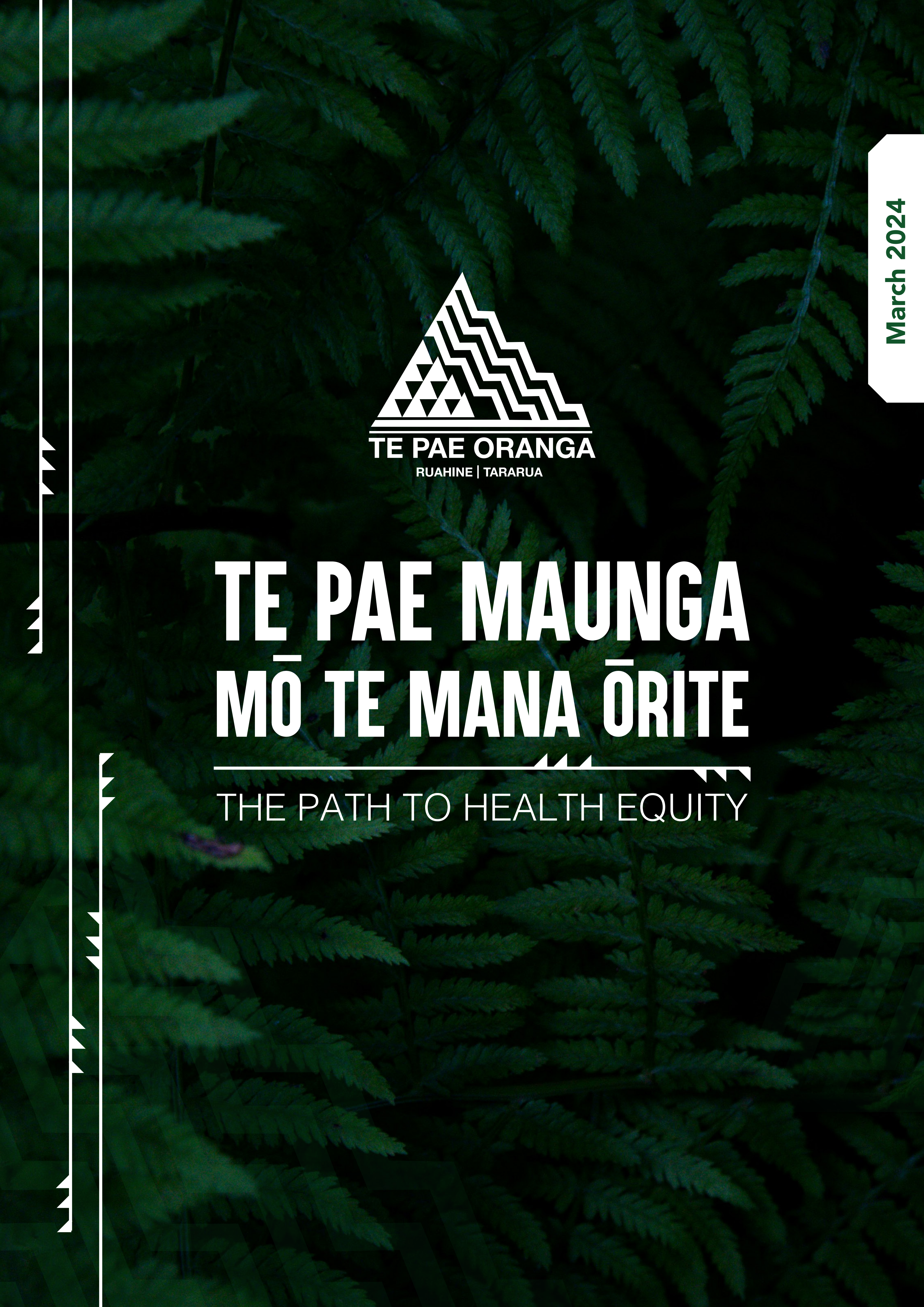
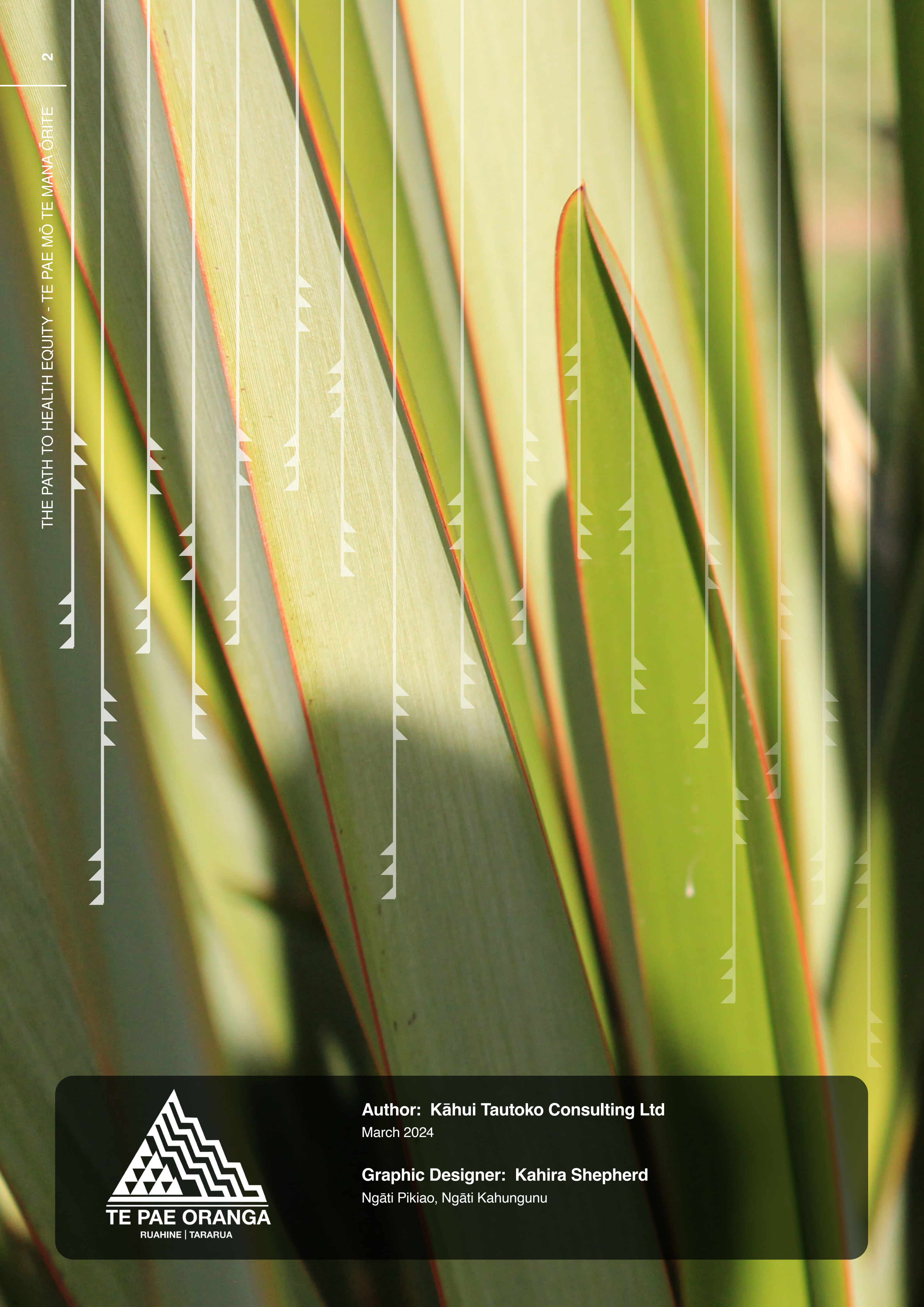


TE PAE ORANGA
RUAHINE | TARARUA

TE PAE MAUNGA MŌ TE MANA ŌRITE

THE PATH TO HEALTH EQUITY

March 2024



TE PAE ORANGA
RUAHINE | TARARUA

Author: Kāhui Tautoko Consulting Ltd
March 2024

Graphic Designer: Kahira Shepherd
Ngāti Pikiao, Ngāti Kahungunu

Te Pae Oranga o Ruahine o Tararua Iwi Māori Partnership Board endorses this document:

"Te Pae Maunga mō te Mana Ōrite: The Path to Health Equity"

Oriana Paewai
CHAIR

Ngā kupu whakamihi - ACKNOWLEDGEMENTS

Te Pae Oranga o Ruahine o Tararua acknowledges the past and present whānau who have and continue to guide our priorities, enabling us to focus our efforts on where it needs to be. We continue to hear that we must ensure every Māori individual and whānau within our Takiwā (region) has access and receives healthcare irrespective of their circumstances and environment. Furthermore, this report would not have been as comprehensive without the open sharing of information from our whānau of which we are so humbled to support.

We would also like to acknowledge the Palmerston North Regional Hospital who have demonstrated their commitment, hard work, and dedication to ensure we make progress towards addressing equity. The commissioning of this report is an example of their investment in collaborative and partnership-based efforts to utilise equitable approaches and achieve improved health and wellbeing.

Source image: David Maunsell_Unsplashed

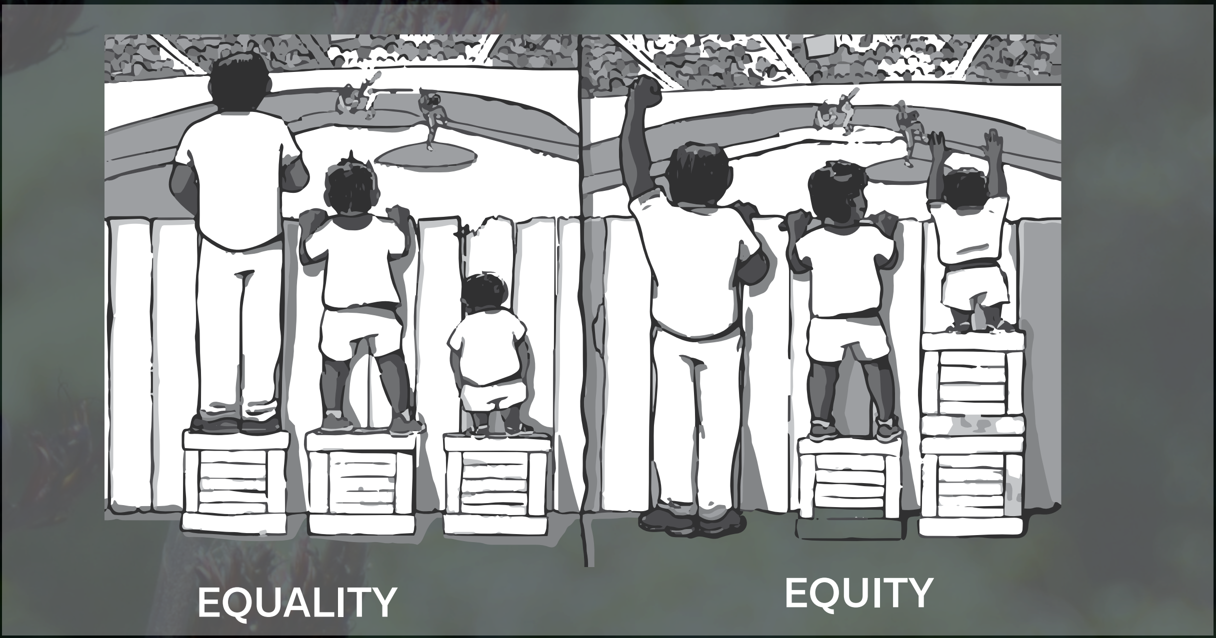
Cover source image: Kendal_Unsplashed
Inside cover: David Maunsell_Unsplashed

Te kupu takimua -
FOREWORD

Te Pae Oranga o Ruahine o Tararua is honoured to present our Te Pae Maunga mō te Mana Ōrite equity plan as a means of creating an equitable approach to improving the health and wellbeing of the Palmerston North, Manawatū, Tararua, Horowhenua and Otaki communities, with a special emphasis on whānau Māori.

To truly reflect transformational change, it requires us to have a sharpened focus on the things that will make the biggest difference for whānau and work with our partners to find those solutions to improve equitable health outcomes for every individual. This does not require us to 'be' the solution but to empower whānau with the tools, information, and options for them to make an informed decision about what is available to them.

We are committed to leveraging off the platform that we have built up over the past years and strive to accelerate change for our whānau through equitable opportunities that improves access to healthcare that is culturally safe and whānau-centred. These inequities have persisted for decades. It is time to take intentional, proactive, and deliberate action to finally take these inequities seriously and address the ever-widening gap between the health status of non-Māori, non-Pacific, and low income whānau. It is our responsibility and our moral duty to do so with urgency.



Rārangi Kaupapa

Contents page

Source image: Claire Kelly_Unsplashed

Ripanga Kaupapa

List of Tables

Papakupu -

Glossary

Term	Definition
Hāpori Māori	Māori community
Hapū	Section of a large kinship group and the primary political unit in traditional Māori society, consisting of a number of whānau sharing descent from a common ancestor
Hauora Māori	Māori philosophy of health and wellbeing
Iwi	Extended kinship group or tribe descended from a common ancestor and associated with a distinct territory
Kaitiakitanga	Guardianship
Kaupapa Māori	Māori ideology, approach, and customary practice
Mātāwaka	Māori who reside in an area who are not mana whenua but are from a hapu / Iwi from another area
Manaakitanga	Generosity
Mana Motuhake	Exercising self-determination and control over one's destiny
Mana whaikaha	Disability support services system
Manawhenua	Māori who belong to a specified hapu / Iwi area and have authority over that area
Mātauranga Māori	The body of knowledge originating from Māori ancestors, including the Māori worldview and perspectives, Māori creativity, and cultural practices
Pasifika	A person or peoples of Pacific Island descent
Pūkengatanga	Knowledge
Rangatiratanga	Chieftainship
Tangata Whaikaha	Disabled Peoples or people who are determined to do well
Tangata Whaiora	Refers to a person seeking health (acknowledgements to Professor Mason Durie)
Te Reo Māori	Māori language
Te Tiriti o Waitangi	The Treaty of Waitangi
Tino Rangatiratanga	Self-determination, sovereignty, and autonomy
Ūkaipōtanga	Home
Wairuatanga	Spirituality
Whānau	Family or families
Whakapapa	Genealogy
Whānau Māori	Māori family or families
Whanaungatanga	Family

Ripanga Kaupapa

List of Tables

Whakapoto - Abbreviation	Abbreviation Definition
IGPS	Interim Government Policy Statement on Health 2022-24
IMPB	Iwi Māori Partnership Board
PHO	Primary Health Organisation
RHWP	Te Ikaroa (Central) Regional Health and Wellbeing Plan
Te Tiriti	Te Tiriti o Waitangi (The Treaty of Waitangi)
The Act	Pae Ora (Healthy Futures) Act 2022
WAI 2575	The Waitangi Tribunal Health Services and Outcomes Inquiry

Source image: Lou Lou B_ Unsplashed

Te kupu Whakataki

Introduction

Purpose

This report outlines the equity priorities and expectations of Te Pae Oranga o Ruahine o Tararua – the Iwi Māori Partnership Board (IMPB) for equity in relation to the Palmerston North Regional Hospital development. The equity expectations that are presented in this report are proposed to guide the Palmerston North Regional Hospital's transformational change to develop a pro-equity hospital and specialist health system for the district.

Scope

The scope of this equity plan was intended to focus on achieving or working towards equity for the Palmerston North Regional Hospital development, however equity cannot be achieved alone by just focusing on hospital and specialist services that might be planned for the site. Hospital services cannot work effectively alone without a strong connection to robust primary and community care services – before and after accessing and utilising hospital services.

For instance:

» if there are insufficient primary care services in the community, then likely the use of emergency departments as a proxy for primary care increases, and patients may use the hospital system inappropriately because of poor access to primary care

» if we do not have a strong referral system to and from our hospitals back to community-based services, then people may end up being re-admitted needlessly

» if we do not have a welcoming accepting and culturally safe hospital environment, then some people will not attend booked appointments in the hospital

» if people cannot reach the hospital because of access challenges, then a wonderfully efficient hospital becomes ineffective for whānau

» if we do not think about what services are best delivered from a hospital site rather than a community-based site, then we are not giving proper consideration to how best to make services meet the needs of whānau, rather than designing a hospital to meet the needs of people who work in the 'system'

» if we do not support the strengthening of Iwi and Māori services, and mana whenua in the community, then we lose an opportunity for those closer to whānau, to support, inform, educate, and advocate for their more seamless and efficient use of the health system (including hospital services)

In other words, we need to think about equity and the hospital development from a broad perspective and not constrain ourselves to thinking about hospital-delivered services alone. We need to know the 'right' services are delivered in the hospital, and not just repeat what has been done before. Inequity data shows that the past forms of design and delivery have not worked for large sectors of the population – this is an opportunity to ensure we get the whole interconnected system right, and not just one part of it.

As a result, some of the recommendations in this plan go beyond direction to the hospital development and asks the 'system' to think about how best to support the hospital development and proposed model(s) of care – to align them to what will be easier and culturally safer for whānau. That may mean revisiting how some current centralised hospital-located services are delivered, and investigating whether these should be delivered at more community-based locations to make it easier for whānau.

Methods

The report includes the following:

- **Review of strategic documents and frameworks**
  An overview of the relevant strategic documents and frameworks to establish the service landscape that supports the MidCentral district and build the foundations for our key focus areas and priorities.
- **Information and analysis of the communities we serve**
  A summary of existing statistics and information for the communities we serve as well as an analysis of this information to help us identify the demographic landscape and local health challenges. Some of this came from Te Aka Whai Ora and some data came from Te Whatu Ora.
- **Our equity expectations and recommendations**
  A description of the equity expectations and recommendations we propose to support defining equity and determining opportunities to reach and maintain equitable services that are grounded in tikanga and kawa. These have been aligned to the strategic priorities in our Strategic Plan.

Limitations

The scope did not include an extensive consultation process as this had already been completed prior to this plan and was summarised for the Te Ika Roa Regional Health and Wellness Plan (RHWP). Therefore, the engagement findings from the RHWP were utilised for this report.

All data was provided by Te Whatu Ora and Te Aka Whai Ora covering different periods and timelines.

There was insufficient time allowed to produce this equity plan, which would have enabled a complete overhaul and updating of all of the data that was supplied to reflect more recent status. For instance, Te Aka Whai Ora's Health Profile for IMPBs used different dates for data than Te Whatu Ora's data for various services. Existing documents that were supplied were used as the primary sources of information and no new studies were commissioned for this report. One of the recommendations in this report is to update the last 2018 Health Equity report so that there is a consistent reflection of the status of inequities across a range of indicators.

Summary

It is proposed that the information presented in this report sets a regional standard for equitable health services that is informed by local insights and approaches. The need for equitable healthcare is a priority for the IMPB as whānau Māori are a key group disproportionately impacted by poor health outcomes. The need for equitable healthcare is also a priority for the Palmerston North Regional Hospital and the Pae Ora Act stresses an obligation to honour the Te Tiriti principles.

Source image: Annie Spratt_Unsplashed

Te Pae Oranga o Ruahine o Tararua –

Iwi Māori Partnership Board

About Te Pae Oranga o Ruahine o Tararua Iwi Māori Partnership Board

Iwi Māori Partnership Boards (IMPBs) are legislated bodies established through an Order in Council process in the Act. IMPBs represent local Māori perspectives about the needs and aspirations of Māori within their rohe or coverage area and monitor system performance against these needs and aspirations. The IMPBs make sure the voices of whānau Māori, including Tāngata Whaikaha, are uplifted and made visible within the health system. IMPBs have a key role in determining locality priorities and embedding mātauranga Māori within locality plans, which influence and inform regional and national planning.

Te Pae Oranga o Ruahine o Tararua was formally recognised under the Pae Ora (Healthy Futures) Act 2022 together with 14 other Iwi Māori Partnership Boards (IMPBs). Te Pae Oranga o Ruahine o Tararua covers the same area as the former MidCentral District Health Board (DHB) rohe i.e. Horowhenua, Manawatū, Papaioea, Ōtaki and Tararua. The IMPB represents the hauora interests of over 45,000 Māori. Te Pae Oranga o Ruahine o Tararua is comprised of a representative from each of the seven iwi that are tangata whenua in the rohe, two mātāwaka representatives and a mana whaikaha representative.

Te Pae Oranga o Ruahine o Tararua IMPB is responsible for exercising tino rangatiratanga on behalf of the local iwi in their engagement with the current health system. We support planning around the health needs, aspirations, and priorities of whānau, hapū, iwi and hapori Māori within our coverage area.

The Te Pae Oranga o Ruahine o Tararua IMPB membership represents the following Iwi and groups:

- Kahungunu ki Tāmaki nui-ā-Rua
- Rangitāne o Tamaki nui-ā-Rua
- Rangitāne o Manawatū
- Ngāti Kauwhata
- Te Kotahitanga o Te Reureu
- Muaūpoko
- Ngāti Raukawa ki te Tonga
- Tāngata Whaikaha
- Mātāwaka

Source image: Duskfall crew_Unsplashed

Our Foundations

Te Pae Oranga o Ruahine o Tararua 10-Year Strategic Plan sets out our vision, mission, core values, and strategic priorities for the services we provide to our whānau, hapū, iwi and communities.

Our Vision is “to support whānau control of their own Hauora outcomes by acknowledging their lived experiences and supporting them with the tools and opportunities to participate and be successful. Our mission is “to influence and advance Hauora Māori planning, commissioning, monitoring, and success across our rohe’s wellbeing sector through a mātauranga Māori lens underpinned by whānau voice. Our core values are rangatiratanga, kaitiakitanga, manaakitanga, whanaungatanga, whakapapa, ūkaipōtanga, pūketanga, wairuatanga and te reo Māori

We have used these components of the Strategic Plan to guide us in developing this report and its recommendations, including by maintaining a focus on our vision and mission, underpinning our findings and recommendations with our values and applying our strategic priorities to recommending equity actions and improvements.

Our Strategic Plan

As the recognised IMPB for the district in the Act, Te Pae Oranga o Ruahine o Tararua IMPB was required to develop a strategy to respond to statutory requirements. In October 2023, Te Pae Oranga o Ruahine o Tararua IMPB developed and confirmed our 10 Year Strategic Plan. In addition to specifying a vision, mission and values centred on empowering whānau to be self-determining and achieve their hauora aspirations, the strategy commits to seven priorities that align with the priorities of Pae Tū. These priorities are described in the table below and act as the basis for how we will achieve equity for Māori and other groups.

source image: Cameron Witney

Table 1: IMPB Strategic Priorities

Te Pae Oranga IMPB Strategic Priority	Aligned to Pae Tū Hauora
1. **Whānau Voice** We place whānau at the heart of our IMPB by providing opportunities for whānau voice to be embedded across the health sector and will elevate whānau voice across all aspects of service planning, design, delivery, review and change in our rohe.	**Pae Tū Priority 1:** Enabling whānau, hapū, iwi and Māori community leadership, decision-making and governance at all levels.
2. **Te Tiriti o Waitangi** Exercising a Te Tiriti based relationship that honours the mana motuhake of iwi, hapū and whānau in our relationship with the Crown and ensuring those we work with do the same in accordance with our expectations for what such a relationship means in action.	**Pae Tū Priority 2:** Strengthening whole-of-government commitment to Māori health.
3. **Accountability** Making all parts of the system accountable on behalf of our iwi, hapū, whānau and communities.	**Pae Tū Priority 5:** Ensuring accountability for system performance for Māori health.
4. **Planning** Providing and participating in key health and social services planning locally, regionally, and nationally, focusing on the priorities identified through the locality planning processes and whānau voices across our rohe.	**Pae Tū Priority 3:** Growing the Māori health workforce and sector to match community needs.
5. **Data Collection and Analysis** Developing greater use of digital services by gathering, collating, analysing and reporting on whānau outcomes.	**Pae Tū Priority 5:** Ensuring accountability for system performance for Māori health.
6. **Monitoring and Improving** Monitoring the system and contributing to its improvement to address inequities in health and wellbeing outcomes for Māori.	**Pae Tū Priority 5:** Ensuring accountability for system performance for Māori health.
7. **Commissioning and Contracting** Working in partnership with funders and investors for the commissioning of health and wellbeing across our rohe focusing on addressing issues of access, racism and discrimination for whānau.	**Pae Tū Priority 4:** Enabling culturally safe, whānau-centred, and preventative primary health care.

These priorities also align with those highlighted within the health sector reforms. Establishing these priorities emphasises the inequitable reality of the current health system. These priorities inform the operations of Te Pae Oranga o Ruahine o Tararua IMPB.

Te Rautaki -
Relevant Strategic Documents and Frameworks

Recent health reforms

Significant reforms of New Zealand's health system were enacted on 1 July 2022. These reforms focussed on coordinating a simpler health system that would tackle the challenges of the past system by:

- Delivering a single nationwide health service that is people-centred, equitable, accessible, and cohesive
- Providing high quality health services for everyone, particularly groups who have historically been underserved.

