses.

Te ārahi i te pūnaha me te mana tautiaki / System leadership and governance

Issues Māori raised relating to health system governance, leadership, and decision making focused primarily on the need to improve and develop Māori participation and representation across the sector at the governance level. This includes shared power and decision making between the Crown and Māori and the influence of funding and contracting arrangements on the distribution of decision-making power.

There was a view from submissions and wānanga participants that support for Māori leadership development was lacking and that there is a need for developing stronger iwi partnerships with DHBs. The need for flexibility to work across boundaries when defining what is local and regional, and a willingness to collaborate with iwi across DHB boundaries was identified, including a focus on, and investment in, local leadership to deliver on local priorities.

Te mana o te raraunga / Data sovereignty

Quality health data collection provides the knowledge base for health and social investments, health service planning, and data sharing. Health technology is also progressing to improve the delivery of health services. Māori have expressed particular interests and concerns in the way that Māori data is collected, analysed, and used. On the one hand Māori data is a powerful tool of self-determination, on the other a method by which Māori are analysed, categorised and described. These issues are discussed more fully in chapter 12: digital and data.

Ngā ratonga Māori / Māori providers and services

Te tira kaimahi hauora Māori / Māori health workforce

Mā te mahi tahi ka anga whakamua

By working together we move forward

A diverse and representative health workforce that understands the importance of achieving health equity is critical to the delivery of equitable health services to Māori. It is clear that New Zealand's Māori health workforce challenges centre on the capacity and capability of the Māori workforce, attracting and retaining Māori health professionals to work in rural areas, and the level of government investment in building the Māori health workforce. It has also been noted that in addition to growing the Māori health workforce, investment and training is required to ensure the non-Māori health workforce is skilled and competent to work with Māori whānau and communities.

We heard from submitters that the current health workforce lacks diversity, that attracting a Māori workforce to rural communities is challenging, and that lack of pay parity between health professionals working for Māori providers and those working for mainstream providers is a challenge for recruitment and retention.

We also heard that the system does not give enough attention to growing the Māori health workforce, appropriate training for Māori health providers is lacking, as is support and investment in mātauranga Māori and kaupapa Māori health workforce. It was suggested that there was a need for dedicated Māori enrolment targets across all health training programmes and specific targets for health employers.

Ngā ratonga Māori / Māori providers

Most commonly, Māori health service providers are iwi or Māori owned and community based, Māori governed, and deeply rooted in Māori values and cultural practices. These providers generally provide services to predominantly Māori high-needs communities. It has been noted that such Māori providers are uniquely placed to deliver on Māori aspirations and concepts of health and wellbeing alongside the delivery of treatment and care.^{108.}

The Māori Provider Development Scheme was established in 1997 to provide funding grants to support the development of Māori providers. This funding is still in place and has been shown to contribute to the capacity and capability development of Māori providers as well as enabling the establishment, maintenance, and advancements of information technology systems. The scheme has also contributed to the development and growth of the Māori health workforce, including an increase in the number of staff who have received additional training and have certified and tertiary qualifications. One challenge Māori providers face is that their staff then became highly sought after and paid better by other providers.¹⁰⁹

There is also a lot to learn from Māori providers. Recent work undertaken by the Ministry of Health to look at Stop Smoking Services and, in particular, to design services that support wāhine Māori (Māori women) to quit, led to a series of co-designed prototype services being trialled with Māori providers.¹¹⁰ Findings from an evaluation of these prototypes has led to new guidance documents being developed for national stop smoking services.

