

Submission to  
**Inquiry into Māori Health Inequities**

28th August 2019

**The Submission is from**

**Whānau Ora Commissioning Agency**

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The Whānau Ora commissioning Agency (WOCA) , formerly known as Te Pou Matakana is located in the North Island. It was contracted in 2014 by Te Puni Kōkiri as one of three agencies to deliver commissioning agency functions for Whānau Ora. WOCA delivers Whānau Ora outcomes by commissioning services through more than 80 Whānau Ora partners across the North Island. In addition, through its research, evaluation and advocacy, WOCA promotes policies to improve whānau wellbeing.

We would like the opportunity to present an oral submission.



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Māori health is in a humanitarian crisis. There is vast literature, research and the recent WAI 2575 Waitangi Tribunal report, which highlight the stark disparities in health for Māori. We support this evidence with our own experience with the system and its effect on our communities, day in day out. The poor state of Māori health outcomes is absolutely unacceptable.

The introduction of the Public Health and Disability Act in early 2000 along with the establishment of primary health organisations was seen as a period of hope. Although the system was an improvement on the previous one, the new legislation was supposed to deal with the health inequities for Māori. However, the health system has failed to deliver on that hope as shown by overwhelming evidence on the inequities and poor health outcomes for Māori.

Since the reforms in 2000, \$220 billion has been pumped into the health system with nil or little measurable improvement for Māori. From before birth through to old age we see inequity in Māori health outcomes. Services are not as accessible for Māori, and even after services are accessed, Māori do not experience the same benefits as non-Māori. There is a distinct pattern of inequities between Māori and non-Māori over their lifetimes.

In this brief submission, we draw attention to the innumerable and grave distortions in the New Zealand health system, which has resulted in unfavourable health outcomes for Māori. We also set out the main causes of these outcomes and propose potential solutions to deal with these crises.

## Māori health inequities

The statistics and data for Māori health are staggering. They reflect the clear failure of the systems to improve Māori health outcomes even after implementing major reforms nearly 20 years ago. Some of these shocking data show the appalling inequities faced by Māori to access and get quality health care, inequities in their disease burden, resulting in inequitable in health outcomes

- Māori die on average seven years earlier than non-Māori do.
- Māori are two-and-a-half times more likely to die from diseases that are potentially preventable with timely and effective health care.
- Māori were rating themselves as having poor health 2.2 times more than non-Māori have.
- Māori were experiencing 1.9 times more racial discrimination than non-Māori

### Chronic Diseases

- Mortality as a result of *chronic lower respiratory diseases* are 2.8 times more in Māori than non-Māori.
- Māori are more than three times likely to get hospitalised, as well as die because of *COPD*
- Māori suffering from *diabetes* are almost two times more than non-Māori.
- Māori have higher rates of registration for cancer than non-Māori.
- Mortality as a result of *all cancers* are 1.7 times more likely in Māori than non-Māori.
- Lung Cancer is 3.6 time higher in Māori

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- Breast, cervical and lung cancer registration is higher for Māori women than non-Māori. But the rate of death for Māori is twice as high in breast cancer, four times higher in cervical cancer and five times more in lung cancer. The same issue is evident for Māori men with lung, stomach and prostate cancer.

#### Mental health

- Bipolar disorder is 2.1 times more diagnosed in Māori than non-Māori.
- Emotional and behavioural problems are 1.6 times more likely in Māori children than non-Māori children.
- Suicide or intentional self-harm is almost twice as likely in Māori than in non-Māori. These numbers are even higher in youth.

#### Unintentional injury and Violence

- Death caused by unintentional injury is 3.5 times higher among Māori children (under 15) than non-Māori
- In Māori adults (15-64 years old) lethal unintentional injuries are 1.7 times more than non-Māori adults.
- Māori are 2.6 times more likely to die from assault and homicide and 3.3 times more likely to be hospitalised.