To achieve a simpler health system, the 20 District Health Board (DHBs) and 30 Primary Health Organisations (PHOs) were merged into two new entities:

- **Te Whatu Ora (Health New Zealand)** manages all health services within the hospital, specialist services, and some primary and community care. Hospital and specialist services are planned nationally and delivered more consistently across the country
- **Te Aka Whai Ora (the Māori Health Authority)** was established to monitor Māori health outcomes and advocate for mana motuhake in the health system. Two of the key functions of Te Aka Whai Ora include providing administrative support to IMPBs and to advocate for an equitable health system.

Source image: Ellie Burgin_ Pexels

Te Whatu Ora is the organisation responsible for delivering hospital and specialist services to our community.
The Palmerston North Regional Hospital is situated in the centre of the Central Region. The Central Region comprises the areas encompassed by Capital & Coast, Hawke's Bay, Hutt Valley, MidCentral, Wairarapa and Whanganui districts of Te Whatu Ora.
As a regional provider of cancer services, the MidCentral site also provides care beyond the Central Region to Taranaki.
It also provides a range of other specialist services to other districts, particularly Whanganui and increasingly Wairarapa.

The aforementioned groups and organisations are responsible for ensuring the provision of services within the district. This report is proposed to be a tool that can guide health service developments across the rohe to achieve and maintain equity.
The provision of hospital and specialist services is undergoing change as the system moves to an integrated network hospital basis. During this time, Palmerston North Regional Hospital is planning major capital investment to address issues with hospital buildings that significantly constrain the current delivery of health care. A fundamental outcome of the new health system, and the investment in Palmerston North Regional Hospital, is addressing existing health inequities and inequality.

To inform this investment process, a Clinical Services Plan is being developed. This sets out the services to be provided based on the district's health needs, forecast population growth, and the hospital's role within the Central Region.

The plan will also confirm the models of care that will be used to deliver the necessary services. The purpose of the plan is to enable Palmerston North Regional Hospital to better address the persistent inequity experienced by Māori and other minority population groups – primarily Tāngata Whai Ora and Pasifika Peoples. The Clinical Services Plan for Palmerston North Regional Hospital sets out at a strategic level what needs to be achieved. It is crucial Te Pae Oranga and Iwi are involved in this plan and consultation that occurs is not tokenistic but is authentic in order to lead to real change for Māori.

This report is complementary to the plan and aims to provide guidance to transform our hospital and specialist services into a pro-equity service and system.

Te Tiriti o Waitangi

Te Tiriti and the partnership between iwi Māori and the Crown has been a journey for several decades with its challenges and fluctuating outcomes. In 2017, the Waitangi Tribunal made the decision to proceed with a thematic inquiry on the health system entitled WAI 2575 – The Health Service and Outcomes Inquiry. The Inquiry brought forth approximately 200 claims and the Hauora Report in 2019 which captures the Waitangi Tribunal's findings and recommendations.

In response to the Inquiry, and to give effect to Te Tiriti in the context of health, a series of principles were recommended in the Waitangi Tribunal's Hauora Report. These principles are also reflected in the 'Health Sector Principles' set out in section 7 of the Pae Ora (Healthy Futures) Act 2022 (the Act). The following principles provide a framework for meeting Crown-Te Tiriti obligations to uphold Māori rights to health that we are committed to:

» **Tino rangatiratanga:** A guarantee of the provision of Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services

» **Equity:** A commitment to achieving equitable outcomes for Māori and acknowledging that people with varying levels of advantage require different approaches and resources to attain equitable health outcomes

» **Active protection:** A requirement to act in earnest to achieve equitable health outcomes for Māori with informed knowledge of the extent and nature of health outcomes of Māori

» **Options:** Provision of resourced Kaupapa Māori health and disability services and an obligation to deliver all services in a culturally appropriate way that recognises and supports hauora Māori models of care

» **Partnership:** A requirement to effectively partner with Māori in the governance, design, delivery and monitoring of health and disability services.

This report is an attempt at interpreting the Te Tiriti principles within the Act. It provides direction to achieve the principles outlined above, particularly the principle of equity.

Te Pae Oranga o Ruahine o Tararua IMPB are committed to establishing and maintaining equity on behalf of the Iwi who formed our rōpu.

National Level

The establishment of New Zealand's new health system led to a refreshed strategic approach to health and healthcare. The Act introduced a new legislative framework for New Zealand's health and disability system. The reformed system is an attempt to shift to a more holistic, whānau-focussed wellness model. It prioritises delivering an equitable, accessible, cohesive and people-centred health system. It moves away from the provider-centric sickness model of the Health and Disability Services (Safety) Act 2001. In July 2023 the Ministry of Health released their Māori

Health Strategy called Pae Tū Hauora. The strategy was developed between the Ministry of Health and Te Aka Whai Ora to progress the momentum of its He Korowai Oranga Māori Health Strategy and Whakamaua Māori Health Action Plan 2020–2025. Pae Tū reaffirms the vision of Pae Ora – Healthy Futures for Māori, and the four outcomes set out in Whakamaua (2020) of Pae Ora (healthy futures for Māori), Whānau Ora (healthy families), Mauri Ora (healthy individuals), and Wai Ora (healthy environment).

The Interim Government Policy Statement on Health 2022-24 (IGPS) provides the public statement of what Government expects the health system to deliver and achieve over the next two years, and Te Pae Tata – The Interim New Zealand Health Plan 2022 outlines the first steps to becoming a health service delivery system that better serves all New Zealand's peoples and communities. These two documents combined with the Act provide a strategic foundation that focusses on embedding Te Tiriti in New Zealand's health and healthcare.

The Act sets out the broad objectives of the public health sector, to:

» protect, promote, and improve the health of all New Zealanders

» achieve equity in health outcomes among New Zealand's population groups, including by striving to eliminate health disparities, in particular for Māori

» build towards pae ora (healthy futures) for all New Zealanders.

The IGPS is a public statement that outlines the Government's expectations on the performance of the health sector. It identifies six priorities for New Zealand's public health system that include:

» Achieve equity in health outcomes

» Embed Te Tiriti o Waitangi across the health system

» Keep people well in their communities

» Develop the health workforce of the future

» Lay the foundations for the ongoing success of the health system

» Ensure a financially sustainable health system.

Te Pae Tata was a joint development between Te Whatu Ora and Te Aka Whai Ora to outline the necessary actions for the system to achieve the Government's six health sector priorities. The interim plan is relevant until July 2024 when it will be replaced by a substantial three-year health plan.

Engagement with stakeholders (agencies and community) during the reforms resulted in the publication of five population-specific strategies, including:

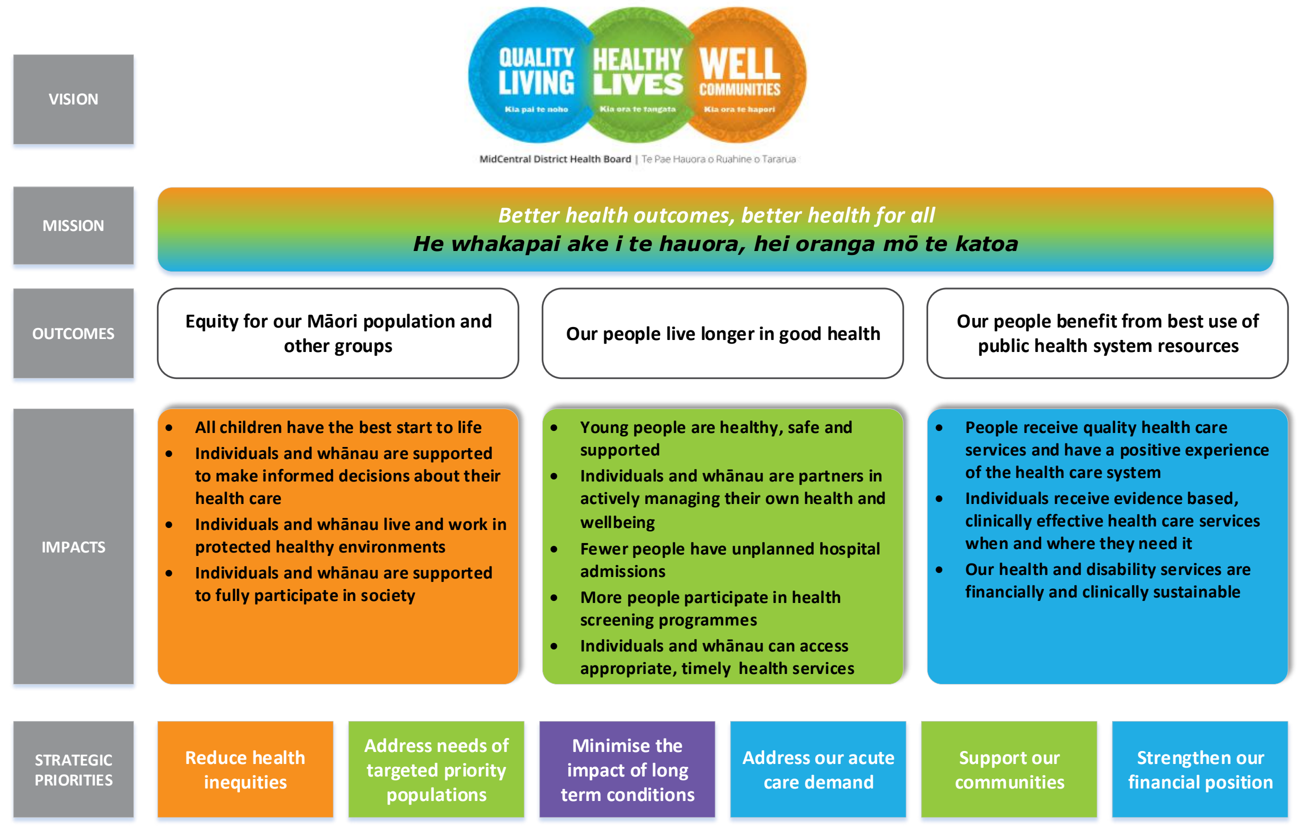
» Pae Tū – Hauora Māori Strategy
» Te Mana Ola – The Pacific Health Strategy
» Health of Disabled People Strategy
» Women's Health Strategy
» Rural Health Strategy.

The strategic documents that have been established as part of the health reforms all emphasise the importance of equity in the delivery of health services. This report is Te Pae Oranga o Ruahine o Tararua IMPB's attempt at interpreting and implementing the strategic priorities of the health sector.

Regional level planning priorities

The MidCentral regional health services are guided by their Strategic Plan which sets out a vision, mission, outcomes, impacts and strategic priorities:

Table 2: Strategic Framework: MidCentral regional health services



VISION

QUALITY LIVING Kia pai te noho
HEALTHY LIVES Kia ora te tangata
WELL COMMUNITIES Kia ora te hapori
MidCentral District Health Board | Te Pae Hauora o Ruahine o Tararua

MISSION

Better health outcomes, better health for all
He whakapai ake i te hauora, hei oranga mō te katoa

OUTCOMES

Equity for our Māori population and other groups	Our people live longer in good health	Our people benefit from best use of public health system resources

IMPACTS

All children have the best start to life Individuals and whānau are supported to make informed decisions about their health care Individuals and whānau live and work in protected healthy environments Individuals and whānau are supported to fully participate in society	Young people are healthy, safe and supported Individuals and whānau are partners in actively managing their own health and wellbeing Fewer people have unplanned hospital admissions More people participate in health screening programmes Individuals and whānau can access appropriate, timely health services	People receive quality health care services and have a positive experience of the health care system Individuals receive evidence based, clinically effective health care services when and where they need it Our health and disability services are financially and clinically sustainable

STRATEGIC PRIORITIES

Reduce health inequities	Address needs of targeted priority populations	Minimise the impact of long term conditions	Address our acute care demand	Support our communities	Strengthen our financial position

Figure 1: MidCentral District Health Board Outcomes Framework

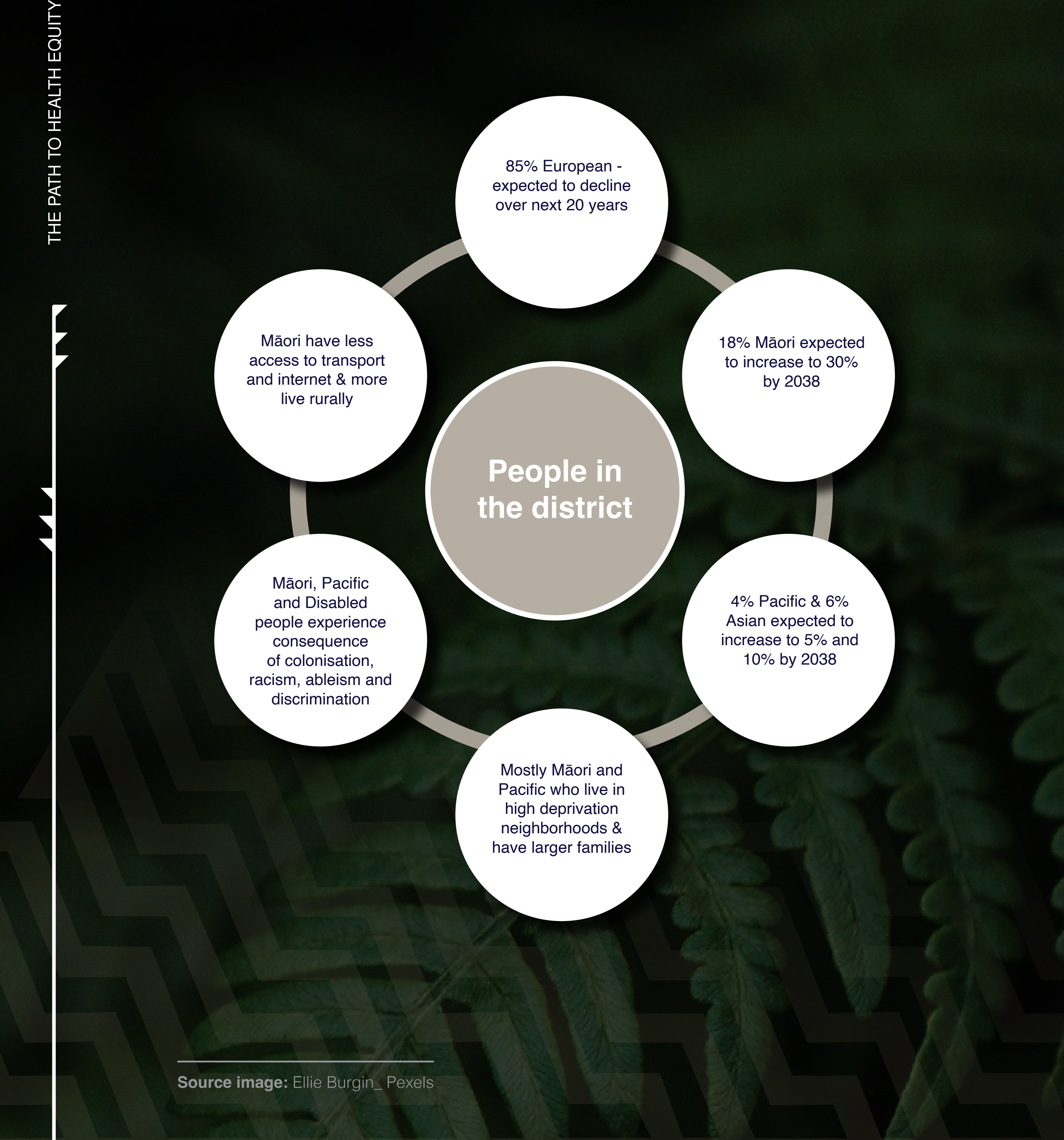
One of the key outcomes in the Strategic Plan to achieve the mission is focussed on achieving equity in the provision of healthcare. The importance of equity is also echoed in the strategic priorities. In summary, the strategic plan emphasises the importance of equity by highlighting the need to:

» Prioritise reducing health inequities
» Focus services on the needs of priority populations within the community
» Reform service provision to improve service delivery and outcomes
» Refine operations to improve the financial position of the organisation.

Tātaritanga –
Population and health need

A full profile of health needs and demographic data is at Appendix 1.

Key highlights from the data are as follows:



People in the district

- 85% European - expected to decline over next 20 years
- 18% Māori expected to increase to 30% by 2038
- 4% Pacific & 6% Asian expected to increase to 5% and 10% by 2038
- Mostly Māori and Pacific who live in high deprivation neighborhoods & have larger families
- Māori, Pacific and Disabled people experience consequence of colonisation, racism, ableism and discrimination
- Māori have less access to transport and internet & more live rurally

Source image: Ellie Burgin_ Pexels

Health & wellbeing of people in the district

Māori have lower life expectacy than non-Maori

More Māori die from avoidable causes than non-Maori

Circulatory and respiratory diseases, diabetes and cancers impact the most

More Māori have lower incomes; are unemployed; and have poor quality housing

Pacific and Asian face health literacy, language and cost/ transport barriers

Key health conditions with equity challenges

Cancer

- Around 20% more Māori are likely to develop cancer and nearly twice as many likely to die compared to non-Māori
- Once diagnosed, Māori experience poorer survival than non-Māori for 23 of the 24 most common cancers.
- Pacific people also experience a higher incidence of and mortality from cancer compared with non-Pacific people

Chronic health conditions

- One in four New Zealanders lives with multiple chronic health conditions that are often experienced by several generations in the same whānau, such as diabetes, heart disease and stroke.
- The greatest burden of chronic conditions is experienced by Māori and Pacific people, who develop these conditions 10-20 years earlier than non-Māori and non-Pacific.
- Māori and Pacific are significantly less likely to receive treatment for gout than Europeans, even though the rates of gout in Māori and Pacific are much higher than Europeans
- Access to dental care is challenging for many adults, especially those on low incomes or living in remote areas. There are disparities in oral health outcomes between different population groups, including Māori and Pacific communities

Tāngata Whaikaha Māori and Disabled People

» Approximately one in four people in Aotearoa New Zealand report that they have a disability

» 40,064 people in New Zealand receive disability support - of these, 49% had a learning disability, 27% autism disorder, and 21% physical disability as their main disability (of the 40,064 – an estimated 2,311 are in Manawatu-Whanganui area)

» Today, disabled people in Aotearoa New Zealand experience a wide range of inequities when accessing health services, and poorer health outcomes compared to non-disabled people.

» Inequities in access to healthcare are worse for Tāngata Whaikaha, Pacific people with disabilities, and disabled people from other minority groups.

Te reo o te tangata me te hāpori -

Whānau voice

The Regional Health and Wellbeing Plan for Te Ikaroa Central (RHWP) is currently under development to describe key actions and milestones for the region that embed Te Tiriti and achieve equity for Māori, Pasifika and Tāngata Whaikaha. In developing the RHWP, significant community engagement was undertaken and captured to inform the priorities, actions and milestones set out in the report. Given the close alignment between the goals of the RHWP and Te Pae Oranga o Ruahine o Tararua's equity plan, and to avoid duplication of efforts by the community to provide their insights and perspectives on equitable approaches, we have drawn on the community voices captured in the RHWP to inform this report.

The community voices captured in the RHWP were captured through significant community engagement undertaken by iwi, providers, Te Whatu Ora and the former DHBs. The below sub-sections express the common themes from this engagement about what was important for whānau to lead happy and healthy lives and discusses how it relates to achieving our goal of pro-equity approaches.

Pae Ora Themes

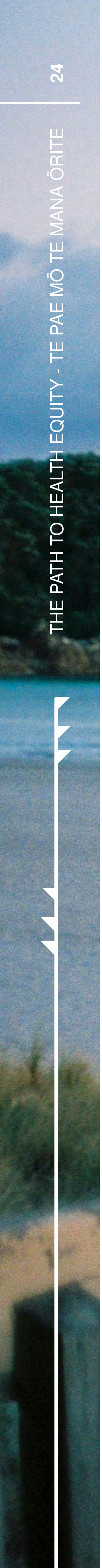
- **Factors influencing people's health:**
  We received significant feedback about the wide range of factors that influence people's health outcomes and their access to, and experience of, health services. These included safe and warm housing, access to affordable and healthy food, sleep hygiene, and connection with whānau, whakapapa and whenua. We also consistently heard that cost of living is a barrier is good health - for example, the high density of alcohol and fast-food outlets in more deprived areas.

- **Preventive models of healthcare:**
  Across engagements, there was strong agreement on the need focus on preventing, reducing and delaying the need to healthcare, including through health promotion and preventing, reducing and delaying at the need for healthcare, including through health promotion and preventive interventions. Examples included offering a range of mental health supports, including alcohol and other drug treatment services, and 'green prescriptions' to support physical activity and improve diets through healthy food choices.

- **Culturally appropriate services:**
  Many people from Māori, Pacific and ethnic communities expressed difficulties navigating the health system. A lack of cultural diversity and integration mens that people from these communities are expected to navigate a health system that has been shaped by European world-views. For example, the use of clinical teminology was often found to be stigmatising and difficult to understand. Many people expressed their aspiration for the health system to better reflect te ao Māori and honour Te Tiriti o Waitangi.

- **A life-course approach to population health:**
  Feedback from across the engagement reflected a desire for the health system to adopt a 'life-course' approach that considers all aspects of health from birth to old age. This includes age transitions and associated health changes, such as puberty and menopause. Many people emphasised the importance of pregnancy and the early years, noting this as a critical period that has a profound effect on long-term health and wellbeing outcomes, This was also particularly expressed by Māori communities as a key opportunity to support inter-generational expriences of health.

The feedback regarding the wider range of factors that impact upon people's health, combined with the statistics showing Māori have poorer education, income, employment and housing outcomes, signal a clear inequity in broader holistic outcomes for Māori and non-Māori. In addition, the feedback signalling a need for preventative, culturally appropriate and life-course support is a way in which healthcare providers can undertake an equitable approach to reducing the negative outcomes and statistics for Māori and potentially other groups impacted by inequity.



Kahu Taurima

(First 2,000 days) Themes

- **Address equity gaps** for hapū māmā and pēpi care, including access to healthcare, lower rates of immunisations and kaupapa Māori services.
- **Address equity gaps:** There are gaps in maternal mental health services. Better support and pathways are needed for whānau dealing with family violence, trauma and alcohol/ drug misuse. Community needs models of breastfeeding educaation/ suport that are sustainable, culturally appropriate and whānau-focussed.
- **Provide alternate options** to mainstream health services that provide tailored support and care for Māori, Pacific and disabled people. Support advancement of kaupapa- Māori based maternal care options. Tailored antenatal education work for Māori, Pacific and young māmā is well accepted and accessed by women. Antenatal education content to reflect and incorporate needs of disabled communities. Provide enabling care and wraparound services for disabled people.
- **Improve health literacy and understanding:** Build understanding of antenatal programmes for mums and whānau with stakeholders. Increase community language/ literacy and consumer knowledge of local services - preferred access point for information is online. Encourage and improve communication between health professionals working directly with māmā, pēpi and whānau. Improve cultural competency, and health literacy to access pathways and services.
- **Improve access** to services, including urgent care services. Improved access to mental health support. Better resourcing for primary care providers to increase early access to care and help ensure people are enrolled in primary care services.
- **Improve coordination** between services. Improve referral pathways. Place women, children and families at the centre of care. Create a sense of ‘village’ through a one-stop-hub as an opportunity to build collective community engagement and trust with health services. Identify and acknowledge the interconnectedness between similar programmes.
- **Increase workforce support and education** with pathways to be inclusive of whānau/ hapū/ iwi knowledge and expertise. Lack of disability rights training: barrier to the delivery of good maternity care. Increase Violence Prevention training opportunities. Grow breastfeeding expertise among providers working with Māori and Pacific communities and families with disabilities. Embed and sustain a peer-led system of training and education for breastfeeding.

A significant area where community feedback signalled inequities in healthcare services was maternity care and support. Inequities across maternity care is a significant issue as it can cause direct and indirect impacts on the longer-term health and wellbeing of the entire whānau, particularly mothers and their children such as alcohol addiction leading to foetal alcohol syndrome or damp housing leading to childhood respiratory illnesses.

Community feedback signalled key areas across maternity care which could be provided to reduce inequities, including providing alternative options, improving health literacy and understanding, targeted access, integrated service pathways and workforce capability development.

Source image: Ben Bell_ Unsplashed

Mate Pukupuku

(Cancer) Themes

Outcome 1: ***A consistent and modern cancer care system - Key Whānau Insights:***

- Kāwanatanga - empower shared decision-making and co-design
- Kotahitanga - increase collaboration between cancer leaders and the community
- Tino Rangatiratanga - Māori cancer leadership is needed at every level
- The Māori cancer workforce needs growth and support
- The cultural capability of the non-Māori cancer workforce needs to improve
- Mātauranga Māori must be supported throughout the cancer workforce
- Whānau want rangatiratanga over their cancer data
- Whānau information needs must be addressed
- Innovative, whānau-centred care is needed.

Outcome 2: ***New Zealanders experience equitable cancer outcomes - Key Whānau Insights:***

- Integrate mātauranga Māori throughout the cancer journey
- Rongoā is important to whānau
- The current system isn't designed for Māori
- Whānau regularly experience racism and discrimination
- Many whānau need cancer navigation services
- Diagnosis can be unnecessarily traumatic
- Whānau deserve to be treated with empathy
- Utilise the expertise of cancer survivors.