A number of the challenges for Māori providers raised by submissions related to concerns about the funding of Māori providers and services, which is addressed in the section on funding above, but one submission provided a useful summary:

Māori PHOs/providers are not financially sustainable due to significant underfunding on an annual basis, and the disparity in resources caused by the uneven playing field in the primary health sector. Māori PHOs are also prejudiced by the DHB model in providing kaupapa Māori models of care across multiple DHB districts.
(Organisation Submission)

Submitters also noted that Māori providers bring value to the system, for example, by delivering kaupapa Māori services, such as oral health services, and in communities with high and complex needs that are being underserved. It was also noted that the Whānau Ora model has had success in improving outcomes, and mainstream services could learn much from that model. There was a call to create opportunities for Māori providers to participate more effectively in local and regional planning and decision making to improve action on health equity for Māori.

Ngā pūmanawa Māori / Māori strengths

Hāpaitia te ara tika pūmau ai te rangatiratanga mo ngā uri whakatupu

Foster the pathway of knowledge to strength, independence, and growth for future generations

Māori have a long history of adaptation and innovation to improve outcomes towards Māori flourishing, and health and wellbeing are no exception. In its submission to the Government Inquiry into Mental Health and Addiction, Tumu Whakarae (National Reference Group of Māori Health Strategy Managers within DHBs) noted the considerable strengths of Māori to find their own solutions. These strengths include the resilience of whānau, leadership of tūpuna (ancestors), iwi advancement, post-Treaty settlements, Māori leadership in government, visionary and strategic Māori leaders, a highly skilled and professional Māori health workforce, and Māori-determined research. Tumu Whakarae contends that achieving the vision of Pae Ora (the ultimate goal of He Korowai Oranga – the Māori Health Strategy) for Māori requires meaningful partnership consistent with te Tiriti / the Treaty:

The best sort of society for the mental health of all people is a society based on the best of what tangata whenua as the indigenous people of Aotearoa can offer, in partnership with what non-Māori as Te Tiriti based partners can provide.¹¹¹

Te Rangatiratanga o te Whānau / Connected and Capable Whānau

Whānau possess an unlimited potential to transfer positive values, to promote healthy lifestyles, and to attain good health through customs and concepts akin to their cultural identity (Waitai and Kingi p127) ¹¹²

The concept of ‘whānau ora’ is not new and can best be described as ‘Māori families supported to achieve their maximum health and wellbeing’. For whānau to achieve the state of wellbeing or oranga, they need to achieve a sense of purpose and control or rangatiratanga over their own health and wellbeing. This concept of whānau rangatiratanga relates to the right of people and whānau to participate in decision making about their own health aspirations and health care needs and to exercise a measure of control over how services are delivered to them.¹¹³

In 2016, the Social Policy Evaluation and Research Unit developed a conceptual framework and measurement tool to identify the key principles and dimensions for measuring whānau wellbeing and empowerment (summarised in Table 3.1). The intention of the measurement framework was to move from deficit framing for measuring whānau outcomes towards measuring and reporting on the development of whānau capability over time.¹¹⁴

TABLE 3.1: WHĀNAU RANGATIRATANGA FRAMEWORK – PRINCIPLES AND DIMENSIONS

The principles that underpin whānau rangatiratanga are which intersect with capability dimensions for whānau ...
▶ Whakapapa thriving relationships	▶ Sustainability of te Ao Māori language, identity, culture, institutions
▶ Manaakitanga reciprocity and support	▶ Social capability trust, volunteering, connectedness
▶ Rangatiratanga leadership and participation	▶ Human resource potential health education and quality of life
▶ Kotahitanga collective unity	▶ Economic employment, wealth and housing
▶ Wairuatanga spiritual and cultural strength	▶ Sustainability of te Ao Māori language, identity, culture, institutions

SOURCE:

Superu. 2016. The Whānau Rangatiratanga Frameworks: Approaching whānau wellbeing from within Te Ao Māori. Wellington: Social Policy Research and Evaluation Unit.
<https://thehub.sia.govt.nz/resources/the-whānau-rangatiratanga-frameworks-research-report-2016/>

Recognition is increasing that culturally relevant approaches to the delivery of health care and culturally specific services can have a positive impact on health outcomes, including through increasing engagement and commitment to treatment. Studies have shown that whānau involvement and recognition of culture and spirituality in care can improve satisfaction in services.¹¹⁵ Different models and approaches have been developed to deliver whānau-centred and responsive services to improve Māori health.