#### Barriers to accessing health care

- In Māori, unmet need for after-hours and GP due to lack of transport is 2.9 and 2.8 times more than Non Maori.
- Unfilled prescription due to cost is 2.2 times higher in Māori.
- Unmet need for after-hours due to cost is 1.8 times more in Māori.
- Unmet need for GP due to cost is 1.5 times higher in Māori.
- For Māori unfilled prescription due to cost in past 12 months is 2.21 times higher.
- Māori are half as likely as non-Māori to benefit from private health insurance.

#### Quality of health systems and services

- Amenable mortality and ASH rates are both significantly (2.4 and 1.6 times respectively) higher in Māori than non-Māori.
- This shows that access or potentially quality of care for Māori populated area is poorer, and Māori experience more hospitalisation due to primary care interventions or lack of intervention.
- Māori kids and adults visit a health professional the same as or more than non-Māori do; yet, Māori report higher unmet needs than non-Māori do.

These statistics are just the tip of the iceberg of the many adversities and inequities in Māori health. For decades, there has been little or nil change to Māori health outcomes. Efforts may have been made, but those efforts have clearly been unsuccessful in meet even the basic health needs and demands of the Māori population. Health is a human right, and these harsh inequities reflect the failure of Crown and the system to provide basic rights to tangata whenua.

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## Causes of these health inequities

The factors that make up the root causes of Māori health inequity are diverse, complex, evolving, and interdependent in nature. It is essential to understand the underlying causes and conditions of Māori health inequities to inform effective interventions and solutions to do this inevitable task. While individual health outcomes are not completely attributed to the Crown and the system, it is substantial to hold the Crown and system responsible for the health inequities amongst Māori. If Māori were treated equally as non-Māori in the healthcare system, there should be no difference in health outcomes. However, as evident from the numbers- it is not so.

This implies that although we recognize the role of social and economic determinants of health on Māori, the Crown catalyses and influences these social and economic determinants and other structural determinants directly and indirectly through its actions and inactions in the system and the wider ecosystem. We identify two principle elements of the Crown, which have resulted in the current state of health for Māori – Policy and Legislation, and Institutional Racism. These structural inequities consciously overlooked by the Crown have limited the Māori population to reach their full health potential for decades. The prejudice suffered by Māori because of these Crown failures is extensive.

### Legislation, Policy and Te Tiriti o Waitangi

We contest that the Crown has used the ‘application’ of the principles of the Treaty to health - partnership, participation and protection in no more than a token way. The Crown has acted inconsistently with the principles of the Treaty-with a number of breaches and lack of commitment to it. Although the health sector was one of the first to incorporate the Treaty into the Health and Disability Act 2000, it is merely seen as an obligation without any accountability. This has manifested in distortions in the health care system – from funding and procurement, to Māori representation and capacity, to quality and accessibility of care to Māori and leading to inequitable health outcomes.

For instance, the arrangement of Māori representation on District Health Boards (DHBs), does not afford Māori and Treaty consistency as Māori lack control of decision-making in relation to the health care design and delivery. In addition, the WAI2575 Tribunal report has found that that on only one occasion (in 2001) did all DHBs have two Māori members (as required by legislation) and at no time since their establishment have all district health boards had proportional Māori representation. Furthermore, the lack of Māori staff in senior levels of the health sector and the 2016 disestablishment of Te Kete Hauora, the former Māori health directorate at the Ministry of Health, and the failure to replace it at the time is also a breach of the Treaty principles of equity and active protection.

A similar state of affairs has been found in funding and procurement of Māori health services and interventions. In 2017-18, only 10% of the health spend of \$16 billion was allocated to Māori patients. Likewise, Māori PHO’s received only 3.1% of the \$907 million funding to primary health organisations. Considering the constituency of Māori (15% of New Zealand population) and having higher needs – clearly highlights the gross under resourcing of the Māori health sector. This has been repeated time



and again and has led to only widening of the gap between Māori health and Non-Māori health. The disregard to the Treaty has also unfavourably affected the socio economic determinants of health that have further fostered the health inequities for Māori.