Outcome 3: ***Cancer Prevention - Key Whānau Insights:***

- Whānau look at prevention holistically
- Increase kaupapa Māori prevention and health promotion
- More work is needed on smoking
- Preventing infectious illnesses is critical
- More knowledge is needed on workplace carcinogens.

Outcome 4: ***Cancer survival, supportive care and end-of-life care - Key Whānau Insights:***

- Improvement is needed in early detection
- Whānau face multiple barriers to primary care
- Whānau struggle to trust primary care professionals - appointments are too short for whakawhanaungatanga (building connections)
- Treatment doesn't feel fair
- Screening should be more patient-centred
- Effective supportive care models reflect the te ao Māori worldview
- Cancer creates many financial barriers for whānau
- Whānau feel forgotten when treatment ends
- More conversation is needed on palliative care and end-of-life-care.

Community feedback was provided across the spectrum of cancer healthcare and support. Whānau recommended implementing a modern cancer care system that is grounded in kaupapa Māori principles that empower them to take control of their cancer journey. This feedback was helpful to consider that inequity, especially for Māori as a colonised population, can sometimes be caused through paternalistic approaches as opposed to self-determining approaches to healthcare. Whānau also suggested alternative and traditional health management approaches, such as Rongoa Māori, are available to support cancer patients.

What is particularly relevant to Palmerston North Hospital and Specialist services is that Palmerston North hosts one of the regional cancer centres that serves whānau, hapū and Iwi not just from the MidCentral coverage area, but also from other areas such as Hawkes Bay and sometimes Tairawhiti. With the high levels of Māori population across all of these areas, the need for culturally safe access to cancer prevention, treatment, rehabilitation and end of life care is critical.

Māuiuitanga Taumaha

(Long-Term Conditions) Themes

- **Culturally responsive care -** Participants expressed the need for more culturally responsive care, noting that there is currently a lack of commitment or dedication to considering patients' cultural beliefs, practices and communities.
- **Cost of services -** The cost of appointments, treatment and travel is outlined as a major barrier to accessing healthcare - including dental care. The cost of specialist treatment often discourages members of our community from getting the care they need.
- **Travel from rural areas -** Participants noted that due to location of services, travel from rural areas into cities/townships isn't always easy, time efficient or affordable.
- **Longer wait times -** The demand and pressures on our healthcare system has led to longer wait times for appointments and referrals and more time sitting in waiting rooms, which has discouraged our community from reaching out for care.
- **Lack of knowledge -** Communities are unsure what services are available, making it more difficult for them to know what care they need and are entitled to.
- **High elderly and aged residential care population -** A number of participants highlighted the potential to overload not-for-profit organisations, their staff and volunteers who are caring for the ageing population.
- **End of life care -** Resources and time have been attributed to be lacking in the support for end of life care. Understaffing and a lack of time has led to unfulfilled wishes for people receiving end of life care.
- **Quality living for older adults -** Participants noted that more support is needed for older adults to stay well longer in their own homes. Older adults can feel isolated and suffer from mental health conditions and there needs to be more support provided to ensure a better quality of life.

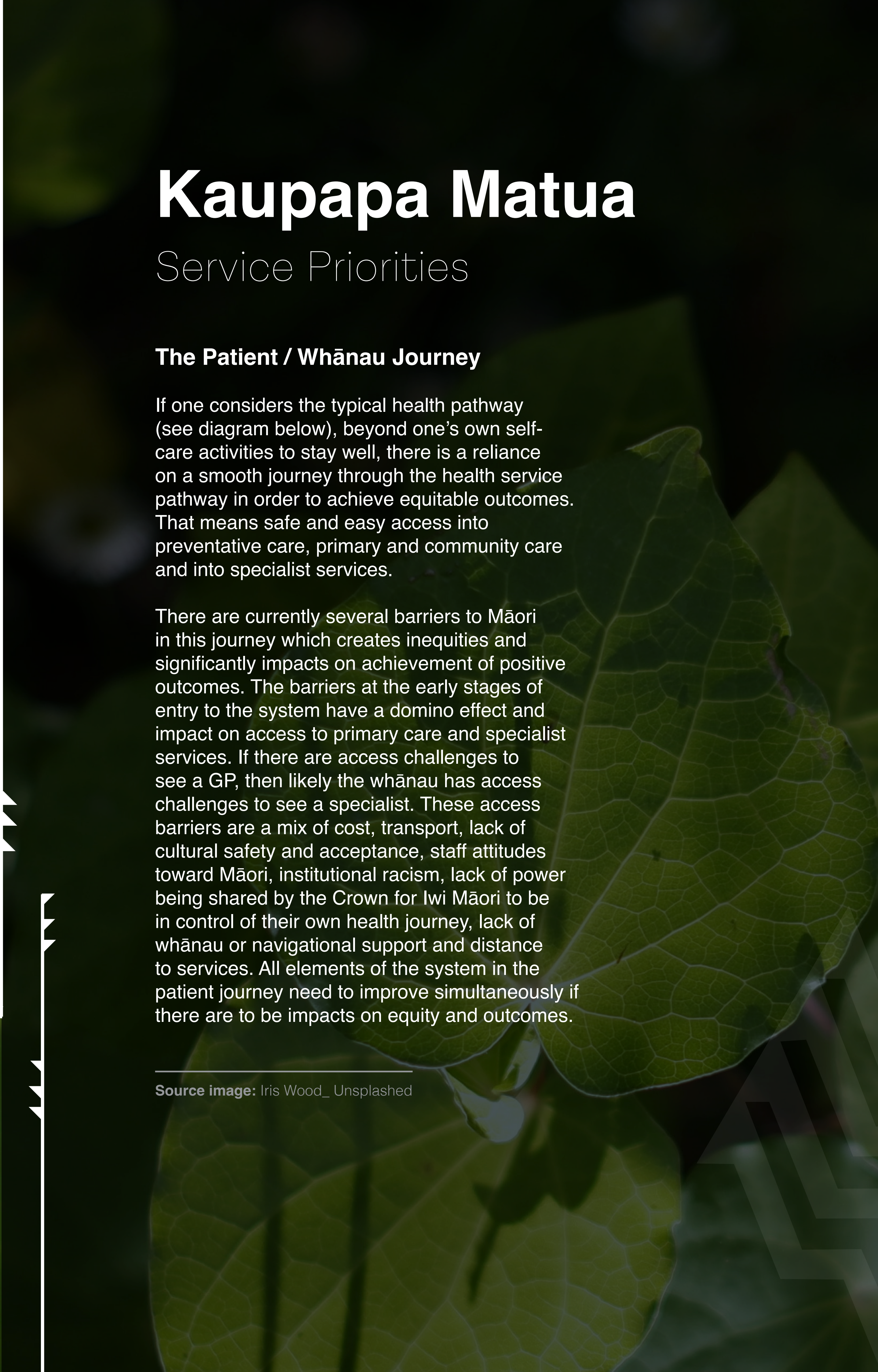
The community provided feedback on the core reasons Māori do not access healthcare which included care not being culturally responsive, the cost of services, geographical barriers, long wait times, lack of knowledge of what is available, high elderly and aged residential care population, insufficient end of life care and lack of support for older adults' quality of life. By targeting support to these areas identified by Māori, it will increase the access by Māori and potentially other groups impacted by inequity to healthcare services and thereby improve equitable outcomes across the population.

Oranga Hinengaro

(Mental Wellbeing) Themes

- **Culturally responsive care -** Participants expressed the need for more culturally responsive care, noting that there is currently a lack of commitment or dedication to considering patients' cultural beliefs, practices, and communities.
- **Lack of services/support -** Many participants feel there is a lack of support and available/affordable services for people living with mental health conditions. This concern extends to whānau, who have expressed they need more guidance around how to care for their family members who are living with mental health conditions.
- **Demand exceeds capacity -** There is an observation that demand for mental health support services outweighs capacity right across the system. These services are burnt-out and struggling to meet the growing demand of the community.
- **Rural communities feel isolated -** The lack of close mental health support within rural communities has been highlighted as an issue, with many people feeling forgotten about and not supported.
- **Timeliness -** Participants highlighted the difficulty in accessing mental health services when they are needed most and receiving care in a timely manner. Communities want timely and easy access to mental health and addiction services within their local communities.
- **Better support from services -** Participants wanted better support from mental health and addiction services across the board. This deficiency has led to many communities feeling unsupported or forgotten about and struggling to cope with their condition.
- **Reduce the presence and impact of drugs -** Participants expressed concern about the impact of alcohol and other drugs in their community, especially the impact on young people and vulnerable families. Participants want local councils and government services to work together to reduce the presence and impact of drugs in their communities.

Mental health, as a core factor influencing greater health and wellness, is discussed in community feedback and service areas identified for improvement. Feedback noted there was a lack of services and support for mental health, particularly in rural areas. This lack of services becomes an equity issue due to reasons such as Māori are more likely to live rurally than non-Māori (as shown in the data section), or Māori are more likely to live in deprived areas and suffer from conditions such as alcoholism or be unemployed which consequently impacts on mental health.



Kaupapa Matua

Service Priorities

The Patient / Whānau Journey

If one considers the typical health pathway (see diagram below), beyond one's own self-care activities to stay well, there is a reliance on a smooth journey through the health service pathway in order to achieve equitable outcomes. That means safe and easy access into preventative care, primary and community care and into specialist services.

There are currently several barriers to Māori in this journey which creates inequities and significantly impacts on achievement of positive outcomes. The barriers at the early stages of entry to the system have a domino effect and impact on access to primary care and specialist services. If there are access challenges to see a GP, then likely the whānau has access challenges to see a specialist. These access barriers are a mix of cost, transport, lack of cultural safety and acceptance, staff attitudes toward Māori, institutional racism, lack of power being shared by the Crown for Iwi Māori to be in control of their own health journey, lack of whānau or navigational support and distance to services. All elements of the system in the patient journey need to improve simultaneously if there are to be impacts on equity and outcomes.

Source image: Iris Wood_ Unsplashed

Figure 1: Patient / whanau journey through health system

Oranga - Wellbeing

- Self-care: taha wairua, taha whānau, taha tinana and taha hinengaro
- health nutrition, exercise and social connection
- Cultural connection

Prevention

- Screening programmes
- Health promotion
- Immunisation
- Health education and information

Primary & Community Care

- General practice & community nursing
- Navigation and advocacy
- Kaupapa Māori Services
- Wellchild, Maternity, Dental & other community care

Hospital & specialist services

- Acute care
- Planned care
- Emergency response
- Specialist services
- Palliative care

A focus of the new Government on five key health targets that include:

- Shorter stays in emergency department – 95% of patients to be admitted, discharged, or transferred from an emergency department within six hours.
- Faster cancer treatment – 85% of patients to receive cancer management within 31 days of the decision to treat.
- Improved immunisation – 95% of two-year-olds receiving their full age-appropriate immunisations.
- Shorter wait times for first specialist assessment – a meaningful reduction in the number of people waiting more than four months to see a specialist (target to be set in government).
- Shorter wait times for surgery – a meaningful reduction in the number of people waiting more than four months for surgery (target to be set in government).

As well as these health targets, a Māori Health priorities research report[1] (2022) identified the high-level strategic priorities which would have the greatest contribution to improving Māori health and wellbeing: Cancer, Long Term Conditions, Mental Health & Addictions, The first 1,000 Days of a child's life and a Culturally Competent Workforce, including a strengthened Māori Workforce.

A full analysis of these service areas is at Appendix 2. The following provides key highlights about these service priorities.

Preventative Care

- Cancer screening: It is essential that Māori are able to be diagnosed early and that they attend screening. While the three screening programmes are well organised, they do not function equally well for all groups, especially Māori and Pacific peoples.
- Access to timely immunisations especially for newborns and tamariki is similarly challenging. Māori child immunisation rates are lower than for non-Māori.
- Māori Influenza and Measles Vaccination Programme (MIMVP) has been implemented with several Hauora Māori providers to increase coverage; however, they need resourcing to maintain this momentum.

Primary and Community Care

- When people are unable to access these services, they may present to hospital emergency departments. Despite subsidies for children and people on low incomes, many people delay visiting the doctor and present to emergency department due to cost barriers.
- Māori and Pacific enrolment and access to primary care is lower than New Zealand European and this compounds acute presentation to ED.
- 55.5% of the total people who died from avoidable diabetes were Māori which is well above their proportion of the Māori population
- The higher proportion of Māori suffering from avoidable deaths indicates an inequity within the system and service Māori are receiving.

---

[1] Māori Health Priorities: Elana Curtis, Belinda Loring, Ricci Harris, Melissa McLeod, Clair Mills, Nina Scott, Papaarangi Reid. 6th March 2022

- Expanding investment in primary and community care is essential to address the health targets.
- Only one Māori-led clinic exists in the MidCentral district. Evidence has already shown that existence of Māori-led clinics in high need areas does have a positive impact on people attending appointments – both at primary care and secondary care level.
- Dental services are another major gap for Māori and considerable inequities exist in this area. A June 2021 report[2] released through the NZ Māori Dental Association Te Ao Marama, confirmed that "the oral health system in Aotearoa has caused negative oral health experiences and outcomes for Māori adults and breached Māori rights under te Tiriti o Waitangi".

Acute Care

- A further investment should be made for case management and follow up for patients not attending appointments (DNAs). Aggressive case management would see better use being made of available specialist appointment time.
- Unmet primary care needs put pressure on urgent care and hospital services: more acute bed days, increases in ASH rates, Māori hospitalisations for preventable diseases.
- Māori experience differences in the quality of care received (e.g. screening for and treatment of ischaemic heart disease, diagnosis and treatment of mental health, diabetes screening and higher levels of adverse events in hospital) leading to higher levels of acute care need.
- Institutionalised racism, lack of cultural understanding and a workforce that is not representative of Māori impacts also on the patient journey for Māori.

Data provided by Te Whatu Ora for waiting times comparing Māori vs non-Māori (as of 5 February 2024) for the past three years for urgent and non-urgent procedures (see Appendix 2 for full report) reflects the following:

Table 3: Summary of Māori and non-Māori wait times for procedures 2020 - 2023

		2020	2021	2022	2023
URGENT					
	Māori	44.1	44	45.1	45
	non- Māori	42	40.5	36.9	35.5
NON-URGENT					
	Māori	101.9	104.9	131.3	127.7
	non- Māori	100.8	98.2	116.4	117.6

This reveals that apart from non-urgent procedures in 2020, in all other areas there is inequity for Māori for the past three years, and that Māori are waiting longer than non-Māori.
In fact, the inequity gap has been steadily increasing.

---

[2] Lacey JK, Thomson WM, Crampton P, Willing E (June 2021) Working towards Māori oral health equity: Why te Tiriti o Waitangi needs to underpin the oral health system, using evidence from the New Zealand Oral Health Survey

Cancer services

- Cancer services are especially important for Palmerston North as a regional delivery centre.
- The most commonly diagnosed cancers are breast, lung, prostate and colorectal cancers. Māori are twice as likely to die from cancer as non-Māori .
- Almost half of people diagnosed with lung cancer have this done at an ED, and of this, almost half (49%) are Māori.[3]
- Pacific peoples and Māori had higher rates of ED presentation for bowel cancer than New Zealand European/Other ethnicities.
- Whilst people being aware of symptoms is a critical first step in diagnosing cancer, there are additional barriers to seeking care, even if people recognise their symptoms. These barriers include distrust of the health care system and an environment where people feel embarrassed discussing some symptoms.

Workforce Development

- Workforce data from Te Whatu Ora indicates that over the next decade, a total of 344 new entrant Māori medical students annually are needed to achieve equity within the total medical workforce; 34 midwifery students; and 1,200 Māori nursing students (nationally). MidCentral-specific data is needed.
- The existing Māori workforce working within the hospital system needs active support and investment to build stronger career options; to identify and accelerate new leaders; and to ensure pay equity across the professions.
- Investments made in teaching cultural safety for the non-Māori workforce has not resulted in the systemic changes that are really needed, despite significant resources being spent in recent decades. The broader health workforce needs better training and understanding of Māori health inequities; Te Tiriti o Waitangi obligations; the need to develop stronger relationships with Iwi and Māori health providers (to provide more options to Māori patients and whānau) and to be more aware of their own unconscious biases toward Māori. This must be mandatory and included in performance assessment.

---

[3] Te Aho o Te Kahu. 2021. He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020. Wellington: Te Aho o Te Kahu, Cancer Control Agency.

Kawatau mana taurite

Equity expectations

Why equity is critical for Māori

» Equity is as defined by Manatū Hauora I Ministry of Health (2018) as:

> ***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 may require different approaches and resources to get equitable outcomes.***

In the context of healthcare, equity refers to the principle of fairness and justice in the distribution of healthcare services, resources, and outcomes. It focuses on ensuring that all individuals have equal opportunities to access and receive appropriate medical care and achieve the best possible health outcomes, regardless of their socio-economic status, race, ethnicity, gender, age, or other characteristics. Equity focusses on need and ensuring the appropriate support is available for the need at hand – regardless of any other factors.

Healthcare equity is a fundamental goal of the healthcare system as it seeks to address and eliminate disparities and inequalities that exist in healthcare access, quality and outcomes.

Achieving healthcare equity is essential for building a healthier and more just society, as well as for improving overall population health. Within this context, equity also ensures that the appropriate resource is allocated to address the issue – saving the organisation time and resource.

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.

Māori, Pacific peoples, Tāngata Whaikaha / people with disabilities experience inequities as a consequence of the overlapping and interconnected nature of colonisation, lack of sharing of power and resources by the Crown, racism, ableism and discrimination. Other communities also experience poorer health and wellbeing outcomes as a result of social and economic disadvantages, racism, discrimination and stigmatisation. Such communities include people with enduring mental health and addiction problems; refugees and migrants; people from gender and sexual minorities; and people experiencing social and economic deprivation.

Creating an equity focussed organisation means that the operations are focussed on what data and intel identify to be the needs – not what society deems to be important within healthcare. It includes identifying the challenges, focussing the resource and monitoring the progress to ensure positive change occurs.

It will take an intentional investment and commitment

Social Investment is about improving the lives of New Zealanders by applying rigorous and evidence-based investment practices. The principles of a social investment approach can be applied to Māori health, focusing on prevention and better targeted services. While we need to invest in current health targets, we also need to "stem the flow" or any good work done to reach targets will be undone by the next wave of illnesses continuing to come through the next generations. A dual strategy is needed to attack current health targets while increasing the focus on keeping people well today so that they do not become tomorrow's statistics and are in a better position to be productive members of society from an economic and social perspective.

The Government's Finance Minister has already alluded to social investment as their preferred approach stating [4] *"the basic idea underpinning Social Investment is that if Government intervenes earlier and more effectively for our most disadvantaged citizens then their lives could be so much better. National's Social Investment approach will identify, fund, and scale up the actions that will have the most positive impact on people in the long run. It will make use of sophisticated data and evaluation approaches to identify what works and, crucially, what doesn't".*

This approach favours Hauora Māori partners as their model of care typically includes the broader prevention and wellness approach and aims to intervene a lot earlier and effectively so that the lives of whānau Māori are improved. Iwi Māori organisations know their communities and whānau the best thus the resources need to shift to Māori without Crown intrusion so Māori can heal their own people.

Investing up front to support people at risk of poor outcomes later in life. For example, ischemic heart disease (IHD) is the highest ranked cause of health loss in New Zealand (NZ), when considering death and disability combined. Cardiovascular Disease (CVD) is also expensive with an estimated annual cost to the health system of US$2.3 billion (~NZ$3.3 billion).

---

[4] https://www.national.org.nz/national_will_create_a_social_investment_fund

For instance, **Table 4** below shows that diet, cholesterol, obesity, and tobacco use contribute to increasing risk of cardiovascular disease and associated conditions / impacts:

Table 4: Example of up-front investment to reduce risk and cost of future disease[5]

RISK FACTOR*	CVD deaths	
	Count	Proportion (%**)
High systolic blood pressure	5400 (4210 to 6470)	45.2
Dietary risk factors - all (see also below for specific components)	3970 (3180 to 4810)	33.3
High LDL cholesterol	3330 (2300 to 4530)	27.9
High body- mass index (BMI)	1940 (1130 to 2850)	16.3
Tobacco (including secondhand smoke ***)	1400 (1270 to 1520)	11.7
High fasting plasma glucose	2000	17
Kidney dysfunction	1200	10.1
Low physical activity	673	5.63
Alcohol use	103	0.87
Lead exposure	258	2.16
Air pollution in the form of ambient particulate matter pollution	172	1.44

Health services contribute to nationwide and family/community economic development in multiple ways:

- Ensuring a healthy population is available to contribute to the workforce that grows the economy
- Providing often lucrative employment circumstances for individuals and families, thereby contributing to the family and tribal economy
- Creating demand for allied services in the provision of health care which then creates jobs in non-medical professions such as orderly roles; gardening; deliveries; catering; administration; maintenance; and driving.

---

[5] Reid P, Paine S-J, Te Ao B, Willing EJ, Wyeth E, Vaithianathan R, et al. Estimating the economic costs of Indigenous health inequities in New Zealand: a retrospective cohort analysis. BMJ Open. 2022;12(10): e065430

A 2005 European Union (EU) research report[6] identified that health is one of several key determinants of economic development and wealth creation. Most countries think of health and delivery of health care as a 'cost that needs to be contained' rather than an area to invest in because of its contribution to economic growth. Human capital contributes to economic growth – since health is a vital component of human capital, health contributes to economic growth. Conversely, bad health can put the brakes on economic and social development. Closing the gap on life expectancy between populations is key to helping reduce income differences – just as investing in protecting the health of the young population today (child obesity) to create a healthy workforce for 'tomorrow.'

The impact at Individual and Household Level is also significant. Wages and earnings brought into the home (healthy people can earn more); labour force participation (healthy people participate at greater levels in the workforce); early retirement (poor health leads to early retirement, loss of experienced workforce); more educated individuals are more productive and obtain higher earnings (impact of health on education) and children with better health can expect to stay longer in school; get better educated; earn more in the future. Studies by Te Puni Kokiri have shown that the greatest Māori employment growth has occurred in the construction industry and the health and community services industry. Therefore, any investment in the latter can only continue to enable Māori to continue their economic and social contributions while increasing the take home revenue to their families.

---

[6] Contribution of Health to the economy of the European Union: European Commission: Luxembourg, 2005

The cost of doing nothing about Māori health inequities

Research shows that Māori experience poorer outcomes[7] :

- Māori were more likely than non-Māori to have ambulatory sensitive hospitalisations resulting in 14,338 excess hospitalisations per year

- Māori received significantly less care: Māori adults were 0.66 times as likely, and Māori children were 0.72 times as likely to receive GP visits as non-Māori (equates to 774,331 less GP visits each year to just receive the same number of GP visits as non-Māori).

- This underservicing 'saved' the health system $51.4 million each year but in return privileged non-Māori access. Table 5 below demonstrates either the loss incurred from whānau Māori not accessing the system or costing more in hospitalisations because they over-use the system or use it inappropriately.

Table 5: "Cost of Doing Nothing" study key highlights

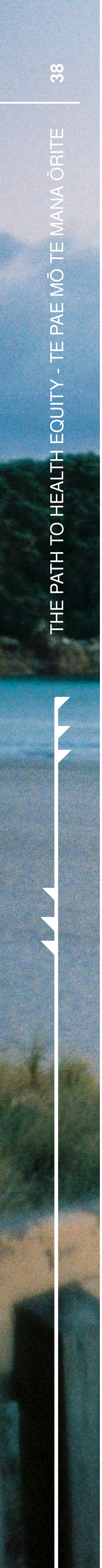
	RR for Māori compared to non- Māori	What this means for Māori/year[1]	Cost/ year of the inequity
ASH Adults	1.57 (1.57 - 1.58)	10,351 excess hospitalisations	$66,476,07
Kids	1.36 (1.35, 1.37)	3987 excess hospitalisations	$9,227,42
Healthcare utilisation			
PHC (GP visits)			
Adults	0.66 (0.66 to 0.66)	621,791 missing GP consults	-$49,743,24
Kids	0.72 (0.72, 0.72)	152,540 missing GP consults	-$1,608,42
Mental health consults			
Adults	1.31 (1.31 to 1.31)	161,059 excess consults	$27,127,10
Kids	1.01 (1.01, 1.01)	558 excess consults	$94,05
Outpatient appointments			
Adults	1.3 (1.30 to 1.30)	75,299 excess consults	$14,489,11
Kids	0.78 (1.78, 0.78)	21,770 missing consults	-$4,189,04

Compared to a scenario where Māori have the same utilisation/ outcome rate as non-Māori

Overall, Māori adult and child health inequities **cost New Zealand society over $1.034 billion per year.** Of this - $36 million per year is a net direct cost to the health system influenced by the under-utilisation of health services by Māori. A larger amount, $998 million, is made up of the indirect costs including years of life lost and lost caregiver wages. These costs should be treated as highly conservative as they exclude the full costs of illness, suffering and premature death.