Whānau Ora – the establishment of three commissioning agencies, the purpose of which was to provide funding support for building the capability of whānau towards improved wellbeing outcomes. The overarching aim is ‘best outcomes for Māori’. The key strengths of this programme are that it is culturally anchored, whānau centred, and strengths based and its flexibility has enabled prioritised funding of services to progress issues of greatest importance for whānau. Challenges include a lack of understanding and buy-in from government agencies, services that often focus on whānau in crisis, and demand for support outstripping available resources. There are also challenges reaching rural and geographically isolated communities. Many mainstream providers opted out of their responsibilities of care, leaving them to be ‘picked up’ by Whānau Ora providers.¹¹⁶

There was a strong call from wānanga participants and in submissions for moving to a whānau-centred model of care. This included the need to support whānau to provide care and support to their members in the treatment and management of health care and for long-term healthcare support. The importance of restoring trusted relationships between whānau and practitioners that recognise and acknowledge the role of whānau in determining their own health needs, and a need to build the health literacy of whānau to empower them to be more involved in decisions about their care were also raised.

Te Wherawheratanga Kaupapa mō ngā Ratonga me ngā Putanga Hauora / Health Services and Outcomes Kaupapa Inquiry (Wai 2575)

The Health Services and Outcomes Kaupapa Inquiry¹⁷ commenced on 30 November 2016 to inquire into nationally significant health issues for Māori. The inquiry is being conducted in three stages. In stage 1, which relates to “priority themes that demonstrate system issues”, the Waitangi Tribunal has heard two claims – from the National Hauora Coalition and the Māori Primary Health Organisations. The remaining claims will be considered in stages 2 and 3 of the inquiry.

The inquiry identified four thematic issues that need to be addressed from the claimant submissions:

- ▶ Treaty-compliance of the New Zealand Public Health and Disability Act 2002 and policy framework
- ▶ funding arrangements for primary care
- ▶ accountability arrangements for primary health care
- ▶ the nature of Treaty partnership arrangements in the primary health sector.

The findings of the Inquiry were published as this report was being finalised so while the Panel acknowledges the significance of the inquiry report (Wai 2575) and the findings and recommendations of the Waitangi Tribunal, this report does not fully consider the specific recommendations. The Tribunal report is summarised in Appendix D (online). The Review will fully consider these in the next phase of the Review.

Directions for change: Hauora Māori

Māori as Tiriti / Treaty partners have not been well served by the health and disability system. Despite many good examples of kaupapa Māori services proving their effectiveness, the system overall has not delivered Māori health and wellbeing outcomes that are fair.

While issues relating to Māori health are addressed throughout the report, key issues include:

RECOGNISING THE TIRITI / TREATY RELATIONSHIP

The Panel believes a health system tailored to meet the needs of all New Zealanders must:

- ▶ *Fully incorporate te Tiriti o Waitangi / the Treaty of Waitangi to provide a framework for meaningful and substantive relationships between iwi, Māori and the Crown and recognise the importance of considering the heterogeneous realities of Māori and kaupapa Māori aspirations*
- ▶ *better meet its obligations regarding the health of Māori communities and embed rangatiratanga (authority, ownership, leadership) and mana motuhake (self-determination, autonomy)*

EMBRACING MĀTAURANGA MĀORI

The Panel recognises that the New Zealand health and disability system has evolved with a strong western medical tradition. The inequities which have arisen for Māori from this system cannot be fully addressed without ensuring that going forward the system also embraces the Māori world view of health

The Panel recognises that progress has been made in incorporating mātauranga Māori into many of our practices but there will need to be an ongoing and deliberate policy to ensure that practice continues to grow and that kaupapa Māori services are more readily available.