## *Institutional Racism*

The severity and persistence of health inequity Māori experienced indicated the system is institutionally racist and hence affecting health and wellbeing of Māori. Our communities and people have always complained of the inherent institutional racism within the sector and wider system; without any real action from the Crown to rectify this. Recent research and evidence from the WAI2575 Tribunal report evidently presented the extent and consequences of the institutional racism within the system. Institutional racism means the procedures or practices of particular organisations result in some groups being advantaged.

In the health sector, this has been seen at multiple levels – delivery of services through to access of service, from legislation to procurement. Māori health organisations are made to jump through more hoops for less funding; medical services are being delivered in a culturally insensitive way, making the patient feel talked down to; or Māori patients are provided different treatments and procedures as opposed to Non-Māori. This institutional racism is also deeply rooted in the historical trauma and persistent injustices suffered by Māori.

The failure to meet the requirement of Te Tiriti o Waitangi, to identify and remove institutional racism have created and aggravated the differences in the ability for Māori to participate and have a voice in policy and political decision-making. These implicit biases have created differential health care service offerings and delivery and have affected the effectiveness of care provided, including a lack of cultural competence.

## **Actions to resolve these inequities**

Only part of an individual's health status depends on his or her behaviour and choice; socio- economic factors like poverty, unemployment, poor education, inadequate housing, etc., along with the historic and ongoing interplay of structures, policies, and norms shape the lives and health of Māori and contribute to health inequities. There is mounting evidence that focusing programs, policies, and investments on addressing these conditions can improve the health of vulnerable populations and reduce health inequities. This includes inclusive policy design and creating greater opportunity for collaborative service innovation, devolution of resources and increased Māori decision-making.

### **1. Commitment and accountability to Te Tiriti o Waitangi**

Under Te Tiriti o Waitangi the Ministry of Health, as steward and kaitiaki of the health and disability system (under Article I), has a responsibility to enable Māori to exercise their authority (under Article II); and enable the health system to achieve equity in health and wellness for Māori (Article III) in ways



that enable Māori to live and thrive as Māori (the Ritenga Māori Declaration). Despite legislation, the Treaty is seen as a mere obligation rather than commitment and responsibility. We demand a genuine commitment to Te Tiriti o Waitangi by the Crown and the health system to achieve health equity for Māori. This entails,

- The Treaty framework must be incorporated within each document, action and policy within the Government. The principles of the Treaty provide a nuanced and substantial guidance on application of the Treaty in the different sectors especially health.
- The Health and Disability Act, all health policies and documents must change to include actions of equity for Māori and a new set of Treaty principles, such as ***tino rangatiratanga*** and ***mana motuhake*** (self-determination), equity, active protection, options and partnership.
- This is to ensure not only being ‘Treaty compliant’ but also imprinting the standard of equity on Crown officials, workforce and practice.
- Accountability in the health system is called into question, and we have pointed on several occasions that health entities are not appropriately held to account for achieving equity.
- Monitoring the health sector by conducting reviews by an independent agency to ensure accountability and transparency of the system to Māori.

## **2. Establishment of separate Māori health authority**

With the current system failing to identify and meet the health needs for Māori, a structural change is utmost priority - the establishment of an independent Māori-led health authority. The development of this authority by Māori, for Māori will channel energy, time and effort more efficiently and effectively to transform the current state of Māori health. Repeatedly fixing up a system that is broken will not help with the issue that has grown to this magnitude.

## **3. Health System Reset**

- The overarching framework of the health system needs to be reset. As found by the WAI 2575 Tribunal report, there is a Treaty clause in the legislation and within the DHB’s which amounts to “a reductionist effort”. It is recommended that this legislation must be amended if the Crown is to be Treaty-compliant. The dominant language in the health sector is “reducing disparities” or “reducing inequality” rather than a commitment to achieving equity or reducing inequities in health outcomes for Māori. This is not just an issue of semantics.
- As stated earlier in this section, there are serious issues around funding and accountability of the primary health care system by the Ministry of Health, particularly funding earmarked for Māori. An urgent and thorough review of the funding for primary health care, to align it with achieving equitable health outcomes for Māori is required.