---

[7] Reid P, Paine S-J, Te Ao B, Willing EJ, Wyeth E, Vaithianathan R, et al. Estimating the economic costs of Indigenous health inequities in New Zealand: a retrospective cohort analysis. BMJ Open. 2022;12(10): e065430 Paine S-J, Li C, Wright K, Harris R, Loring B, Reid P. The economic cost of Indigenous child health inequities in Aotearoa New Zealand-an updated analysis for 2003–2014. The New Zealand Medical Journal (Online). 2023;136(1568):23-6



Te Whakapaunga i tenei kaupapa

Conclusions and Priorities

The following conclusions and key priorities inform the recommendations in the next section. They are intentionally aligned to our IMPB Strategic priority areas and are provided to enhance and support the development of the Clinical Services Plan. Each of our priorities are identified below (in green boxes) followed by a short narrative of the challenges faced by whānau which impact equity and outcomes.

IMPB STRATEGIC PRIORITY 1: Whānau voice

We place whānau at the heart of our IMPB by providing opportunities for whānau voice to be embedded across the health sector and will elevate whānau voice across all aspects of service planning, design, delivery, review and change in our rohe.

There has been significant value generated from previous community, whānau and Iwi engagements that have occurred to date by the former DHB and health system, with some rich information now inherited by Te Whatu Ora. The 'whānau voice' section of this plan highlight very specific themes that need to be addressed, and over time one should expect that concerns will decrease, and improvements will be visible to whānau. However, gathering, engaging, listening, and responding to the voice of whānau is an ongoing process – and it needs to occur in multiple ways to provide multiple avenues for whānau to engage and contribute to system improvements and to their own health and wellbeing.

Engagement includes whānau who work in the system for they too are whānau and they too have whānau who use the system. Ensure the workforce has a voice.

We need to adequately resource those voluntary and advocacy groups who represent whānau and provide avenues of support and compassion for whānau, as many whānau cannot speak for themselves due to mistrust of the system, literacy challenges and challenges understanding the complex health system.

IMPB STRATEGIC PRIORITY 2: Te Tiriti o Waitangi

Exercising a Te Tiriti based relationship that honours the mana motuhake of iwi, hapū and whānau in our relationship with the Crown and ensuring those we work with do the same in accordance with our expectations for what such a relationship means in action.

Partnership, leadership and decision-making

As noted in many of the national and regional strategic health plans, under Te Tiriti, the Health system is obligated to partner with Māori to deliver support that is equitable and empowers whānau Māori to be self-determining and grow their own sovereignty. This includes ensuring manawhenua have a key partnership role in the design or re-design and delivery models for services. Services that are under review at a national level that are provided locally should be included. For Iwi it is now about sharing power and resources by the Crown and no longer the Crown deciding what works best for us, how much the decide to allocate to us, how we must carry out services or how we must report back. Sovereignty is true partnership.

It is incumbent on the system to elevate Māori to roles in leadership and decision-making, by preferencing recruitment to achieve workforce equity, and by identifying and supporting emerging leaders to advance. Preferential recruitment practices should be applied such as use of Māori recruitment firms, shoulder-tapping potential Māori candidates within departments, providing training in interview techniques and CV enhancement.

Care Coordination and Integration

Community feedback indicated a need for the system, and its variety of services, to be better connected to support a reduction in whānau becoming confused or disengaged. By connecting services across the health industry and also into social sectors, it will help with improving Māori and Pacific outcomes by ensuring efficient care pathways. Patient advocates and support personnel should be encouraged and widely promoted and invested in by the system.

Front-line staff working in different areas should have genuine knowledge of the local Iwi Māori and Pacific service providers that they can refer patients to; to build meaningful and enduring relationships with; and to support with specialist advice and resources. Specialist staff can offer different models of care to better integrate their delivery with community-based delivery such as use of telehealth, or operating clinics in Iwi, Māori, and Pacific settings. It is no longer about tokenism and meaningless consultation and ticking boxes.

Furthermore, given Māori and Pacific come from cultures that prioritise broad connection across families and philosophy, it is important that their healthcare system considers is broad and interconnected.

Culturally Competent Care

The community feedback and data on Māori outcomes provided strong indication of a lack of culturally competent and appropriate care for Māori. Key health inequities exist in avoidable deaths, and these are specific areas that can be targeted by the system to accelerate progress and impact:

» Lung cancer
» Ischaemic heart disease
» COPD
» Cerebrovascular disease
» Diabetes
» Suicide

Circulatory system diseases, respiratory diseases and cancers cause the large majority (around 60%) of all deaths for Māori in the District. Comparisons of inequities in rates of these diseases between Māori and non-Māori since 2006 show the problems have worsened or not changed.

Pacific engagement and data analysis reveal similar patterns of avoidable hospital admissions and worse health outcomes.

This is unacceptable and shows that the system has not made any progress with inequities at least in the last 17 years – almost a whole generation. The data supports the finding that persistent systemic racism and discrimination continue to pervade the system and that the system is not working for Māori and Pacific communities.

Ultimately more must be invested in health promoting behaviors and lifestyles delivered by Māori and Pacific providers and communities for themselves, in their own way, and using their own culturally relevant models of care. We are now paying for the divesting away from the likes of health promotion over the last few decades. Improvements are needed to improve access to primary and specialist care so that people are diagnosed earlier and supported to manage their conditions, and to ensure all services are culturally safe when whānau DO access care. More work is needed to hold mainstream providers and practitioners to account for non-performance and to measure their success or failure to address inequities through robust monitoring and accountability mechanisms. If providers are not delivering equitable care for Māori and Pacific, then they should not be continually funded for these populations and the resources should shift to providers who will have an impact.

Workforce Development

It is clear that the staff within Te Whatu Ora and across the system need intensive, continuous, and multi-layered education and training to confront and eradicate systemic racism and discrimination. There is no tolerance for this, and it must be stamped out. The workforce needs training in unconscious bias, power, and privilege and in understanding their own identities if they are to understand the identities of others. This is a matter of urgency and should be manawhenua and Pacific led for their own communities to reflect their own tikanga and kawa and cultural protocols.

Increasing the proportion of Māori and Pacific staff working in high priority service areas impacting circulatory and respiratory diseases and cancers is a matter of priority. The system needs to actively invest in increasing the visibility of culturally safe staff to improve the health care experience for Māori and Pacific.

The Māori and Pacific primary and community care workforce needs to grow especially in areas to significantly raise the profile and understanding of leading healthy lifestyles. This workforce has a better understanding of the socio-economic circumstances that whānau/fanau live with every day and their approaches will be more relevant and applicable to those circumstances. Increasing Māori and Pacific primary care service options / clinics is a critical necessity as it is clear that the current primary care range of services is not contributing to reducing inequities for Māori and Pacific whānau.

Recognition is also needed for life experiences Māori and Pacific bring as solely qualifications based on western methodologies is not the sole approach and is a major barrier for many indigenous people into the health sector.

Patient Navigation and Outreach

The data on Māori demonstrated access barriers in the form of being more likely to live rurally, have no vehicle, and have no telecommunications. The community feedback also confirmed this with Māori noting a number of challenges they face in accessing care.

As such, additional navigation and outreach support is required to achieve improved outcomes for Māori and more broadly equity in health outcomes.

IMPB STRATEGIC PRIORITY 3: Accountability

Making all parts of the system accountable on behalf of our iwi, hapū, whānau and communities.

Transparency and Communication

The community feedback indicated a lack of understanding of what healthcare supports existed and how they could be accessed. Creating more user-friendly informational resources and information on how to access support persons to guide whānau, is one way this type of feedback could be addressed by supporting greater transparency and other improved communications to whānau.

Performance Measurement and Accountability

Whānau want their feedback to influence real change and improvements to accessing services and to the delivery of services. They want to know that gaps are closing and that Māori and other vulnerable populations are accessing the services they are entitled to when they need them. There is a need to establish metrics that monitor progress towards equity goals and mechanisms to hold healthcare providers and non-health focussed entities accountable for achieving equitable outcomes. Equity tracking tools for key health indicators (that have already developed within the system and used previously) should be re-instated and publicly reported on a regular basis.

Continuous Quality Improvement

The community feedback indicated poor cultural capability among healthcare staff. Implementing a culture of continuous quality improvement when it comes to equity will help those groups worse off to feel more comfortable with healthcare if staff are being open and honest about flaws in the system and how they can be addressed.

IMPB STRATEGIC PRIORITY 4: Planning

Providing and participating in key health and social sevices planning locally, regionally, and nationally, focusing on priorities identified through the locality planning processes and whānau voices across our rohe.

Equitable Resource Allocation

The data on Māori health and related outcomes demonstrated that Māori suffer from worse health outcomes than non-Māori. In the community feedback, Māori commented that there was a lack of services and support suitable to their needs. As such, resource allocation needs to be specifically targeted via equity mechanisms directly to Iwi and hapu to achieve equitable health through improved outcomes for those, such as Māori, with the worst health.

Develop a Pro-Equity commitment for hospital and specialist services in Palmerston North

Many national and regional strategic planning documents were founded on a vision, mission and principles which emphasized the need and ambitions for achieving equity in health outcomes. These planning components aligned well with one another. These components are essential to developing and embedding in any pro-equity approach going forward, and act as a helpful mechanism to align our approaches with other key strategies across the healthcare system. This alignment is especially important given the feedback from community suggesting approaches across health services and support should be integrated.

IMPB STRATEGIC PRIORITY 5: Data collection & Analysis

Developing greater use of digital services by gathering, collating, analysing and reporting on whānau outcomes.

Research and Innovation

While the data on Māori and non-Māori, and the community feedback, provides a useful window into the needs and aspirations to achieve equitable support, it is noted that it is brief and not specific to equity goals (although equity is one underlying consideration of the information). Further and continued research and innovation will be required to ensure the needs of those groups worse off continue to be supported.

Ethnicity data collection

To track progress with health inequities, utilisation, access, and outcomes – it is essential that accurate ethnicity data is collected and reported by all providers. Still today the system has allowed some providers (e.g. Aged residential care) to operate without collecting ethnicity data. Furthermore, previous research [8] has shown that often there are many errors that occur in the collection and reporting of ethnicity-based data. In order for health inequities to be reported and tracked accurately, the staff collecting, inputting, analysing and reporting health data MUST be trained to undertake this role properly. Ethnicity data audits need to be routinely undertaken to check on error rates in specific areas of the system or with specific workers.

IMPB STRATEGIC PRIORITY 6: Monitoring & improving

Monitoring the systems and contributing to its improvement to address inequities in health and wellbeing outcomes for Māori.

---

[8] https://www.otago.ac.nz/__data/assets/pdf_file/0020/331841/-improving-and-maintaining-quality-in-ethnicity-data-collections-in-the-health-and-disability-sector-600098.pdf

Assess and track current Inequities

Several inequities have been identified in the Te Pae Oranga o Ruahine o Tararua Health Profile. While they are noted in this report, further research must be undertaken to understand the full extent of the inequities and how they can be addressed. The MidCentral Health Equity data report of 2018 needs to be updated at least 3-yearly and more intensive tracking needs to be undertaken and action taken sooner rather than later.

Health Literacy Initiatives

Coupled with the absence of culturally safe services, there is a broad lack of understanding of the health system, how it operates, and its terminology which was noted in community feedback as a specific barrier to health. Providing health literacy to groups suffering from the worst outcomes will help improve their access and understanding of the healthcare they need.

IMPB STRATEGIC PRIORITY 7: Commision and Contracting

Working in partnership with funders and investors for the commisioning of health and wellbeing across our rohe focusing on addressing issues of access, racism and discrimination for whānau.

Contribute to addressing Social Determinants of Health

The community feedback and data on Māori outcomes strongly indicated that health is impacted by a wide range of determinants and, for Māori, the outcomes for their social determinants are significantly worse than non-Māori. This demonstrated a clear need for holistic support to be provided to improve social outcomes which will in turn improve whānau health and wellbeing.

The data indicates Māori were less likely to be educated (limiting future employment opportunities which in turn can impact mental health and self-esteem and income); less likely to be employed; more likely to be looking after disabled or ill household or non-household members; more likely to have a total income of under $20,000 – directly impacting on the standards of living the individual can achieve; more likely to live in a decile 8-10 (deprived) area which can in turn cause physical health issues through issues such as poor housing stock or increased presence of alcohol or junk food retailers; and more likely to live in damp or mouldy housing – directly impacting on physical health through respiratory or related issues. These issues present inequities in the broader system for Māori but as noted can have a mixture of direct and indirect impacts of the health and wellbeing of Māori. For this reason, it is necessary for support to be holistic and integrated across the system to effectively address health issues for Māori.

Prioritise investment in services and supports that directly target inequity for Māori

Evidence shows that Māori experience higher rates of illness and mortality across a wide range of chronic conditions. Many whānau often present later, die earlier and experience worse outcomes than non-Māori. Suggestions have been made in the analysis for necessary areas of investment to (a) improve the overall Māori patient journey (b) increase Māori primary care access to have a positive impact on H&SS access and use (c) increase the Māori workforce (d) to use more creative methods for delivering care (community-based clinics, telehealth) and (e) to invest in more prevention activity.

Commissioning and delivering services to match the population

The population profiles in the district of Māori Pacific and non-Māori/Pacific are vastly different. Over 55% of Māori and Pacific populations are under age 24 years so they need increased maternal, child and youth health services to keep them well. By 2038 the number of Māori aged 65 years and over living in the MidCentral district is expected to almost triple (290% increase from 2013). A large increase in the number of Māori aged 25-44 years is also projected to occur (80% increase between 2013 and 2038). On the other hand, the European population has a vastly higher population of over 65-year-olds.

Much of the health resource is spent on the elderly non-Māori non-Pacific in long-term care, aged residential care, and home support. Many Māori and Pacific whānau do not benefit from this due to their lower life expectancy; inability to afford costly residential care; reluctance to be placed in large institutional settings and lack of culturally appropriate options. However, a similar weighted investment of the health budget needs to be reflected in the investment in the younger Māori and Pacific population. The investment needs to be made now as the future population growth changes of Māori and Pacific will have a significant impact on the health system if that population experiences the same inequities and carry the same health burdens as they do today. The system will simply not cope. A proactive prioritisation approach needs to be made now to keep the current young population well and to address health inequities in conditions that will place a greater burden on the population in the future.

Whaikupu
Recommendations

The following recommendations are made as a result of the findings and analysis in this plan. However - it is also acknowledged that work on addressing equity has already occurred in the district and there are a number of investments and initiatives in place that should continue and be built upon.

The following recommendations are expected to form the basis of an Equity Action Plan to be fully costed by Te Whatu Ora working alongside the IMPB, once the recommendations have been considered and endorsed:

IMPB Strategic Priority - WHĀNAU VOICE

#	Recommendation	Expected Outcome (s)
1	Use the current community whānau voice themes (in the RHWP and in this plan) as a baseline indicator of whānau satisfaction / dissatisfaction with current services and create a tool to monitor these themes/concerns over time. Prioritise those services where there is high Māori and Pacific utilisation or under-utilisation, and where equity gaps exist (reporting to the IMPB annually on shifts / changes / new emerging issues)	» Whānau voice has intentionally influenced service design / re-design – with ability to report back to whānau » A baseline whānau voice status is established that can be updated at least 3-yearly to assess improvements or lack of movement in areas of importance to whānau
2	Establish multi-media platforms / tools to gather whānau voice (ensuring ethnicity data is collected and analysed) on an ongoing basis including: a. Use of social media b. Face to face engagements c. Workshops d. IMPB & Localities whānau engagements e. Pacifica provider engagements and feedback f. Online webinars g. QR code surveys h. Patient advocacy group feedback and input i. Working with Māori patient advocacy groups (e.g. Te Ahuru Mowai for cancer support) j. In-clinic 'fast surveys' or instant feedback tools for patient feedback k. Phone follow-up post surgeries and assessments and hospital stays of samples of Māori patients at least 50 annually l. Interviews with Pou Tikanga, Māori patient advocates and navigators m. Interviews with Iwi and Hauora Māori providers n. Resource Iwi and Māori providers to have analyst to capture and interpret whānau voice Provide a report to the IMPB on the overall whānau voice activities listed above, and themes – annually, identifying trends and changes from prior reports.	» Whānau voice drives decision-making, planning, investing and service delivery » Whānau have multiple options to provide their voice into the health system » The IMPB has access to system-gathered whānau voice to complement its own source data from whānau, hapu and Iwi

#	Recommendation	Expected Outcome (s)
3	The Māori and Pacific workforces in health is also part of 'whānau voice'. Create mechanisms to specifically interview and engage the Māori and Pacific workforces in Hospital & Specialist services; primary and community care (including Māori and Pacific providers) and in preventative care. This may be through quality forums on a regular basis; invitations to be interviewed; random sampling; or tapping into Māori and Pacific health professional groups such as Te Runanga o Aotearoa and Te Kaunihera o ngā Neehi. Talking to the district-located Māori and Pacific workforces about what they are seeing and noting amongst whānau who are accessing or not accessing health care, will provide valuable evidence on the quality of care being delivered and received. Properly resource organisations to participate and provide feedback loops as too often they are interviewed and that's it.	» Māori, Pacific, Asian employees within the health system contribute to whānau voice and service improvements » Tangata whaikaha working in the health system contribute to whānau voice and service improvements » Employee voice is respected and acknowledged as a key contributor to service improvements
4	Invest in Māori and Pacific patient advocacy groups (whether voluntary or not) to expand the advocacy networks for Māori and to better understand the needs of underserved populations and involve them in decision-making processes.	» Advocacy support is available for Māori and Pacific whānau to improve access to, and use of, health services
5	Ensure the design or review of all settings and services includes the voice of whānau so that they are tailored to what whānau / fanau want to see, feel, and experience. This will improve their trust of the system and levels of comfort in accessing and experiencing the system.	» A mechanism exists to demonstrate how whānau voice that is collected directly influences service planning and improvement

IMPB Strategic Priority – TE TIRITI O WAITANGI

#	Recommendation	Expected Outcome (s)
Partnership, leader, and decision-making		
6	Create and foster intentional partnerships with Iwi within the district (and including the IMPB) to have an ongoing relationship with Te Whatu Ora (Palmerston North Hospital) to co-partner, co-develop, co-design and review plans, reports, and data. This should include design of any new capital infrastructure through to opening / operationalising (create and fund dedicated positions on project teams similar to the roles that cultural monitors play in resource management). Encourage and listen to honest feedback and input and compensate what is provided (do not expect free advice! Pay for it as you would other specialist advice). Note the example of strong partnership with manawhenua by NZTA in the building of the new highway between Palmerston North and Woodville. This is an example of authentic partnership that is mutually beneficial.	» Iwi partnerships with Te Whatu Ora are an authentic demonstration of Te Tiriti partnership

7	Invest in recruiting, growing, and investing in Māori leaders within the system. Target an equitable proportion of positions (17% minimum to match Māori proportion of total NZ population) of Māori in management / supervisory positions across all departments of the organisation. Report on progress of Māori vs non-Māori workforce to the IMPB across departments and organisation levels [9]. Resource Iwi Providers to have data analysts to make better use of their data to be to be better involved in decision-making.	»	Māori workforce in the health system is comparative to the Māori population in the district including at all levels of Te Whatu Ora
Care Coordination and Integration:			
8	Ensure all staff working within Wards including reception and booking staff, are briefed, and informed about Iwi Māori and Pacific providers in the district (directory) and how to encourage and inform Māori and Pacific patients to connect with them for pre- and post-surgical and specialist care, to help prevent barriers in the patient journey. This includes referral to patient advocacy groups.	»	Whānau in hospital are actively made aware of the available Iwi Māori / Pacific providers in the community to support them
9	Enhance care coordination and integration across healthcare settings to ensure seamless and efficient delivery of services, especially for patients with complex health needs. This should include Māori clinical, non-clinical and cultural support staff / navigators who can work across hospital and community care settings	»	Māori navigators are available across the system to support whānau within the system (could be combined with #11)
10	Encourage care coordinators to work across sectors to support Māori patients and whānau in an effort to tackle social determinants of health (access to nutritious food, housing challenges and budget help for instance).	»	Whānau are supported to access other social supports when they need them
Culturally Competent Care:			
11	Invest in Manawhenua to create a district-wide cultural human resources, and informational resources, that can support patients in hospital settings; provide cultural advice and education for service delivery staff; and connect whānau to services. Prioritise areas that are involved in circulatory, respiratory and cancer service delivery.	»	Māori navigators and informational resources are available within manawhenua entities to support whānau members to utilise the health system
12	Ensure hospital settings are relevant to the local manawhenua tikanga, awa, maunga and whenua. Actively include manawhenua representatives in early design, construction, and internal / external design (colours, artwork, carvings, naming) for all facilities. Include local Māori artists, landscapers in design and construction.	»	Whānau feel culturally safe in Hospital physical environments which are reflective of the mana whenua aspirations and important taonga within the service coverage area of the hospital
13	Create service information that is easy to understand, accessible in multiple forms, and simplify processes and paperwork – bi-lingual for Māori and in different languages for Pacific and Asian, and tangata whaikaha Māori	»	User friendly written information is available to all population groups

---

[9] Note reporting on workforce ethnicity by profession and level was routinely carried out by all of the former DHBs and collated by Central TAS. This tracking system should be reinstated.

Workforce Development:		
14	Implement training programs to enhance the practice of culturally competent healthcare providers. This will improve communication and understanding between providers and patients from diverse backgrounds, leading to better health outcomes.	» A comprehensive culturally safety programme is designed and implemented across the health workforce in the district – and becomes part of performance assessment
15	Ensure staff are well trained to work with Māori patients and whānau (see comments on health workforce previously) by working with credible trainers over longer periods of time	» Credible Iwi / Māori trainers endorsed by mana whenua provide the training (above)
16	Track and report on proportions of Māori staff at all levels across a range of service areas and disciplines. Specifically target areas where few Māori work, and actively invest in increasing those numbers.	» Same as #7 above – baseline to be determined
17	Invest in the Māori primary and community care workforce with free trainings (online and in person) to build capability and capacity in the community. Invest in data analysts and communication FTE for Iwi and Māori providers.	» Iwi Māori providers have strengthened capability through: • access to communication and data capability to strengthen their relationship with and knowledge of the health system • ability to provide whānau with robust information on hauora matters • having staff able to access cost-free training from Te Whatu Ora (on clinical and non-clinical, administrative and management training subject matter)
Patient Navigation and Outreach:		
18	Explore resourced opportunities to deploy services into the community so they also become part of the solution. This should include specialist clinics being held in Iwi Māori provider settings and on Marae for instance.	» Whānau access is improved by having specialist services reviewed to determine ability to provide more care options in the community closer to home (than having to travel to the hospital)
19	Create more opportunities for specialist services to be carried out via telehealth (cardiology, psychiatry) for instance using Iwi Māori health settings as vehicles for this when desirable where technology is not freely available in whānau homes	» Increased telehealth options are available for whānau who live rurally or have challenges physically attending services on hospital campus
20	Ensure specialists take time to visit with Iwi Māori providers and spend time understanding their service profile (so they can refer); their staff challenges with 'the system' and whānau dynamics at the front-line	» Strengthened relationships between specialists and Iwi Māori providers that can benefit whānau

IMPB Strategic Priority - ACCOUNTABILITY

#	Recommendation	Expected Outcome(s)
Transparency and Communication:		
21	Communicate openly and transparently with patients, staff, and the community about the organization’s efforts to achieve healthcare equity and progress made towards the goal (reporting out on trends and feedback)	» Te Whatu Ora issues regular updates on specific interventions addressing inequity to stakeholders (equity updates)
Performance Measurement and Accountability:		
22	Establish metrics that monitor progress towards equity goals and hold healthcare providers and non-health focussed entities accountable for achieving equitable outcomes (identified by IMPB). *Whānau ora approach needs to be brought in to help measure performance and other Matauranga Māori not just western clinical approaches.*	» Equity report (above) includes established baselines and ongoing reporting on movements (or not) in inequities across a range of specialist indicators » Active steps are taken and reported, on areas identified as high priority by the IMPB
Continuous Quality Improvement:		
23	Implement a culture of continuous quality improvement within the hospital and specialist services. Use data-driven approaches (hence the need for data analysts for Iwi and Māori providers) to identify disparities and develop targeted interventions to address them starting with the national health targets and then specific targets where Māori inequities are greatest – report to IMPB quarterly on trends that are occurring	» As above: ensure agreed equity indicators with IMPB and Iwi, are reported and that actions are captured as part of quality management system reporting
24	The IMPB and the Quality and Risk team work together to undertake a Tiriti o Waitangi compliance audit across the range of services over a 3-year period (refer example Counties Manukau DHB example). Services each year to be prioritised according to data-driven indicators of greatest inequities for Māori	» Te Tiriti o Waitangi audit completed and identified actions progressed within 12 months of report » Annual updates carried out, and audit repeated 3 yearly