#### **4. Integrated and cross sectoral approach**

Health inequities cannot be addressed by the health sector alone, but no sector is better positioned and mandated to advocate for action to address this preventable and unjust burden of death and disability. The health sector can only urge other sectors to consider the health equity impacts of their policies, in leading by example.

#### **5. Whānau Ora as a tool to resolve health inequities**

The Whānau Ora Review Report – Tipu Mātoro ki te Ao (2019) has demonstrated the success of the approach and its positive impact on whānau lives. Whānau Ora holds the key to not only wrapping holistic support around whānau, but also facilitating an integrated and cross-sectoral approach to mitigate the negative effects of the complex determinants of health. Whānau Ora should be promoted and implemented more widely within the Māori population. This requires appropriate knowledge of Whānau Ora and its Kaupapa, increased funding and stronger relationships between Māori Whānau Ora providers and the Government to build trust, collaboration and scale-up Whānau Ora.

#### **6. Life course approach**

The current system has been reactive and prescriptive to surfacing issues, rather than looking at the bigger picture and future scenario. The public health system must deploy a life course approach to each of its activities to mitigate the sustained and intergenerational inequities. This implies resources and support to tailor whānau-centred services that focus on addressing the whole-of-life issues and needs.

#### **7. Better navigation and support systems- Kaiārahi**

Establishment of a strong navigation and support system for Māori whānau to help navigate the systems to meet their needs has proven to be crucial to whānau success in the health sector. The Kaiārahi (navigator) service will help reduce barriers to access health care, ensure timely use of services and compliance in the management of health conditions. It will also be instrumental in dealing with institutional racism and hence the mitigation of health inequities in Māori whānau.

#### **8. Strengthening data and research**

We observe that the Crown does not collect sufficient qualitative or quantitative data to truly ensure health care sector is performing for Māori. The lack of this data is identified as a breach of the Treaty principles of active protection and equity. This is also applicable to research in the field.

- There have been a number of research projects implemented to serve the professional, political, and academic needs of non-Māori researchers, with little or no translation into improving health outcomes for Māori.





- Strengthening the building of data infrastructure and capacity is required to collect, track, integrate data and make more informed decisions. Likewise, promotion of community research and increasing funding for community research and the translation of community research for evidence based decisions and policies is required to improve health outcomes for Māori.

## **9. Māori advancement and capacity building**

For many decades, Māori have sought mana motuhake (self-determination) over the planning and delivery of health services – by Māori, for Māori. There are currently over 200 Māori-owned and Māori governed health providers across the country that serve largely, but not exclusively, Māori populations. Providing a platform where health services are delivered ‘by Māori for Māori’ is integral to improving Māori health and honouring the Crown’s obligations under Te Tiriti o Waitangi.

- The Whanau Ora Commissioning Agency (WOCA) has always advocated that what works for Māori, is by Māori with Māori. There has only been a relatively small funding stream to allow Māori to make that happen. Tools to do this include partnership models in decision-making and a co-design approach to developing services with consumers and Māori communities. This also means building Māori capacity by giving services, organisations and staff the knowledge, tools and official sanction to do so.
- Further, develop Māori health capacity and capability through a viable Māori provider network with the resources and authority to provide Kaupapa Māori and whānau-centred models of care. This includes Māori models of health and wellbeing, rongoā (traditional healing), and innovation. These are referred to as ‘Kaupapa Māori’ models of care.
- The System needs to be led by Kaupapa Māori, where whānau have control over their own health and system itself. This will also aid tackling the ongoing institutional racism and barriers to access and quality of services for Māori.

## **10. Funding and procurement**

The funding of health services for Māori is hampered and outright undermined – the ability of the primary care sector to improve inequitable Māori health outcomes. Furthermore, Māori health services catering for Māori clients are underfunded and not fully supported by their District Health Boards, and Māori health services with high-needs clients were also under-resourced. The system has been set up to fail Māori.