IMPB Strategic Priority – PLANNING

#	Recommendation	Expected Outcome(s)
Equitable Resource Allocation		
25	Ensure that resources, including staffing, funding, and technology, are allocated in a way that prioritizes the needs of the community – particularly the marginalized and underserved communities – using data-driven indicators (e.g. cancer screening, immunisation, patient advocacy and support in ED, expanded primary care)	» As per #22 above, with specific actions for marginalised and under-served communities being report
26	Work with Te Whatu Ora workforce team to breakdown the national workforce Māori inequity gap across all disciplines, to the MidCentral district. Make specific investment to address the workforce inequities in the district data across the disciplines with specific targets (and this should include preferential recruitment practices into leadership positions)	» Māori workforce inequity data completed for MidCentral District as baseline » Annual reporting on movements
Develop a Pro-Equity commitment for hospital and specialist services in Palmerston North		
27	Create a clear and compelling commitment to equity and social justice in healthcare delivery. Involve key stakeholders, including hospital leadership, staff, patients, and community representatives, in shaping this and track inequities in a robust and consistent manner.	» Public commitment by Te Whatu Ora to achieving equity developed and widely socialised
28	Ensure ALL service plans are co-designed with manawhenua and/or the IMPB with appropriate commensurate investment	» All service plans co-signed by Te Whatu Ora and Manawhenua / IMPB
29	Implement the prioritisation algorithm from the former Auckland DHB to Māori and Pacific on waitlists within the MidCentral district (or similar prioritisation method that preferences Māori and Pacific in an effort to target inequities in access and treatment outcomes). *It is understood through informal communications with TWO staff that this may already have been initiated – but ceased in recent times.*	» Inequitable Māori waiting times for urgent and non-urgent procedures are urgently addressed and equity is maintained over time

IIMPB Strategic Priority – DATA COLLECTION & ANALYSIS

#	Recommendation	Expected Outcome(s)
Research and Innoation		
30	Invest in research and innovation that addresses healthcare disparities and identifies effective strategies for improving equity in healthcare. Disseminate research to keep stakeholders informed.	» Health Equity (2018) report updated at least 3 yearly and published » At least one specific research project on a high priority area (identified by IMPB) undertaken to investigate drivers, causes and effective interventions

Ethnicity data collection		
31	Conduct ethnicity data collection audit on a sample of specialist services to determine levels of errors in collection and reporting (note this has been done previously at some former DHBs and revealed variable results across different services. It shows either the ethnicity question is not asked and/or answered, or that staff are miscoding ethnicity. These errors impact on inequity, service utilisation and outcome reporting for Māori and therefore on any associated assumptions and investments).	» MidCentral ethnicity data collection occurs across all services and has 1% or less error rate » Baseline determined by 2025 and annual reporting undertaken
32	Ensure all staff responsible for patient data collection are properly trained and reviewed on their competency in ethnicity data collection and reporting	» All data collection staff are trained in ethnicity data collection during induction and annually
33	Ensure ANY reports being produced on health service utilisation are mandatorily produced with ethnicity-based analysis	» All published data includes specific ethnic categories

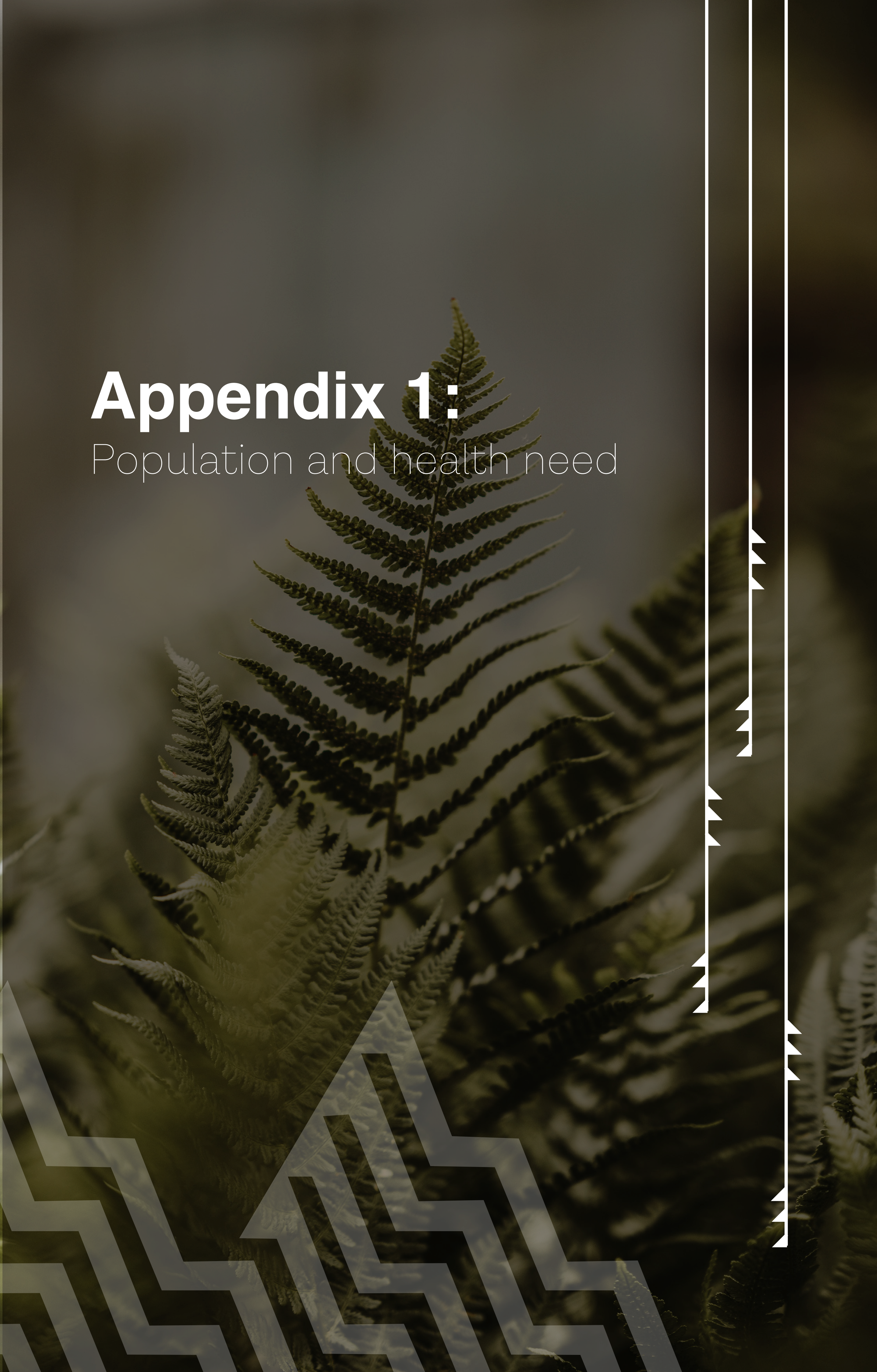
IMPB Strategic Priority – MONITORING & IMPROVING

#	Recommendation	Expected Outcome(s)
Regularly assess and track Inequities		
34	Update the 2018 MidCentral Health Equity Data report and then review this data report every 3 years. Specifically target areas where there are worsening inequities or no changes for immediate action and accountability.	» As per #30
35	Conduct a thorough assessment of the hospital and specialist services to identify existing disparities in access, quality, and outcomes across all service areas	» All specialist service areas are examined, and disparities reported routinely » Investigations as to causes and impacts are undertaken for those areas identifying major inequities (as agreed with IMPB) – see also #36 recommendation below
36	Analyse patient demographics, health outcomes, and healthcare utilization patterns to understand the specific areas that require improvement. Report out on specific locations (e.g. Tararua) where Māori patient service use, DNA rates, ED admissions, complaints / compliments, treatment outcomes are identified to support the IMPB in its monitoring and improvement role	» As per #35
Health Literacy Initiatives:		
37	Develop health literacy programs and resources that are accessible to the community to empower patients with the knowledge and skills needed to make informed healthcare decisions and actively participate in their care.	» Ensure there is a designated lead for Health Literacy in the organisation » See also #13 above

IMPB Strategic Priority – COMMISSIONING & CONTRACTING

#	Contribute to addressing Social Determinants of Health:	
38	Recognize and address the impact of social determinants of health, on health outcomes. Collaborate with community organizations, social services, and public health agencies to address issues related to housing, education, employment, and access to healthy food. The best method to achieve this is through multisector localities-based forums and engagements, and co-planning / co-design.	» Multi-sector forums are regularly held and there is evidence of joint initiatives to advance cohesion across sectors (report specific initiatives)
39	Seek out opportunities for the health system to be part of community events supporting whānau e.g. community health and wellness days; Iwi celebration days	» Number and type of events participated in by Te Whatu Ora staff (staff from different departments).
Prioritise investment in services and supports that directly target inequity for Māori and other populations to meet Te Tiriti o Waitangi obligations		
40	Te Whatu Ora MidCentral make specific commissioning investment in more Māori primary care and dental care for all communities that access and use Palmerston North hospital. There are currently only two Iwi led primary care clinic exists across the entire district.	» Increased Māori-led primary care services across the district
41	Increase investment in Māori professional workforce (drawing on specific MidCentral district workforce inequity data)	» Increased funding into specific Māori workforce initiatives
42	Invest in more Māori patient advocacy and navigational support services	» Report investment. See #4 and # 9 - 11
43	Ensure healthcare settings are co-designed, partnered and completed with manawhenua so that healthcare environments are locally tailored, appropriate, and relevant to whānau Māori in the district (e.g. using local Māori artists). This should include increasing the number and scope of Māori suppliers (e.g. landscapers, architects, consultants, artists) in the procurement of external services for any infrastructure projects.	» Report investment in mana whenua-determined healthcare environmental activity (e.g. artwork)
44	Set a target of at least 10% of all procurement across the organisation to be with Iwi and Māori suppliers. Establish 2024 baseline and track progress annually.	» Report % of investment in Māori suppliers (set baseline and then report annually)

Commissioning in a manner that reflects the population		
45	Review current investments in services for children and youth and ensure there is significant and impactful prioritisation of investment in Māori and Pacific children and youth given around half of these populations are under age 24 years. Invest now to protect their health and wellbeing for the future. This should include increasing Kahu Taurima investments with Māori and Pacific providers; school-based services and health promotions; mobile dental services; kaupapa Māori and Pacific child and youth mental health services; and youth self-esteem / self-confidence and cultural connection strategies.	» Report overall investment in: • Kahu Taurima services • Youth services • School-based services • Including breakdown by mainstream, Māori, and Pacific providers
46	Work with manawhenua and the IMPB to begin now to develop Māori and Pacific 'aged care' strategies to plan for future planned exponential growth of the aging population. This should include broader options for residential care; home support; whānau-based care options and kaumatua wellbeing day programmes. Work with Iwi around infrastructure investment potential for residential care supported by longer term contracts for services within residences.	» Joint Aged care/ Kaumatua care strategy completed by Te Whatu Ora with IMPB / Mana whenua » Strategy action plan implementation initiated within 6 months of production of strategy



Appendix 1:

Population and health need

Appendix 1:

Population and health need

NOTE: Table references/numbering applies to the source document and are unable to be changed for the purposes of this report due to documents being supplied in PDF form (and original documents being unable to be sourced).

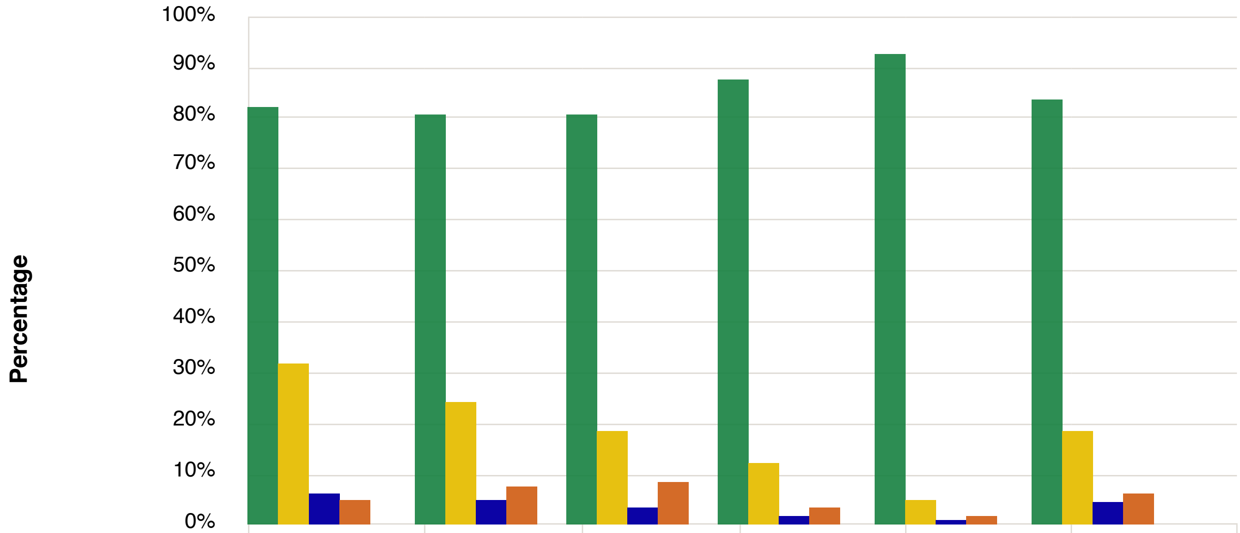
Ethnic profile of the district [10]

The MidCentral district population is ethnically diverse. The ethnic groups to which the majority of people living in the MidCentral district belong are NZ European and Māori. There are also smaller numbers of people who identify with Pacific, Asian and a range of other ethnicities.

Population age profile and ethnicity

Of all of the people who stated their ethnicity in the 2013 Census, almost 85% of the total MidCentral population identified as NZ European and Other, 18% identified as Māori, almost 4% identified as Pacific, and 6% identified as Asian (see Figure 6). Younger age groups had higher proportions of people who identified as being of Māori and/or Pacific ethnicity as compared to older age groups.

Table 6: MidCentral DHB population by ethnicity and age, 2013



	0-14years	15-24years	25-44years	45-64years	65 years and over	MDHB - all ages
🟩 **European and Other**	82.4%	80.9%	80.8%	87.0%	93.4%	84.9%
🟨 **Māori**	31.5%	24.1%	18.8%	12.5%	5.5%	18.3%
🟦 **Pacific**	7.5%	5.2%	3.7%	1.9%	0.8%	3.7%
🟧 **Asian**	6.7%	8.5%	9.0%	4.3%	2.3%	6.1%

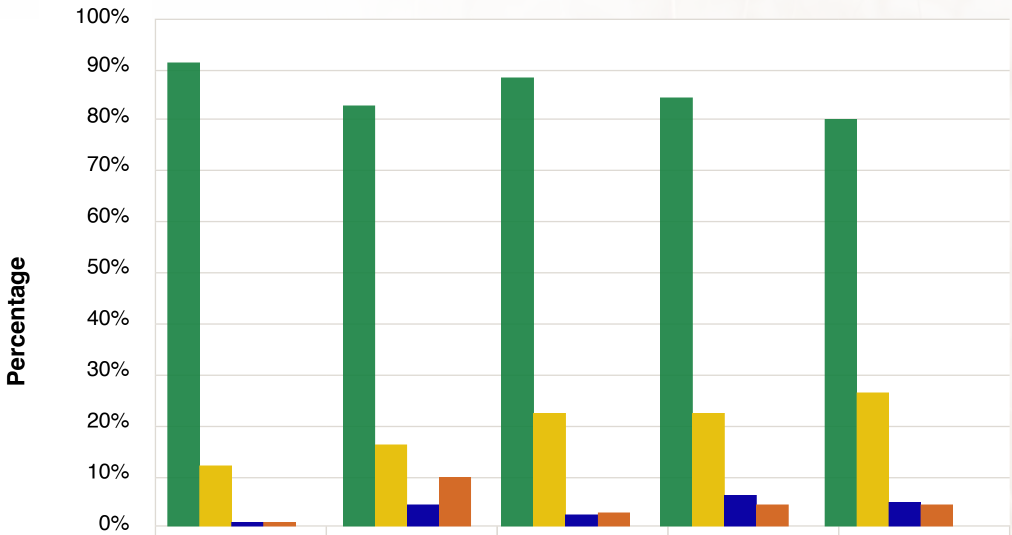
Source: Statistics NZ, Census 2013 (District Health Board constituency tables)
Note: Percentages do not add up to 100% as people are able to identify with more than one ethnic group

---

[10] Data in this section has been drawn from MidCentral DHB Health Equity Data Report 2018 and draft Regional Health and Wellness Plan 2023.

More than 80% of people living in all MidCentral DHB localities identify as being of European or Other ethnicities. This proportion is highest in Manawatu where more than 92% of people identify as European or Other. The TLA areas with the highest proportion of residents identifying as Māori are Tararua, Horowhenua and Otaki – in all of these areas at more than one-fifth of all residents are Māori. The proportion of people living in Manawatu and Tararua who identify as Pacific is very low (1.6% and 1.5% respectively). The proportion of people identifying as Pacific in the other three localities is between 4% and 5%. Palmerston North City has the greatest proportion of residents who identify as Asian (9.7%), with relatively low proportions (between 1.8% and 3.8%) of Asian residents living in the other geographical areas.

Table 7: MidCentral District population by ethnicity and locality, 2013



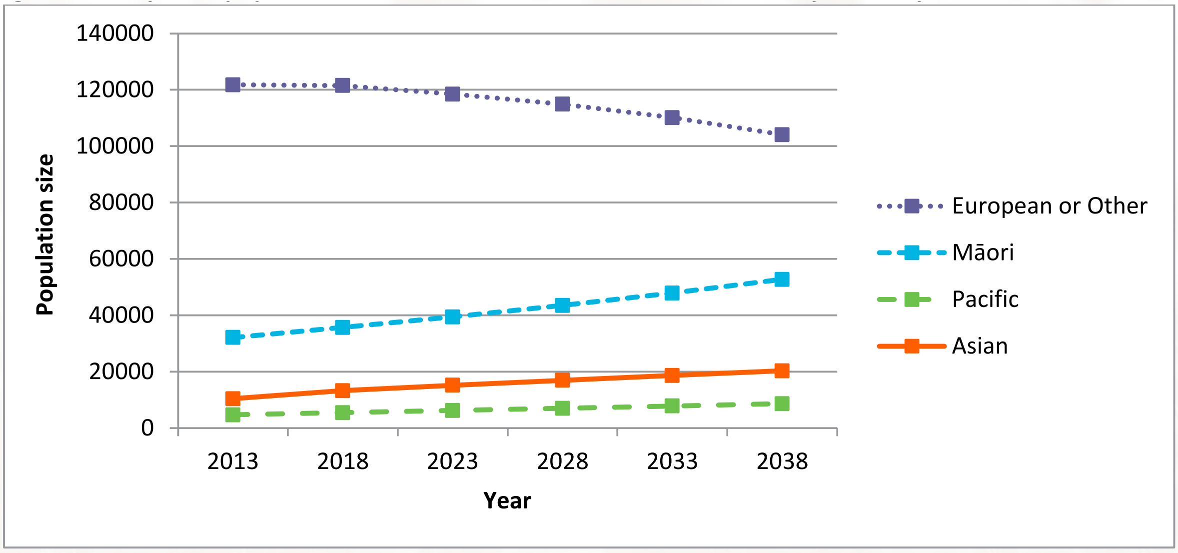
	Manawatu	PN City	Tararua	Horowhenua	Otaki Ward
🟩 **European and Other**	92.3%	82.3%	87.4%	84.6%	80.1%
🟨 **Māori**	14.8%	16.5%	21.2%	22.8%	26.4%
🟦 **Pacific**	1.6%	4.5%	1.5%	4.9%	4.1%
🟧 **Asian**	1.8%	9.7%	2.1%	3.4%	3.8%

Source: Census 2013, Stats NZ

Changing ethnic diversity

The ethnicity profile of the people living in the MidCentral DHB area is also expected to change over the next 20 years (see Table 8). The proportion of people identifying as being of European or Other13 ethnicity is projected to decrease whilst the proportions of people identifying as Māori, Pacific or Asian are all expected to increase.

Table 8: Projected population estimates for MidCentral District to 2038, by ethnicity



Source: Statistics New Zealand, DHB population projections (medium projection)

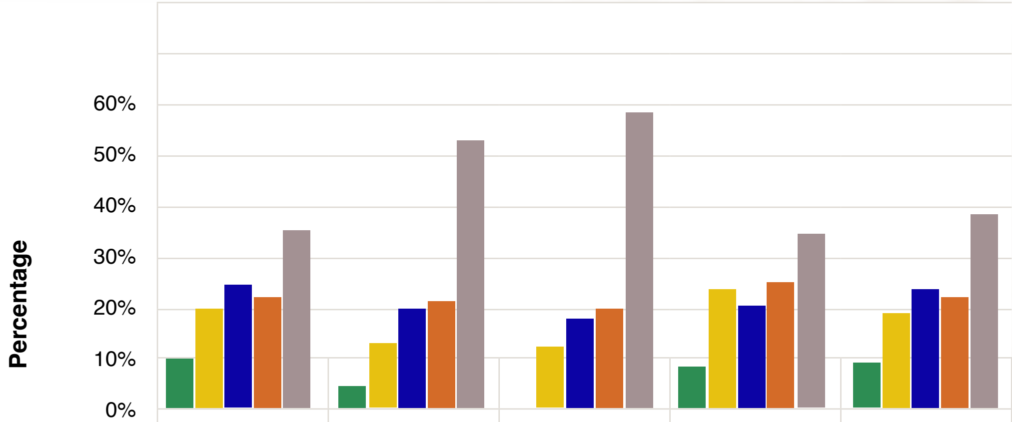
By 2038 it is expected that the proportion of people living in the MidCentral district identifying as Māori will increase to almost 30%, with Asian and Pacific people making up about 10% and 5% of the total population respectively. The proportion of the population identifying as NZ European and Other is expected to fall to about 60%.

How ethnically diverse are we?	
2013 Census	**Looking forward to 2038**
In 2013, about 85% of MidCentral residents identified as NZ European and Other, 18% identified as Māori, 6% identified as Asian, and 4% identified as Pacific.	Our population is becoming more ethnically diverse.
There are higher proportions of people identifying as Māori and Pacific in younger age groups.	Significant growth is expected in the proportion of people identifying as belonging to Māori, Pacific and Asian ethnic groups.
Across the localities, Manawatū has the highest proportion of people who identified as NZ European and Other (92%).	By 2038 it is expected that the proportion of people identifying as Māori will increase to almost 30%, with Asian and Pacific people making up about 10% and 5% of the total population respectively.
More than 20% of people in Tararua, Horowhenua and Otaki ward identified as Māori.	The proportion of the population identifying as NZ European and Other is expected to fall to about 60%.

Socioeconomic deprivation by ethnicity

The proportion of people experiencing different levels of socioeconomic disadvantage varies by ethnicity. Across New Zealand, Māori and Pacific peoples are more likely to live in neighbourhoods with high deprivation scores than people of other ethnicities. This nationally evident pattern is also apparent in the MidCentral district.

Table 9: Socioeconomic deprivation in the MidCentral District by ethnicity, 2013



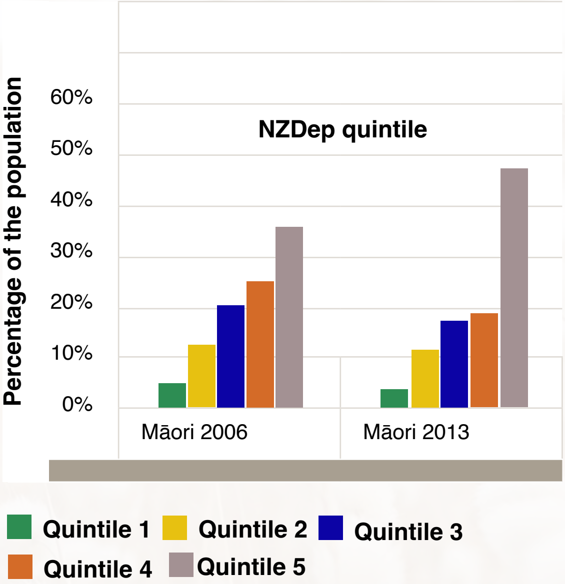
	European and Others	Māori	Pacific	Asian	MidCentral DHB, all ethnicities
🟩 **Quintile 1**	8.6%	3.6%	2.0%	7.5%	7.9%
🟨 **Quintile 2**	17.7%	11.3%	11.2%	21.0%	17.0%
🟦 **Quintile 3**	21.9%	17.4%	16.0%	18.0%	21.0%
🟧 **Quintile 4**	19.8%	19.2%	17.8%	22.4%	19.9%
▨ **Quintile 5**	32.0%	48.4%	53.0%	31.1%	34.3%

Source: Census 2013, Stats NZ and NZDep13 (Census Area Unit data)

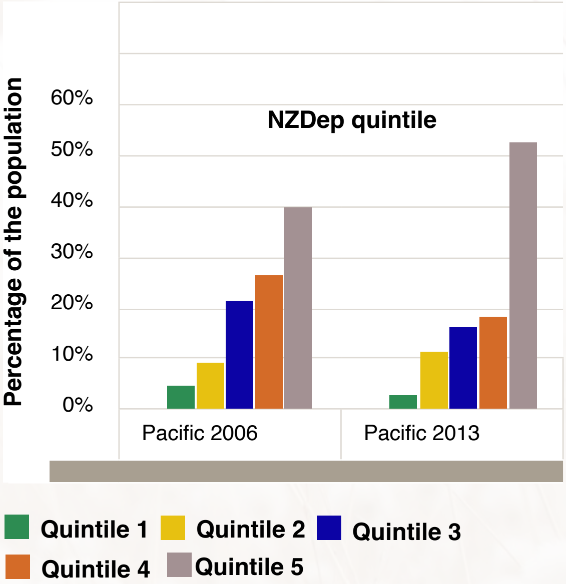
Table 9 shows that for each ethnic group there are higher proportions of people living in quintile five areas than in areas with lower NZDep scores. This reflects the fact that in the MidCentral district overall there is a higher proportion of people living in areas with high deprivation scores than in areas with low deprivation scores.