- A review and assessment must be undertaken to determine the underspending by the Crown on current and past Māori providers and organisations.
- The procurement process must be more transparent and fair to Māori providers who despite being smaller than mainstream non-Māori organisations, are more equipped and experienced to lead change for Māori whānau – capability over capacity.





- The current population-based funding model is impeded where District Health Boards use Māori ethnicity as a factor to receive funding, but are not obliged to spend that money on Māori health initiatives. A **shift to a needs based model** is vital to bridge the gap in the health inequities for Māori.

## **11. Platform to support Innovation and test new models of care**

Literature and experience demonstrates a number of interventions and best practices to address the health disparities and its consequences. Unfortunately, due to lack of resourcing and buy-in, these innovative models of care are unable to scale solutions to a wider reach. In addition, there is not sufficient room to test and support innovative ideas to tackle health challenges for Māori. Some such ideas include Kaupapa models of care, mobile clinics and secondary care services, telehealth and e-health and other best practice indigenous models of care (Nuka System in Alaska). Encouragement and support for innovation is needed to tackle the ongoing challenges.

## **12. Community engagement and solutions**

We cannot emphasise enough on the role of Māori communities to promote and address health equity. The communities know best what actions are needed by the many and varied stakeholders that are part of communities or support them, as well as the root causes and structural barriers that need to be overcome. Engagement with communities on policies, identifying real issues, and designing informed solutions is key to addressing the rampant health inequities.

## **13. Workforce development**

- Addressing the under-representation of indigenous health professionals is recognised internationally as being an integral component of the overall response to addressing indigenous health inequities. We have seen some changes in the growth of Māori health workforce in the past few years, but there is a long way to go to achieve population parity. Sustained efforts to grow the Māori health workforce are needed to ensure it can meet the higher demand from a larger Māori population.
- Enable a hauora competent workforce along with more Māori in the health and disability workforce.
- Equally important is the need to build a culturally competent and culturally safe health and disability workforce. Moving from cultural competence to achieving cultural safety is fundamentally about eliminating racism and discrimination.

Equity necessarily is about ensuring justice – and eliminating unjust differences in outcomes. Unless equity is explicitly considered and understood, and legislation and strategy are updated to that effect, health inequities are unlikely to reduce. This must translate into the action plan discussed above. It is also essential that this fundamental social consensus be given expression at the policy level with multisector and urgent measures. If we do not take robust actions and initiatives now, the status quo will never change and health inequities will only get worse for our communities and for Māori.



## Concluding Remarks

For decades, there has been fundamental and consistent evidence of the health inequities amongst Māori. This submission echoes these facts, and delineates the causes of and the potential solutions to health inequities in the Māori population. It challenges the government and the health sector - to understand and address these inequities in Māori health outcomes, and calls attention to the importance and urgency for the government to take action.

Inequity is not about Māori making bad choices, genetics or accessing care - *it is a measure of unfair and avoidable differences between groups*. It is essential to take a systems view – how systems create, cause and can resolve the health inequities; how systems can be changed to better meet the needs of Māori who they are not serving well. Health equity will not just “happen” without strong commitment from government backed by strong support from all the sectors, especially the health sector. Action is needed on multiple fronts. A collective approach and a collective commitment are critical to remedying a situation that has lasted far too long. Making minor changes to a system that is designed to fail will not help in any way. What is needed is a reset of the system and the appropriate action in the right direction to make the transformation.

This inquiry will only significant change inequity, if there is an action following it. Enacting with an evidence informed discussion with Māori and an action plan for Māori will support the government and health sector to understand and mitigate these avoidable health inequities amongst the Māori population. We expect a range of work to emerge from this inquiry and acknowledge the role of Māori communities and Whānau Ora and Health and Social Providers in supporting system changes and providing solutions. As the Whānau Ora commissioning Agency, we extend our support and participation in the process to take action and provide solutions for our communities.