The ethnic groups with the largest proportions of people living in quintile 5 neighbourhoods (highdeprivation scores) are Māori and Pasifika (48.4% and 53.0% respectively). There are very low proportions of Māori and Pasifika people living in quintile 1 neighbourhoods (3.6% and 2.0% respectively). Although the European and Others ethnic group has a lower proportion of people living in quintile 5 neighbourhoods than Māori and Pacific ethnic groups, almost three-quarters of all people living in quintile 5 neighbourhoods in the MidCentral district belong to the European and Others ethnic group.

Table 10: Socioeconomic deprivation for MidCentral District Māori and Pacifika, 2006 compared to 2013

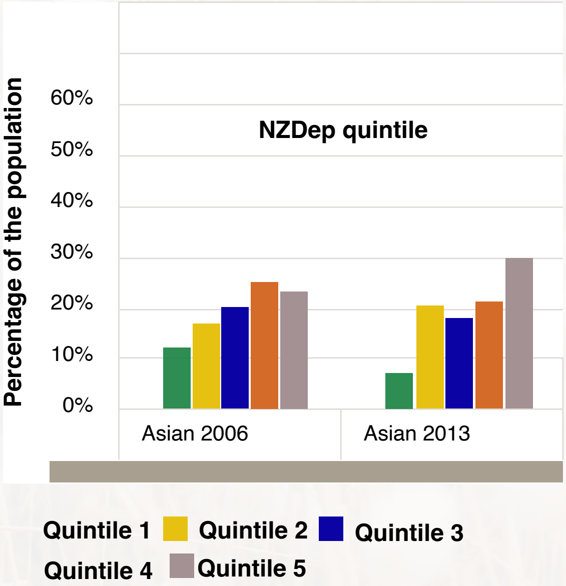


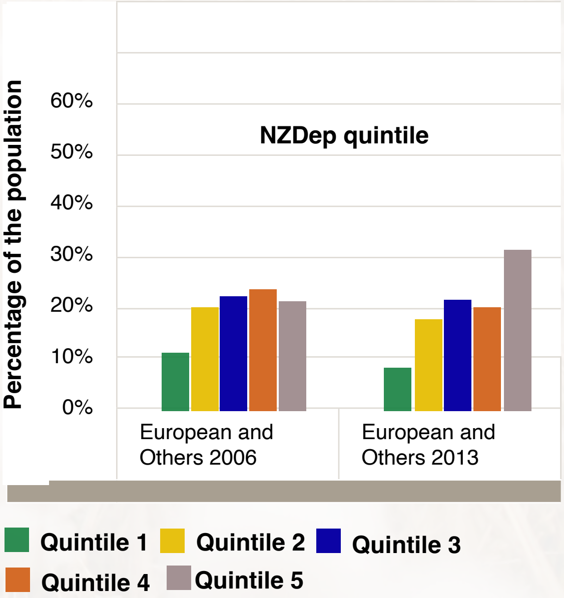
Source: NZDep06 and NZDep13 Census Area Unit data



Source: NZDep06 and NZDep13 Census Area Unit data

Table 11: Socioeconomic deprivation for MidCentral District Asian, European, and other, 2006 compared to 2013





The tables above show that for all ethnic groups there are higher proportions of people living in areas with higher deprivation scores and smaller proportions of people living in areas with the lowest deprivation scores in 2013 as compared to 2006. MidCentral Māori and Pasifika populations have the greatest proportions of people living in the areas with the highest deprivation scores.

Cultural needs differ

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. Māori, Pacific peoples, Tāngata Whaikaha I Disabled people experience inequities as a consequence of the overlapping and interconnected nature of colonisation, racism, ableism, and discrimination. Other communities also experience poorer health and wellbeing outcomes as a result of social and economic disadvantages, racism, discrimination, and stigmatisation. Such communities include people with enduring mental health and addiction problems; refugees and migrants; people from gender and sexual minorities; and people experiencing social and economic deprivation. Equity is purposeful investment of resources that transforms pathways of disadvantage to advantage. Equity, therefore, requires investment to rectify differences that are avoidable, unfair, and unjust. Equity also requires that we embed Te Tiriti o Waitangi and ensure our system is culturally safe, competent, and enabling of wellbeing. We will know that we have achieved equity when we see equity of access, quality, and outcomes in the region, particularly for Māori and then for all others who are affected unnecessarily by disadvantage.

A prominent theme arising from engagements in the district is the need to address specific cultural needs within healthcare services, in particular for Māori, Pacific, refugee and immigrant communities. Concerns were raised around the lack of culturally appropriate care. Lack of accessibility to healthcare services that align with an individual's culture and understanding has discouraged some communities to seek the care they need. Communication methods and language barriers are mentioned as example issues. Many whānau wanted alternative options to mainstream health services, particularly access to Rongoa Māori and more holistic healthcare options.

Expected Population Growth

Nationally, we are expecting a cumulative population growth of 15% in the next 20 years. The Central Region is expected to grow by 9% over 20 years. The growth in older age groups is higher (38%), while younger age groups are growing at a significantly slower rate (1.1%). We will see a 38% increase in people aged over 70 years.

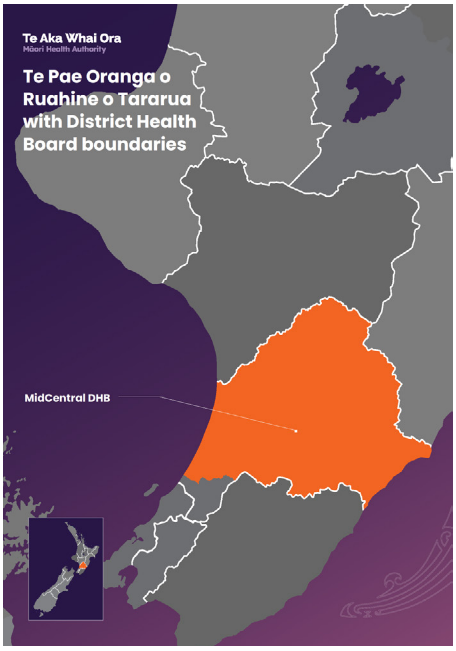
In 20 years’, time we are expecting 86,780 more people in the Central Region – bringing the total to over one million people (1,066,305). About 11% of the population (120,000 people) will be over the age of 70. Population growth, particularly from an aging population, will result in much higher demand for health services across our region. Our health workforce is aging too with a forecasted decrease in people aged 50-59 years (as at 2018/19).

Over the next 20 years our communities will also become more diverse with more Māori and Asian people. By ethnicity, the Central Region population profile will change for Māori from 20% to 25%, Asian from 11% to 17%, and European/ Other from 63% to 52%. Pacific is expected to remain at 6%.

Source image: claire Kelly_ Unsplashed

Māori

Te Aka Whaiora completed a report in 2023 entitled Iwi-Māori Partnership Board Health Profile: Te Pae Oranga o Ruahine o Tararua Volume 1 that outlines the key demographic information for the MidCentral region. We have drawn on the data and information within this profile to guide our identification of areas requiring additional focus to reach our pro-equity aspirations.



For context to the data and information outlined in this section, it is noted that Te Pae Oranga o Ruahine o Tararua IMPB is home to an estimate of 45,550 Māori as at 2023 and consists of the geographic area of the former MidCentral DHB in Manawatū, serving Palmerston North, Manawatū, Tararua and Horowhenua, and Ōtaki.

Growing and Young Māori Population

Data projections for the population in the Te Pae Oranga o Ruahine o Tararua region indicates the Māori population will continually increase over the next 20 years, while the non-Māori population will dip. Provided Māori health outcomes remain consistent, the comparative increase in the Māori population will create a need for Māori-focused services to be increased to maintain an equitable approach.

Table 12: Population age distribution, Māori vs non-Māori

Age Groups (years)	Māori			non-Māori		Total IMPB number
	Number	Age distribution	% of IMPB	Number	Age distribution	
0-14	12,890	30%		22,680	15%	35,570
14-24	8,175	19%		17,330	12%	25,505
25-44	10,895	26%		35,960	24%	46,855
45-64	7,490	18%		37,570	26%	45,060
65+	2,790	7%		33,595	23%	36,385
Total	**42,550**	**100%**	**22%**	**146,860**	**100%**	**189,410**

Table 13: Population projections, Māori vs non-Māori 2023 - 2043

Year	Māori					non- Māori				
	Residents	%	%	%	%	Residents	%	%	%	%
		of IMPB	0-14	15-64	65+		of IMPB	0-14	15-64	65+
2023	42,550	22%	30%	62%	7%	146,860	78%	15%	62%	23%
2028	46,850	24%	28%	63%	8%	148,100	76%	15%	60%	26%
2033	51,320	26%	28%	63%	9%	147,990	74%	13%	59%	28%
2038	56,050	28%	27%	62%	10%	146,420	72%	12%	58%	30%
2043	60,000	29%	26%	63%	11%	144,450	71%	12%	58%	31%

There is a significant gap in the ageing populations of Māori and non-Māori. Over the next 20 years, both the Māori and non-Māori populations will see an increase in the proportion of 65+ years and a decrease in the proportion of 0-14 years, signalling the population overall is ageing. However, the 65+ years population will grow more substantially with non-Māori than with Māori. Despite the ageing population of Māori, those aged 65+ years will remain disproportionately low.

The disproportionate population ages make it important to target services in two ways:

1. Increase and focus on effective support for Māori to live longer
2. Ensure sufficient support is available for the disproportionately high number of young Māori.

Shorter Life Expectancy and Mortality

The table below describes for the Te Pae Oranga o Ruahine o Tararua region, in order, life expectancy, leading causes of death, and leading causes of avoidable deaths for Māori and non-Māori.

Table 14: Life expectancy, Māori vs non-Māori

Sex	Māori Years (95% credible interval)		non- Māori		Difference in years
Female	79.4	(78.0, 80.8)	83.4	(83.0,83.9)	-4.0
Male	77.9	(75.4, 80.3)	79.9	(79.4,80.4)	-2.0

The data on life expectancy and causes of death indicate Māori have a slightly lower life expectancy which is likely a contributing factor to the proportionally low aged population among Māori. In addition to this, the proportion of Māori who died from leading causes tended to align to the Māori proportion of the total population, whereas the proportion of Māori who died from avoidable leading causes of death tended to be significantly higher than the proportion of the total population they represent.
For example, 19.35% of the total people who died from diabetes mellitus were Māori, which is close to the Māori proportion of the total population of 16.5%.

Whereas 55.5% of the total people who died from avoidable diabetes were Māori which is well above their proportion of the Māori population. The higher proportion of Māori suffering from avoidable deaths indicates an inequity within the system and service Māori are receiving.

Table 15: Mortality causes, Māori vs non-Māori

Cause	Av. no per year	**Māori** Age- standardised (95% CI)		Av. no. per year	**non- Māori** Age- standardised (95% CI)		**Māori/ non-Māori rate ratio (95% CI)**		**Rate difference**
Female									
Lung cancer	9	28.7	(12.8,54.9)	33	9.4	(5.8,13.9)	**3.07**	**(1.41,6.71)**	19.3
Ischeamic heart disease	9	27.3	(12.2,51.9)	92	11.4	(8.1,15.3)	**2.38**	**(1.15,4.94)**	15.9
COPD	6	18.9	(6.7,41.6)	32	6.8	(4.0,10.5)	**2.78**	**(1.09,7.06)**	12.1
Cerebrovascular disease	4	11.1	(2.4,30.5)	58	7.0	(4.7,9.8)	1.58	**(0.51,4.88)**	4.1
Suicide	3	15.3	(2.7,46.5)	8	8.2	(2.5,17.9)	1.87	**(0.44,8.03)**	7.1
Male									
Ischeamic heart disease	11	42.7	(20.9,77.0)	122	31.0	(23.5,39.5)	1.38	**(0.72,2.64)**	11.7
Suicide	4	21.9	(5.2, 58.1)	16	18.1	(9.3,30.9)	1.21	**(0.38,3.90)**	3.8
Dianetes mellitus	3	13.8	(2.4,41.1)	16	4.7	(1.6,9.3)	2.93	**(0.73,11.79)**	9.1
Lung cancer	3	12.7	(2.7,36.0)	36	10.6	(6.6,15.8)	1.19	**(0.37,3.86)**	2.1
Cerebrovascular disease	3	11.2	(1.8,34.3)	47	9.8	(6.0,14.5)	1.14	**(0.32,4.05)**	1.4
Total									
Ischeamic heart disease	20	34.9	(21.1,54.2)	214	20.7	(16.7,25.2)	**1.69**	**(1.04,2.74)**	14.2
Lung cancer	12	21.5	(11.1,37.5)	70	9.9	(7.2,13.2)	**2.17**	**(1.15,4.11)**	11.6
COPD	8	14.3	(6.2,27.8)	66	6.8	(4.9,9.2)	2.09	**(0.99,4.41)**	7.5
Suicide	7	18.1	(6.8,38.5)	24	13.0	(7.6,20.4)	1.39	**(0.56,3.45)**	5.1
Dianetes mellitus	6	11.7	(4.1,25.9)	31	3.6	(1.8,6.0)	**3.32**	**(1.21,8.66)**	8.1

Similar patterns of inequity for Māori in the MidCentral district as compared to the MDHB total population were found for many of the health indicators examined in this report. Between 2006 and 2014, large differences in mortality rates between Māori and the total population in the MidCentral district were found for a range of causes of mortality, including premature deaths1 that are considered somewhat preventable through good access to high-quality health care (amenable mortality). There was also evidence to suggest that for many of the mortality indicators no progress was made towards reducing the equity gaps, and for some, the gap widened further.

Table 16: Summary of key health equity findings for Māori in MidCentral District compared to total population

Indicator	Rate comparison over time (based on line-of-best-fit)					
	Difference between rates (per 100,000 population)		Difference between rates (percent)		Size of difference in 2014	Direction of change (2006-2014)
	2006	2014	2006	2014		
All-cause mortality	164.4 per 100,000	242.0 per 100,000	36.2%	60.7%	+++	**Difference increased**
Mortality due to circulatory diseases	54.8 per 100,000	91.2 per 100,000	36.4%	74.7%	+++	**Difference increased**
Mortality due to cancers	34.6 per 100,000	86.0 per 100,000	24.2%	69.1%	+++	**Difference increased**
Mortality due to respiratory diseases	20.3 per 100,000	20.2 per 100,000	59.2%	59.8%	+++	**Largely unchanged**
Mortality due to external causes	30.2 per 100,000	2.9 per 100,000	60.6%	6.6%	+/-	**Difference decreased**
Malignant cancer registrations	No data	No data	No data	No data	-	-
Amenable mortality	121.7 per 100,000	69.2 per 100,000	94.3%	67.2%	+++	**Difference decreased**
Acute hospitalisations**	361.5 per 100,000	223.5 per 100,000	3.7%	2.1%	+/-	**Largely unchanged**

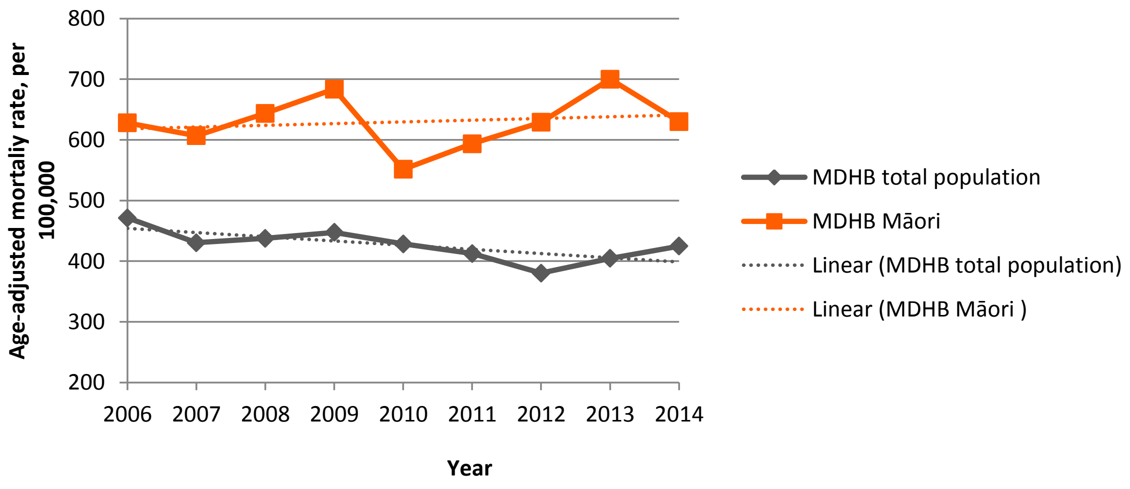
Key to size of differences (2014): **+/-** = <10% difference; **+** = 10-<20% difference; **++** = 20-<40% difference; **+++** = ≥40% difference

**Note: Acute hospitalisation data is for 2006 and 2016 (not 2014)

All-cause mortality

Table 17 shows that age-adjusted all-cause mortality rates for MidCentral Māori were higher than all-cause mortality rates for the total population in the MidCentral district between 2006 and 2014. The data suggests that all-cause mortality rates decreased slightly for the MDHB total population over the last decade whilst they have remained relatively constant or may have been slowly increasing for MidCentral Māori.

Table 17: All-cause mortality rate (age-adjusted), MidCentral District Māori compared to total population (2006 - 2014



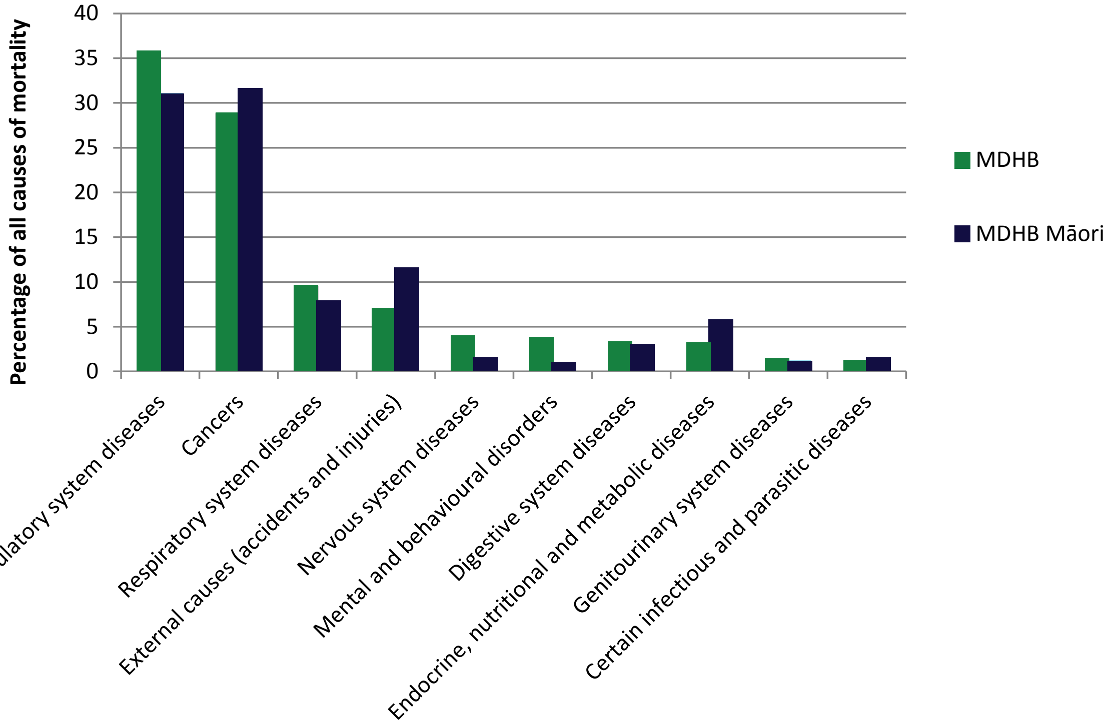
Source: MidCentral DHB Health Needs Assessment 2017

Dotted lines represent the "line of best fit" for each data set

Most common causes of mortality

Table 18 shows the ten most common causes of mortality as a percentage of all deaths for MidCentral Māori residents as compared to the total MDHB population for the four-year period from 2011 to 2014.

Table 18: Most common (top ten) causes of mortality, MidCentral District Māori compared to total population (2011 - 2014)



Source: MidCentral DHB Health Needs Assessment 2017

Based on top ten most common causes of mortality for MDHB total population

MDHB Māori top ten causes of mortality did not include:

- Mental and behavioural disorders (0.93% - 13th most common cause of mortality for MDHB Māori)

MDHB Māori top ten causes of mortality included:

- Certain conditions originating in the perinatal period (1.11% - 9th most common causes of mortality for MDHB Māori)

This graph shows that circulatory system diseases and cancers cause the large majority (>60%) of deaths for MidCentral Māori and the MDHB total population. The percentage of all deaths caused by cancers was slightly higher for MidCentral Māori than for the total population and the percentage of all deaths caused by circulatory system diseases was slightly lower for MidCentral Māori than for the total population. Also of note is that the percentage of all deaths occurring as a result of external causes (injuries and accidents) was considerably higher for MDHB Māori than for the total population during this time period. The ten most common causes of mortality shown in the graph are based on the ten most common causes for the MDHB total population. Mental and behavioural disorders do not appear in the ten most common causes of mortality for MidCentral Māori (13th most common for MidCentral Māori). Instead, certain conditions originating in the perinatal period are included in the ten most common causes of mortality for MidCentral Māori (9th most common for MidCentral Māori).

The four most common causes of mortality in the MidCentral district (for both Māori and the total population) from 2011-2014 were circulatory diseases, cancers, respiratory system diseases and external causes of death (injuries and accidents). Each of these top four causes of mortality will be considered separately over the next few pages of this technical report.

Overall Health equity assessment

The MidCentral Māori population had considerably higher rates than the MDHB total population for almost all of the key health indicators examined in this report. As shown in Table 14, the differences tended to be large (>40% difference between MidCentral Māori and the MDHB total population on average in 2014) and for 3 indicators (all-cause mortality, circulatory disease mortality and cancer mortality) the difference between MidCentral Māori and the MDHB total population appeared to be increasing. The difference between Māori and the total population for mortality due to respiratory disease was high and remained largely unchanged between 2006 and 2014. Amenable mortality rates were considerably higher for MidCentral Māori than for the MDHB total population in 2014, however the difference between groups appeared to have decreased since 2006. The difference between MidCentral Māori and the MDHB total population for external cause mortality was relatively small in 2014 and the data suggested it had decreased from a much larger difference in 2006. Despite the clearly poorer mortality outcomes for MidCentral Māori shown by this analysis, it is interesting to note that acute hospitalisation rates are similar for MidCentral Māori when compared to the MDHB total population.

Table 19: Summary of key health findings for MidCentral District Māori compared to total population

Indicator	Rate comparison over time (based on line-of-best-fit)					
	Difference between rates (per 100,000 population)		Difference between rates (percent)		Size of difference in 2014	Direction of change (2006-2014)
	2006	2014	2006	2014		
All-cause mortality	164.4 per 100,000	242.0 per 100,000	36.2%	60.7%	+++	**Difference increased**
Mortality due to circulatory diseases	54.8 per 100,000	91.2 per 100,000	36.4%	74.7%	+++	**Difference increased**
Mortality due to cancers	34.6 per 100,000	86.0 per 100,000	24.2%	69.1%	+++	**Difference increased**
Mortality due to respiratory diseases	20.3 per 100,000	20.2 per 100,000	59.2%	59.8%	+++	**Largely unchanged**
Mortality due to external causes	30.2 per 100,000	2.9 per 100,000	60.6%	6.6%	+/-	**Difference decreased**
Malignant cancer registrations	No data	No data	No data	No data	-	-
Amenable mortality	121.7 per 100,000	69.2 per 100,000	94.3%	67.2%	+++	**Difference decreased**
Acute hospitalisations**	361.5 per 100,000	223.5 per 100,000	3.7%	2.1%	+/-	**Largely unchanged**

Key to size of differences (2014): **+/-** = <10% difference; **+** = 10-<20% difference; **++** = 20-<40% difference; **+++** = ≥40% difference

**Note: Acute hospitalisation data is for 2006 and 2016 (not 2014)

Māori have greater Whānau Composition

Table 20: Whanau composition in IMPB area compared to NZ

Whānau description	Te Pae Oranga o Ruahine o Tararua		Aotearoa	
	%	(95%CI)	%	(95%CI)
Size of whānau				
10 or less	57.1	(51.2,63.0)	52.1	(50.6,53.6)
11 to 20	23.6	(19.2,27.9)	24.2	(23.0,25.4)
More than 20	19.3	(15.5,23.2)	23.7	(22.3,25.0)
Groups included in whānau				
Parents, partner, children, brothers and sisters	98.3	(97.0,99.6)	97.4	(97.0,97.8)
Grandparents, grandchildren	40.8	(35.0,46.6)	39.0	(37.5,40.5)
Aunts and uncles, cousins, nephews and nieces, other inlaws	50.5	(44.6,56.3)	48.6	(47.1,50.2)
Close friends, others	22.8	(18.7,27.0)	22.6	(21.3,23.8)

Access difficulties for Māori

Māori tend to access healthcare services less than non-Māori. Reported evidence[11] reveals that for the Te Pae Oranga o Ruahine o Tararua region, those living in urban and rural areas, those with no access to motor vehicles, those no access to telecommunications, and how many are already enrolled in primary care – reveals inequities for Māori across the board.

As Māori are more likely than non-Māori to live rurally, and less likely to live in urban settings, it can cause barriers to access of healthcare services. In addition to this, the data shows Māori were 1.86 times more likely than non-Māori to have no access to a vehicle and 2.11 times more likely to have no access to telecommunications. Combined, this data indicates a significant equity gap in the form of access challenges for Māori.

Finally, the data indicates that Māori were 0.83 times less likely to be enrolled in primary care. This can be attributed to the access issues identified, or other factors such as Māori uncomfortable with care that is not culturally appropriate or aware.

---

[11] Te Pae Oranga o Ruahine o Tararua Health Profile, Te Aka Whai Ora, 2023

Culture and Spirituality Needs

The below table reports for the Te Pae Oranga o Ruahine o Tararua region, the importance to Māori of their culture and spirituality:

Table 21: Importance of culture and spirituality for whānau – IMPB area vs Aotearoa

	Te Pae Oranga o Ruahine o Tararua		Aotearoa	
	%	(95%CI)	%	(95%CI)
Importance of being invlolved in Māori culture				
Very important	20.1	(16.5,23.6)	22.1	(21.1,23.1)
Quite important	20.0	(16.3,23.6)	23.2	(22.1,24.3)
Somewhat	30.9	(26.0,35.7)	25.8	(24.7,26.9)
A little important	17.7	(13.4,22.1)	18.3	(17.1,19.5)
Not at all important	11.3*	(7.0,15.6)	10.6	(9.7,11.6)
Importance of spirituallity				
Very important	27.5	(22.9,32.2)	30.7	(29.5,31.9)
Quite important	16.6	(12.7,20.6)	18.0	(16.9,19.0)
Somewhat	19.1	(15.0,23.1)	16.8	(15.9,17.8)
A little important	18.2	(14.6,21.8)	15.3	(14.3,16.2)
Not at all important	18.5	(13.6,23.4)	19.2	(18.1,20.4)

The majority of Māori in the Te Pae Oranga o Ruahine o Tararua region considered it somewhat to very important to be involved in Māori culture and spirituality. Despite this, only 11.4% of Māori accessed traditional healing and massage. The discrepancy could be a result of a lack of suitable and accessible traditional healing and massage services, demonstrating a potential inequity within the system.

Other Factors Impacting Māori Health Outcomes

Mātauranga Māori has established a strong argument for the importance of considering the holistic needs and aspirations of whānau and providing an integrated and connected support system to be able to effectively improve Māori health and wellbeing. The evidence from the IMPB Health profile reports for the Te Pae Oranga o Ruahine o Tararua region, adults with a Level 2 certificate or higher, employment status, those engaged in unpaid work, those with an income of $20,000 or less, how many live in each decile category, how many have housing quality issues.

Data indicates Māori were:

- Less likely to be educated – limiting future employment opportunities which in turn can impact mental health and self-esteem
- Less likely to be employed – directly impacting mental health and self-esteem
- More likely to be looking after disabled or ill household or non-household members – directly impacting mental health and related pressures, as well as potentially contributing to issues such as no income or overcrowded homes
- More likely to have a total income of under $20,000 – directly impacting on the standards of living the individual can achieve
- More likely to live in a decile 8-10 (deprived) area – which can in turn cause physical health issues through issues such as poor housing stock or increased presence of alcohol or junk food retailers
- More likely to live in damp or mouldy housing – directly impacting on physical health through respiratory or related issues.

These issues present inequities in the broader system for Māori but as noted can have a mixture of direct and indirect impacts of the health and wellbeing of Māori. For this reason, it is necessary for support to be holistic and integrated across the system to effectively address health issues for Māori.

Source image: Tony Stoddard_ Unsplashed

Pacific communities

'Pacific' is a collective term used in New Zealand to recognise the diversity of nationalities, ethnic groups, and languages of people from the Pacific Islands.

Although Pacific peoples have a high level of enrolment in primary health care organisations, more Pacific children and adults end up in hospital with preventable health conditions that reflect high unmet need impacted by the wider social determinants of health. There are a range of factors that influence Pacific people's access and utilisation of health care services. Common issues experienced by the Pacific community includes:

- Health literacy, difficulty understanding health terminology and communication with health workers
- Not being able to get an appointment at an appropriate or desired time
- Not being able to afford doctor fees and medication costs
- Lack of transport to attend clinics and appointments
- Difficulty getting time off work to attend health appointments or take children to appointments.

The way people are treated and engage in their care and the quality of care and support they receive can impact their quality of life and wellbeing. Systemic racism and discrimination were identified in the Ministry's community talanoa as serious issues that stop many Pacific people from going to see the doctor. Pacific peoples in Aotearoa New Zealand experience significant inequities leading to poor health outcomes. Life expectancy for Pacific peoples is 5 years lower for males and 4.5 years lower for females compared with the rest of New Zealand's population. Poor health outcomes and inequities for Pacific peoples can largely be attributed to long-term conditions, such as cardiovascular disease, diabetes, and cancer.

Through the Te Pae Tata consultation process, Pacific communities have told us that they want:

- A strong emphasis on prevention and the wider determinants of health
- To be active leaders of their wellbeing, equipped with what they need to stay well
- A strong voice in the health system and involvement in design and development of services
- Access to their data and to know that we are using their health information well
- Services that are high-quality, seamless, consistent, and accessible
- To feel confident, safe, and respected when accessing services
- To see themselves in the workforce and to be valued and supported.

A companion document to Te Pae Tata titled Ola Manuia Interim Pacific Health Plan July 2022 to June 2024 [12] (Ola Manuia) outlines a programme of work that will support Pacific families and communities in Aotearoa New Zealand to stay well and access the care they

---

[12] Ola Manuia Interim Pacific Health Plan July 2022 – July 2024

need when and where they need it.
Six key Pacific health enablers are identified in Ola Manuia to build critical Pacific health foundations and infrastructure, and address the needs of Pacific communities:

1. **Population health approaches and intersectoral collaboration:** We will ensure population health approaches are embedded in the system and collaborate with other sector agencies to take action on the Socio-economic and wider determinants of health. Health is a key partner in the All-of-Government Pacific Wellbeing Strategy, led by the Ministry for Pacific Peoples.

2. **Community voice:** We will ensure the diverse voices of Pacific consumers, aiga and communities are heard and will implement robust mechanisms for these insights to be embedded throughout the health system.

3. **Health data, intelligence, and insights**: We will establish a robust Pacific health data and intelligence function to ensure that Pacific health data is collected and used appropriately.

4. **Strengthen Pacific commissioning:** We will strengthen the dedicated Pacific commissioning function and build on the successes from COVID-19 to ensure commissioning with Pacific providers is high-trust, flexible and outcomes focussed, and the needs and priorities of Pacific communities are reflected in commissioning across the health system.

5. **Pacific provider development:** We will provide sustainable and equitable funding to enable Pacific health and disability service providers to grow and respond to current and future Pacific health needs.

6. **Pacific workforce development:** We will support and develop the Pacific health workforce to ensure Pacific people are represented equitably in all areas of the health system, including clinical, support and leadership roles throughout the health system.

Our Pacific health providers have worked closely with communities to design services that reflect Pacific families and their lives. We have invested in more community owned and led health responses and have begun to engage with communities more meaningfully. Over the next two years, we will embark on an exciting programme of work that will build and strengthen the foundations for Pacific health in the reformed system, while starting on a long-term path to address key Pacific health priorities.

Cancer

There is significant inequity in cancer outcomes, with around 20% more Māori likely to develop cancer and nearly twice as many likely to die compared to non-Māori. Once diagnosed, Māori experience poorer survival than non-Māori for 23 of the 24 most common cancers. Pacific people also experience a higher incidence of and mortality from cancer compared with non-Pacific people. While cancer survival is improving in Aotearoa, our rate of improvement is slower than in other comparable countries and we risk falling behind.

Reduce cancer incidence through health promoting behaviours: To promote healthy living at an early age, we are providing the Healthy Active Learning programme to schools and early learning services across the region, in partnership with Sport Wellington and the Ministry of Education. The Healthy Active Learning programme promotes healthy food and drink (water and plain milk only) and is targeted at low decile schools with higher numbers of Māori and Pacific students. The National Public Health Service also supports schools to adopt water-only (healthy food and drink) policies.

Source image: Alex Perry_ Unsplashed

Improve cancer outcomes through early identification of cancer, and early access to treatment: To identify and address cancer early, our regional screening services are employing a range of strategies to ensure all eligible people are screened for breast, cervical and bowel cancer. Our screening services are particularly focussed on improving the screening rates for Māori and Pacific people. Once a diagnosis of cancer is confirmed, we want to ensure patients receive timely, well-coordinated and seamless care, including timely access to a specialist appointment and treatment.

Chronic health conditions

One in four New Zealanders lives with multiple chronic health conditions that are often experienced by several generations in the same whānau, such as diabetes, heart disease and stroke. The greatest burden of chronic conditions is experienced by Māori and Pacific people, who develop these conditions 10-20 years earlier than non-Māori and non-Pacific.

The best way for us to tackle these chronic health conditions is to support people to live healthy lives, reducing the burden and prevalence of these diseases. To improve treatment for these chronic health conditions, we will ensure our health services will work alongside whānau to improve the health and wellbeing of affected people and reduce the need for hospital stays that disrupt people’s lives.

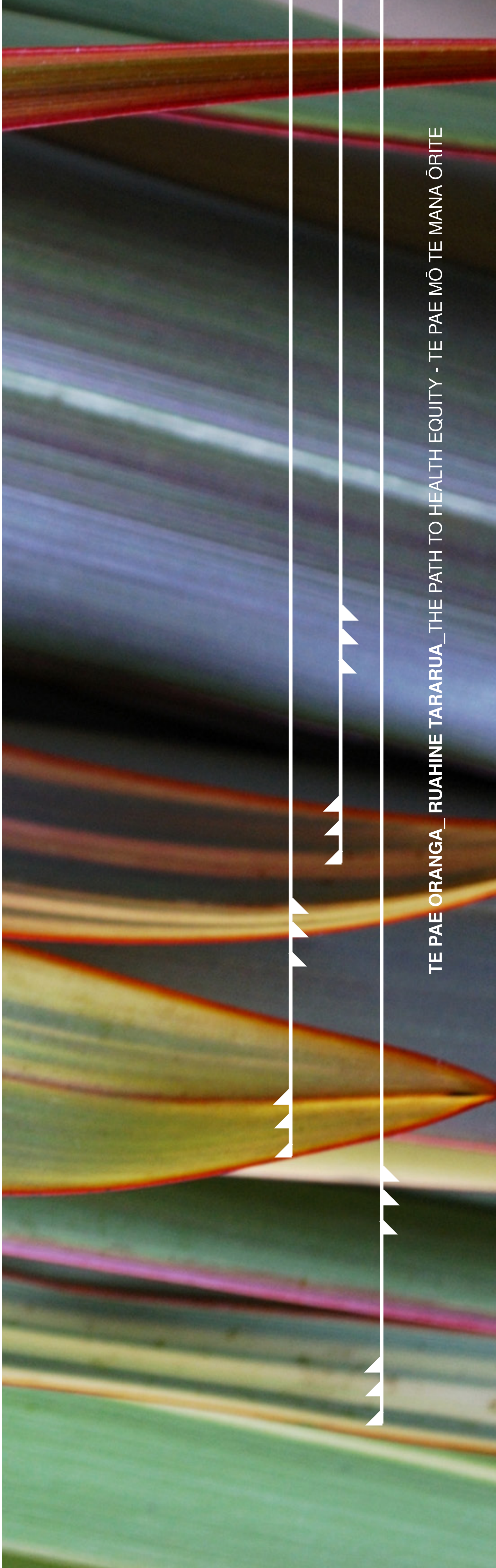
- **Diabetes:** To improve outcomes for people with diabetes, Manatū Hauora, Te Whatu Ora, and Te Aka Whai Ora are leading the development of a National Diabetes Plan. The plan will include goals to support whānau becoming the kaitiaki of their own health when it comes to diabetes. In Te Ikaroa, greater collaboration is required within the sector, with partner agencies, and importantly changing ways of working so that local community led approaches are understood and central to evolving equitable policy, planning and delivery. We also need to improve access to Podiatry services across the region to ensure we meet the needs of Māori, Pacific, and disabled people.

- **Gout:** Gout is highly amenable to treatment once it is diagnosed. Data from the Health Quality & Safety Commission shows that Māori and Pacific are significantly less likely to receive treatment than Europeans, even though the rates of gout in Māori and Pacific are much higher than Europeans. There are existing programmes in three of the five districts within the region, which involve the diagnosis and treatment of gout using general practice, Kaiāwhina, and pharmacies. The success of these will be reviewed and the need for a regional plan investigated. Any plan should be targeted to areas with high concentrations of Māori and Pacific. Experience has shown that the involvement of the whole whānau is essential to the success of any such plans. Māori and Pacific providers are key for the success of any programmes.

- **Respiratory Diseases:** While there a significant amount of work proceeding across the region to prevent respiratory diseases, it is not spread evenly across the region. As for the metabolic diseases a there is a need for a review and evaluation of the existing programmes so that a regional plan can be developed, which considers the major variation due to ethnicity, deprivation, and location. The Asthma & Respiratory Foundation 2021 report makes several recommendations.

  Three of the important ones are: urgent new and extended programmes to reduce the severe ethnic and socio-economic inequalities in respiratory disease; targeted programmes in Māori and Pacific communities and in the most socio-economically deprived neighbourhoods to reduce not only inequalities, but overall rates of respiratory disease; and initiatives to improve housing quality and warmth, and reduce dampness, in order to reduce respiratory illness.

- **Adult Oral Health:** Left untreated, poor oral health can become a chronic condition that can lead to other health and social issues. Access to dental care is challenging for many adults, especially those on low incomes or living in remote areas. There are disparities in oral health outcomes between different population groups, including Māori and Pacific communities. Concern about access to adult oral health services has been raised by our IMPBs. It is also clear from our community engagement feedback that many people find private dental care unaffordable. Some people employ other management strategies such as taking painkillers, using medication to numb the area or, when things get bad, extracting teeth. It is not uncommon for people to pull their own teeth to end the infection and pain. Unmet oral health care needs are high, especially among priority populations and the elderly. Some elderly patients are living with pain and infection in their final years with dental problems that are undiagnosed or are unable to be treated.36 There is a need for affordable, community-based oral health care services for people on low incomes, including the elderly. Potential options to be explored further include:



Tāngata Whaikaha Māori

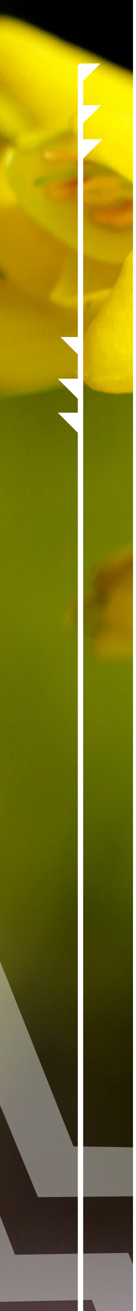
and Disabled People

We know that approximately one in four people in Aotearoa New Zealand report that they have a disability, but we do not have data on the numbers or types of disability by region. However, we do have information about people who receive disability support from the Manatū Hauora (Ministry of Health). In 2019/20, there were 40,064 people in New Zealand receiving disability support. Of these, 49% had a learning disability, 27% autism disorder, and 21% physical disability as their main disability. It is important to emphasise, however, that only a small section of the disability community have access to disability support services.

Table 22: Number of people allocated disability support services, by domicile region, 2019 / 2020 financial year

Region`	Female	Male	Total	% of NZ total
Northland	798	1,013	1,811	5%
Auckland	4,328	7,468	11,796	29%
Waikato	1,579	2,534	4,113	10%
Bay of Pleny	1,249	1,778	3,027	8%
Taranaki	527	645	1,172	3%
Gisborne	154	227	381	1%
Hawkes Bay	**560**	**782**	**1,342**	**3%**
Manawatu -Whanganui	**1,031**	**1,280**	**2,311**	**6%**
Wellington	**1,573**	**2,297**	**3,780**	**10%**
Nelson - Malborough -Tasman	634	781	1,415	4%
West Coast	126	183	309	1%
Canterbury	2,300	3,251	5,551	14%
Otago	822	1,157	1,979	5%
Southland	433	554	987	2%
Total	16,114	23,950	40,064	100%

Source: Ministry of Health. 2022. Demographic Report of Disabled People Accessing Manatū Hauora (the Ministry of Health) Disability Support Services 13



Source image: Sandy Millar_ Unsplashed

Approximately one in four (24%) of the population has a disability.11 Mobility, agility, hearing, sight, and memory are the most common disabilities in adults, while learning, speaking and psychological/ mental health disabilities are the most common in children. In children, disabilities present at birth are the most common type. In middle age groups, disease, illness, and injuries are important with older people experiencing disabilities associated with the ageing process. Over half of people living with disabilities report more than one type of disability.

Disabled people have the same healthcare requirements throughout their lives as non-disabled people and need to be able to access the same healthcare services, as well as any specific healthcare needs related to their disability. The health system we have now in Aotearoa New Zealand does not work well for Tāngata Whaikaha I Disabled people.

Today, disabled people in Aotearoa New Zealand experience a wide range of inequities when accessing health services, and poorer health outcomes compared to non-disabled people. Inequities in access to healthcare are worse for Tāngata Whaikaha, Pacific people with disabilities, and disabled people from other minority groups. Three key values will help people in the new health system understand and approach disability in a different way to ensure disabled people are included and respected:

1. **Human Rights Model of Disability:** The new health system will recognise, understand, and prioritise the human rights and dignity of Tāngata Whaikaha I Disabled people when designing, planning, and delivering healthcare services. We will be guided by Te Tiriti o Waitangi and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) when making these decisions.

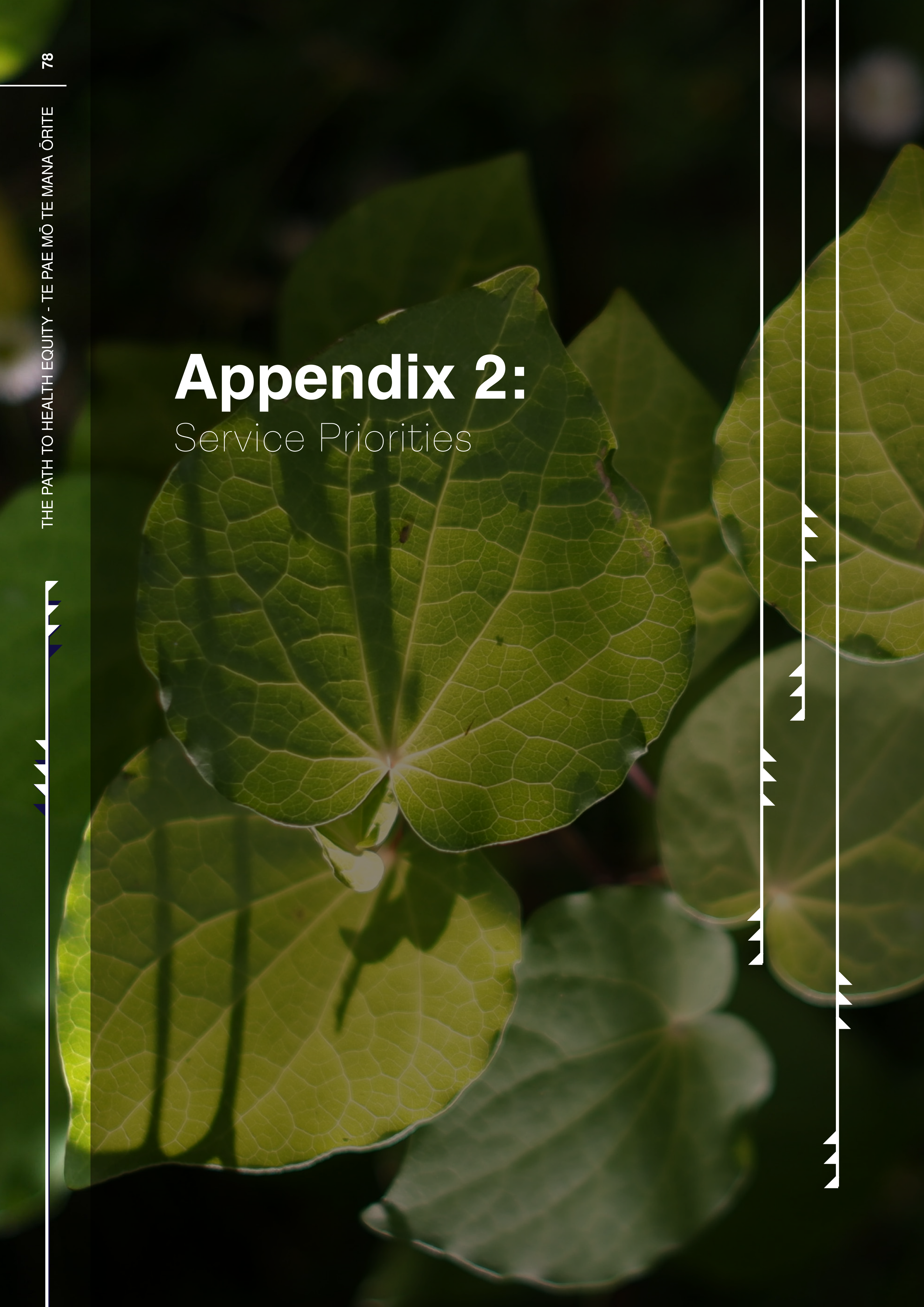
2. **Nothing about us without us:** Tāngata Whaikaha I Disabled people must lead the conversation about what an equitable health system means to them at every step of the way. We will apply the Enabling Good Lives principles to work with disabled people and make sure their voices are included and valued when designing, planning, and delivering healthcare services.

3. **Connected, holistic models of care:** Tāngata Whaikaha I Disabled people are treated as whole people who may need and want different things at different times in their lives, including culturally and age-appropriate care. The new health system will use:

   » data and digital technology to make it easier for disabled people to communicate what they need, and get the same respect and quality of care no matter what service they are accessing

   » the new “localities” approach, to set up a wider range of health services in local communities, working with local communities including disabled people to design services that work better for the people who live there.

By recognising disabled people as a priority group in Te Pae Tata, Te Whatu Ora and Te Aka Whai Ora are making a commitment to designing a new health system that will take responsibility for providing appropriate, accessible healthcare for Tāngata Whaikaha I Disabled people.



Appendix 2:

Service Priorities

Preventative

Care

Based on the findings of the report of Te Aho o te Kahu – Cancer Control Agency – it is essential that Māori are able to be diagnosed early, ideally in a primary and community care setting, and that they attend screening. Screening is one way of preventing cancers from developing and/or treating them early. Aotearoa has three cancer screening programmes: breast, cervical and bowel cancers.

While the three screening programmes are well organised, they do not function equally well for all groups, especially Māori and Pacific peoples.

As well as access to screening challenges for Māori, access to timely immunisations especially for newborns and tamariki is similarly challenging. The government has determined priority immunisation targets:

» **Childhood immunisation (24 months)** – improve immunisation rate by five percentage points or achieve a 95% immunisation rate among eligible patients.

» **MMR immunisation (1-17 years)** – improve immunisation rate by five percentage points or achieve a 95% immunisation rate among eligible patients.

» **Influenza vaccination (65 years and over)** – improve immunisation rate by five percentage points or achieve a 75% immunisation rate among eligible patients.

Currently (according to the latest MOH immunisation data) nationally 75.1% of NZ European children are fully immunised at 6m compared to Māori children at only 48%. By 24m the coverage is only 68%. This is a huge inequity – less than half of Māori children are fully immunised. It is an issue that must be addressed urgently if collectively we are to meet the Government's target of 95% coverage.

Hauora Māori providers have ably demonstrated their ability to vaccinate through the Covid-19 period and their efforts saw Covid vaccination rates sour, with the right investment. The effort to get full coverage for Māori children will take a similar investment – not just in primary care but also to support the now trained vaccinators; the support staff who follow up the population, provide transport, set up vaccination booths and events and who support whānau to achieve vaccination.

To further evidence Hauora Māori provider success in vaccinations, the Māori Influenza and Measles Vaccination Programme (MIMVP) is a Ministry of Health programme which supported 36 Hauora Māori providers to vaccinate. The evaluation of this programme [13] highlighted that MIMVP supported Māori service providers and the former DHBs to improve equity for Māori by increasing their access to influenza (flu) and measles (MMR) vaccinations. The evaluators of the MIMVP noted that "Māori providers know what works in their community, and they want to be trusted to do the mahi. Māori providers put relationships with whānau first. They listen to their communities and want to respond to their needs. They want to invest in staff and resources sufficiently to respond to their community. Māori providers also have a culture of continuous learning because they are intrinsically motivated, with a deep passion for helping their community. They would value the opportunity to share their knowledge and learn from others within the broader health system to improve immunisation and more general health outcomes for Māori".

---

[13] Wehipeihana, N., Sebire, K., Spee, K. & Oakden, J. (2022). In Pursuit of Māori Health Equity. Evaluation of the Māori Influenza and Measles Vaccination Programme. Wellington: Ministry of Health. Published in May 2022 by the Ministry of Health

The success of MIMVP is not just about flu and MMR vaccinations. MIMVP (and MIVP) has elevated a whānau-centred, holistic approach as essential for Māori health equity; affirmed Māori health providers as crucial to engaging with Māori in the pursuit of equity; highlighted Māori provider-led service design as critical within a whānau-centred approach; and identified the need for the Ministry, HNZ and MHA to develop the capacity to engage, contract and fund Māori health providers directly.

Primary

and Community Care

Primary, urgent, and after-hours care see the majority of acute minor presentations. When people are unable to access these services, they may present to hospital emergency departments. Despite subsidies for children and people on low incomes, many people delay visiting the doctor and present to emergency department due to cost barriers. Māori and Pacific enrolment and access to primary care is lower than New Zealand European and this compounds acute presentation to ED. Good-Year and Ashton found (2019), of the 28% of the population that reported inability to access primary care in the 12 months prior, 38% were Māori. Unable to pay and/or timely access were cited as reasons. Further, despite attempts to address the cost of Primary Care through subsidies, in 2014 the authors reported 44% of people categorised as high need were not enrolled in the Very Low-Cost Access scheme. One outcome from this lack of service is demonstrated by the data that states 55.5% of the total people who died from avoidable diabetes were Māori which is well above their proportion of the Māori population. The higher proportion of Māori suffering from avoidable deaths indicates an inequity within the system and service Māori are receiving.

Expanding investment in primary and community care is essential to address the health targets. Not only will additional primary and community care help divert people from using EDs as their first contact health service, but it will provide more options for Māori to access in their local communities. More available Māori-owned practices will contribute to increasing immunisation rates, keeping people out of EDs, and earlier diagnosis of conditions such as cancer. Furthermore, Hauora Māori providers who have incorporated primary care clinics also tend to offer a range of other services through their more holistic model of care, such as mental health, health promotion, child and youth health and community education/transport and patient advocacy. These additional services offer a broader range of services for whānau to address other needs, which often go un-diagnosed (e.g., mental health needs, missed screening appointments).

Of the total 1,000+ GP clinics in New Zealand [14] Te Aka Whai Ora has identified that 83 are Māori-owned clinics – only one of these is in the MidCentral district. Addressing the funding and responsiveness of general practice services to Māori health need will be an important (but far from the only) element of the Crown's response to the Tribunal's recommendations for WAI 2575".

Engagement with Māori practices identified that wait times and limited availability of GP and specialist appointments in rural areas were identified as alarming issues. Whānau have normalized these challenges and require comprehensive

---

[14] https://gpnz.org.nz/general-practice-in-new-zealand

wraparound support to manage their long-term conditions. Health care providers capable of delivering holistic care are needed.

Evidence has already shown that existence of Māori-led clinics in high need areas does have a positive impact on people attending appointments – both at primary care and secondary care level. Furthermore, it should similarly see people not having to travel to both urban and rural hospitals for ED appointments.
Te Whatu Ora needs to invest in more Māori-led primary care in the district in order to have a positive impact on hospital and specialist care. Currently there is only one Iwi-led primary care clinic in Palmerston North and a shared one in Te Awahou with THINKHauora but no others in any other part of the district. This needs to change to help alleviate pressure on hospital services and provide better access for whānau especially in rural areas of the district.

This additional capacity would be specifically required to target immunisations, specialist appointment compliance, medication advice and compliance, virtual consultations for rural patients, diverting of patients from use of EDs back to primary care and ensuring timely attendance to FSAs and specialist appointments. Māori-owned clinics are specifically adept at this where they have the additional capacity and support staff in allied health to case manage patients.

Dental services are another major gap for Māori and considerable inequities exist in this area. A June 2021 report [15] released through the NZ Māori Dental Association Te Ao Marama, confirmed that “the oral health system in Aotearoa has caused negative oral health experiences and outcomes for Mäori adults and breached Mäori rights under te Tiriti o Waitangi”. The report also noted that “data published from the 2009 New Zealand Oral Health Survey provide evidence of breaches of te Tiriti, given that they highlighted the oral health inequities experienced by Mäori children and adults in both oral health status and access to oral health services. Mäori adults had a greater accumulated lifetime experience of dental disease than non-Mäori, were less likely to visit a dental professional, and were more likely to avoid dental care due to cost (Ministry of Health, 2010)”.

The authors note that the Crown has failed to uphold Mäori rights to Öritetanga (Article 3) not only through the inequities in oral health and access to dental care, but also through the failure to collect adult oral health data which would allow for the monitoring of Mäori adult oral health. The paper drew on data collected from the 2009 NZ Oral Health Survey because this is the most recent population-wide data-set available, despite the original intention to have a 10-year commissioning cycle, so that the survey would have been repeated in 2019. This highlights the urgent need for a comprehensive nation-wide oral health survey to explore issues such as the impact of oral health on the quality of life of adults in 2021. This is important in terms of collecting Mäori health data because there is insufficient qualitative and quantitative data collection to fully inform the Crown (Waitangi Tribunal, 2019). Further investments need to be made by the Crown for Iwi Māori delivered dental care in both fixed and mobile forms, to expand the reach of dental services for Māori. Better data on the oral health of Māori also needs to be routinely collected.

A further investment should be made for case management and follow up for patients not attending appointments. Aggressive case management would see better use being made of available specialist appointment time.
This investment would be targeted in locations where Māori DNA rates are particularly high for specialist appointments and FSAs.

---

[15] Lacey JK, Thomson WM, Crampton P, Willing E (June 2021) Working towards Māori oral health equity: Why te Tiriti o Waitangi needs to underpin the oral health system, using evidence from the New Zealand Oral Health Survey

This will enable the following outcomes to occur:

- Increase financial sustainability of Hauora Māori Providers to deliver services that support the health targets
- Helps to build a stronger Māori workforce to contribute to overall sector outcomes
- Increases workforce of Hauora Māori providers in clinical and non-clinical positions to accelerate a case-management approach to ensuring patients reduce their use of EDs for primary care
- Addresses access gaps in areas of NZ with no options for kaupapa Māori primary care
- Focuses on diverting Māori patients using ED for primary care, as well as eliminating DNAs for Māori attendances at specialist appointments

Unmet primary care needs put pressure on urgent care and hospital services:

Hospital and Specialist

services

- Māori have 65% more acute care bed days (indicator that integration between community, primary and secondary care needs to improve for Māori).
- 35% increase in ASH rates for 0-4-year-olds from 2022 to 2023 (45% for Pacific and 22% for Māori children).
- Māori rates of hospitalisation for potentially preventable diseases are much higher than non-Māori, non-Pacific:
  - COPD (3.7x)
  - Stroke age 35+ (1.8 x)
  - Cardiovascular disease age 35+ (1.8x)
  - Gout (3x)
  - Young children and infants with acute bronchiolitis (3.2x)
  - self-harm (1.3x).

Māori also have higher levels of unmet health need which often means that when they present with one condition, there are often other health needs that may not have been previously diagnosed or treated. These unmet health needs often relate to the fact that 43% of the Māori population lives in rural areas with less access to care.

Māori experience differential access to healthcare (e.g. Māori experiencing unmet need, and longer and slower pathways through health care). Māori also experience higher levels of acute care need.
In an unprecedented, comprehensive investigation of New Zealand ED admissions by ethnicity, Curtis et al (2019) found additional evidence of inequitable outcomes. Indigenous and minoritised ethnicity patients waited longer, had differential pain management and less evaluation and treatment of acute conditions. Consistent with other research, Curtis et al found socioeconomic deprivation impacted ED presentation with Māori in the most deprived decile twice as likely than non-Māori in the same decile to use ED.
Māori experience differences in the quality of care received (e.g. screening for and treatment of ischaemic heart

disease, diagnosis and treatment of mental health, diabetes screening and higher levels of adverse events in hospital) leading to higher levels of acute care need.

Reid et al found, in a recent 10-year study of ICU admissions in New Zealand, Māori were more likely than non-Māori to die within 180 days of ICU admission. Māori were 13 years younger at ICU admission and had a markedly higher risk of mortality and of other adverse outcomes. The adverse outcomes for Māori patients were due to Māori presenting with more comorbidities, more likely to be admitted to ICU in an emergency and having more severe illness than non-Māori

Institutionalised racism, lack of cultural understanding and a workforce that is not representative of Māori impacts also on the patient journey for Māori.

In a systematic equity study of pharmacist led medicine review services for older Māori adults, Hikaka et al ((2019) found "Māori adults more likely to be prescribed 'high risk' medicines to treat acute issues and less likely to be prescribed medicines used to prevent or treat chronic conditions, when taking into account predicted disease burden." The study also reported the major cause of adverse drug events in older adults, including morbidity, hospitalisation (between 10 – 30% of all admissions) and mortality is potentially inappropriate prescribing".

In order to contribute to the health targets around wait times at ED and for surgeries for Māori, the primary care sector needs to be more accessible and available. Expanded operating hours in evenings and weekends would allow for more Māori to access a GP to be diagnosed early.

If the Government's targets for FSAs and surgical waitlists are to be met a parallel strategy needs to operate alongside expanded primary care. Māori attendance rates for FSAs and other surgical treatments have traditionally suffered high non-attendance levels. Compared with the population as a whole, Māori in NZ experience high levels of deprivation, reduced life expectancy, more potentially avoidable admissions and higher Did Not Attend (DNA) rates. Access to primary care services is similarly affected.

For cancer additional capacity is needed to in effect undertake case management and promotion to address DNAs and ensure Māori patients with appointments are given all the additional support needed to attend specialist appointments. As an example, a Kaitiaki Service initiative which began in October 2020 at Nelson Hospital where First Specialist Appointment did not attend (DNA) rates were at 9.3 per cent for Māori had dropped significantly to 5.8 per cent in just 8 months.

There are many other examples of this impact such as one at Counties Manukau [16] reported by the NZ Medical Council where it was identified that Māori and Pacific peoples in Counties Manukau had a higher proportion of avoidable hospitalisations than non-Māori. In fact, it was estimated that 38% of all Māori hospitalisations were potentially avoidable. The rates of potentially avoidable hospitalisations were highest in the age group of 1–14 years and accounted for 50% of all Māori 1–14-year-old admissions.

At the time of NZ Medical Council report, Counties Manukau had a Māori DNA rate of 24% (1245 out of total 5179 outpatient clinic appointments). Gender has no bearing on missed appointments, but Māori under the age of 14 years were more likely to miss an outpatient clinic appointment. A prior survey noted that 66% of Māori accessed a health service compared with 76% for non-Māori; 49% of Māori surveyed said that cost was the main reason for not seeing a GP; 22% said that "they did not want to make a fuss"; 17.1 % could not get an appointment when they wanted it; 17.3%

---

16 THE NEW ZEALAND MEDICAL JOURNAL Vol 116 No 1169 ISSN 1175 8716

reported lack of time; and 13.1% cited lack of transport. Helping to facilitate access through a Māori case-management approach helped to address these stark statistics. This involved ensuring Māori patients using the hospital were actively enrolled in Māori-owned primary care and secondly that the link with Middlemore Hospital ensured people were reminded and supported to attend specialist appointments. The results from the Māori Case Management Clinic were very encouraging. The very rapid growth of the case management approach, and the fact that most clients were Māori suggested high acceptability by the target group. The clients of the service reported very high levels of satisfaction with the service in a quite comprehensive sense. Although fee levels are important, the overall patient focus of the Māori-led service was also a major driver of patient satisfaction.

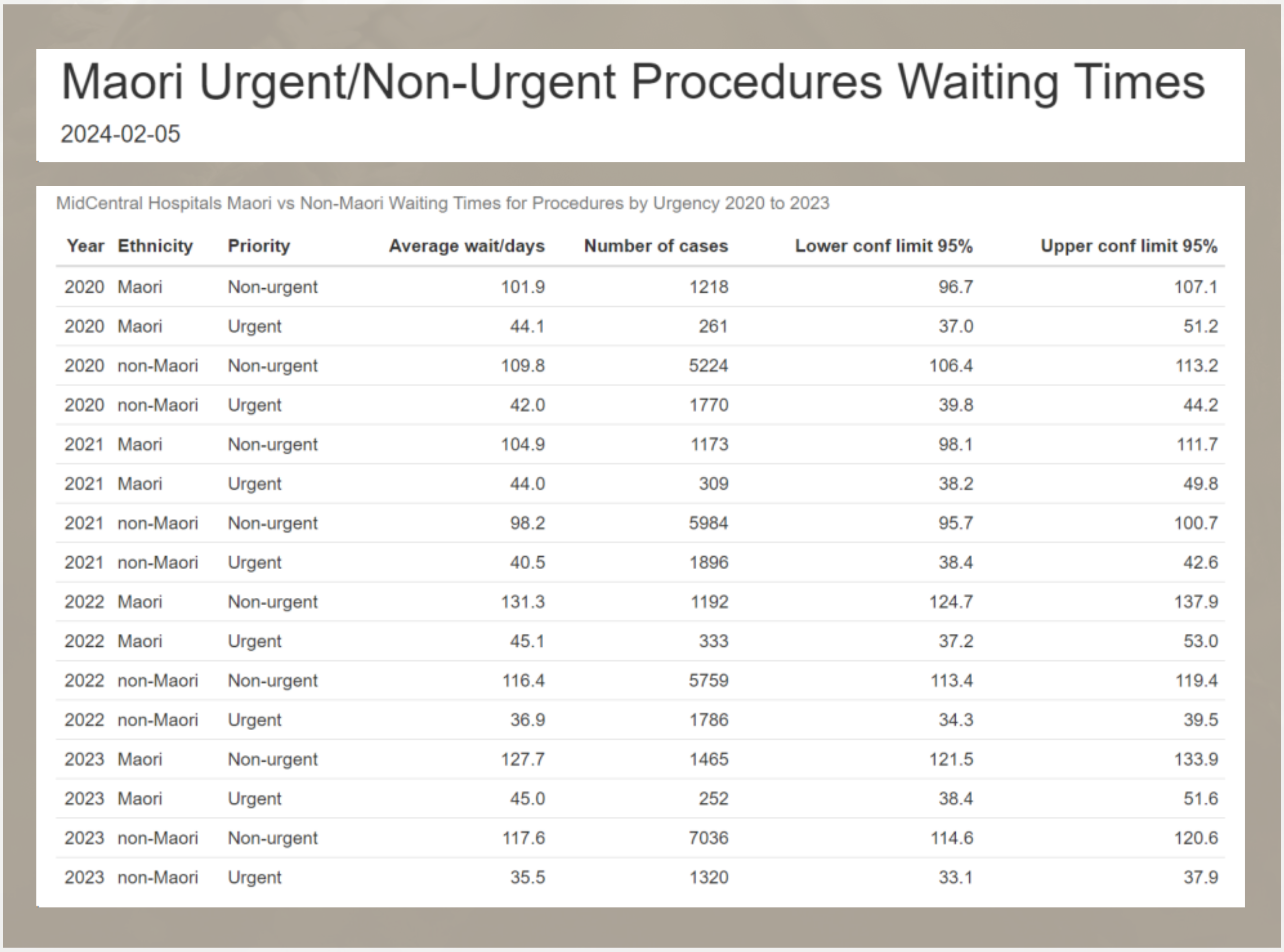
Managing wait times

Data was provided by Te Whatu Ora for waiting times comparing Māori vs non-Māori (as of 5 February 2024) for the past three years for urgent and non-urgent procedures.

Table 23: Māori vs non-Māori wait times for urgent and non-urgent procedures (2020-2023)

This reveals that apart from non-urgent procedures in 2020, in all other areas there is inequity for Māori for the past three years, and that Māori are waiting longer than non-Māori. In fact - the inequity gap has been steadily increasing.

A Reset and Restore Plan was released by the Planned Care Taskforce in September 2022. This plan provides 101 recommendations on actions to be taken locally, regionally, and nationally by Te Whatu Ora and Te Aka Whai Ora to improve equity, increase access, and reduce waiting lists for planned care.



Maori Urgent/Non-Urgent Procedures Waiting Times

2024-02-05

MidCentral Hospitals Maori vs Non-Maori Waiting Times for Procedures by Urgency 2020 to 2023

Year	Ethnicity	Priority	Average wait/days	Number of cases	Lower conf limit 95%	Upper conf limit 95%
2020	Maori	Non-urgent	101.9	1218	96.7	107.1
2020	Maori	Urgent	44.1	261	37.0	51.2
2020	non-Maori	Non-urgent	109.8	5224	106.4	113.2
2020	non-Maori	Urgent	42.0	1770	39.8	44.2
2021	Maori	Non-urgent	104.9	1173	98.1	111.7
2021	Maori	Urgent	44.0	309	38.2	49.8
2021	non-Maori	Non-urgent	98.2	5984	95.7	100.7
2021	non-Maori	Urgent	40.5	1896	38.4	42.6
2022	Maori	Non-urgent	131.3	1192	124.7	137.9
2022	Maori	Urgent	45.1	333	37.2	53.0
2022	non-Maori	Non-urgent	116.4	5759	113.4	119.4
2022	non-Maori	Urgent	36.9	1786	34.3	39.5
2023	Maori	Non-urgent	127.7	1465	121.5	133.9
2023	Maori	Urgent	45.0	252	38.4	51.6
2023	non-Maori	Non-urgent	117.6	7036	114.6	120.6
2023	non-Maori	Urgent	35.5	1320	33.1	37.9

The overarching goal is to:

- Eliminate the growing inequity of access affecting Māori and Pacific on planned care wait lists
- Ensure high clinical priority care is delivered within clinically acceptable timeframes
- Eliminate excessively long waiting lists in system order with timeframes for achieving
- Ensure an effective monitoring and evaluation framework is developed.

The Central Region Planned Care Clinical Oversight Group has been established to provide clinical leadership at the regional level, and support implementation of the Reset and Restore Plan at the regional and local level. This group provides expertise, direction and advice to the Central Region Director, Hospital and Specialist Services and the Regional Integration Team.

The Planned Care Clinical Oversight Group is overseeing a regional work programme to:

- Understanding the impacts of acute care and how to continue to deliver both planned and acute care when systems are under surge pressure.
- Understand unmet need for planned care across the region, so that we can provide more equitable access to planned care.
- Ensure that decisions are clinically led and support an equity approach.
- Deliver additional volumes and initiatives that support the standardisation of access for care across the region, and the maximum amount of care for the funding available.

The immediate aim was to have no patients waiting over one year for treatment in Te Ikaroa region by the end of 2023, and no orthopaedic patients waiting over one year by 30 June 2024. Over the longer term, the group wants to expand its focus to understand the whole planned care continuum, from diagnosis to treatment, to ensure we make the most effective use of resources within region and do not return to extended waitlist times. A long term regional planned care work programme will be developed that implements the Reset and Restore Plan recommendations and delivers the planned care that is needed by the people of Te Ikaroa.

The former Auckland DHB algorithm used to prioritise Māori (and Pacific) on waitlists was very successful, provided there was the additional support for patients to attend procedures (transport, accommodation etc). It is understood that MidCentral – Palmerston North Hospital also implemented this algorithm at one point, and this should be given priority to either maintain or re-institute as an approach to addressing the waiting time gap. This needs to be given priority in order to halt the increasing inequity gap in wait-times.

Cancer
services

Cancer services are especially important for Palmerston North as a regional delivery centre. Lifting New Zealand's game on cancer is a priority for the National Government. They intend lifting the free breast cancer screening age from 69 to 74 and to fund 13 cancer treatments that are available in Australia but not New Zealand. The Coalition Government is in agreement with this intention.

Currently 450 Māori women are diagnosed with breast cancer every year; 250 are diagnosed with lung cancer and 100 with colorectal cancer. For Tane Māori, 300 are diagnosed with prostate cancer, 300 with lung cancer and 100 with colorectal cancer. Each year, approximately 25,000 people are diagnosed with cancer in Aotearoa, with nearly 3,000 of those people being Māori. The most commonly diagnosed cancers are breast, lung, prostate, and colorectal cancers. Māori are twice as likely to die from cancer as non-Māori [17].

Almost half of people diagnosed with lung cancer have this done at an ED, and of this, almost half (49%) are Māori. Pacific peoples and Māori had higher rates of ED presentation for bowel cancer than New Zealand European/ Other ethnicities. Whilst people being aware of symptoms is a critical first step in diagnosing cancer, there are additional barriers to seeking care, even if people recognise their symptoms. These barriers include distrust of the health care system and an environment where people feel embarrassed discussing some symptoms.

The engagement with Māori undertaken by Te Aho o te Kahu highlights that it is not the specific screening act, or treatment act that is the main issue for Māori. It is access – access to screening at an appropriate and safe place at the right times; access to primary care to diagnose suspected symptoms; and access to treatment options at the 12 Cancer centres (transport, tautoko during treatment, accommodation, hardship with kai during treatment for patient and whānau, impact on job and income; and organising support for dependent children). Furthermore, accessing palliative care and rehabilitation services for survivors is also a barrier for many whānau Māori.

Te Aho o te Kahu also confirm that "Kaupapa Māori approaches may improve all facets of hauora for Māori who are living with cancer and their whānau. This includes prevention initiatives directed at Māori, wairua and mauri support, education, psychosocial support, treatment, rehabilitation, and palliative care. Kaupapa Māori services are often well received by Māori and fill gaps in the provision of culturally appropriate cancer services. There are varying degrees to which Māori world views, models and mātauranga are expressed and applied across the cancer continuum. This includes Māori initiatives led and delivered by Māori organisations; initiatives led by Māori staff within non-Māori organisations and initiatives led by Māori staff from a range of organisations".

Workforce Development
Increasing the Māori Workforce

Te Aka Whai Ora invested additional funds in Budget22 to increase the Hauora Māori Scholarship scheme (now called Te Pitomata – the Power of Potential) funding to increase the sum available.

This is spread across several disciplines including:
- Medical
- Nursing
- Midwifery
- Dental and other oral health disciplines
- Allied Health
- Management / clerical

---

[17] Te Aho o Te Kahu. 2021. He Pūrongo Mate Pukupuku o Aotearoa 2020, The State of Cancer in New Zealand 2020. Wellington: Te Aho o Te Kahu, Cancer Control Agency.

Workforce data from Te Whatu Ora indicates that over the next decade, a total of 344 new entrant Māori medical students annually are needed to achieve equity within the total medical workforce; 34 midwifery students; and 1,200 Māori nursing students. Analysis of this data should occur to determine the specific equity gaps in workforce apply to the MidCentral district alone, so that Te Whatu Ora, Iwi, the IMPB and Hauora Māori providers can actively contribute to addressing inequities in the workforce. However, this should not prevent Te Whatu Ora acting now to intentionally target Māori recruitments into hospital vacancies and to increase the proportion of Māori staff across the hospital workforce. The focus also should not be on the new and emerging workforce alone, however.

The existing Māori workforce working within the hospital system needs active support and investment to build stronger career options; to identify and accelerate new leaders; and to ensure pay equity across the professions. Māori in the workforce with potential for leadership should be actively supported with training and development investment to help them advance to leadership roles. An equitable Māori workforce at all levels – from front-line to leadership – is essential to contribute to efforts in tackling inequity as Māori are more empathetic, more naturally make more culturally appropriate decisions for Māori patients and are likely more culturally competent.

Investments made in teaching cultural safety for the non-Māori workforce has not resulted in the systemic changes that are really needed, despite significant resources being spent in recent decades. The dominant institutional culture has not changed despite many years of efforts by Iwi and Māori in sharing their knowledge and expertise. A better priority is to put that money into increasing the Māori workforce in the community and in leadership roles across the system.

Developing the broader Health workforce

The new Government wishes to target Doctors and midwives and have developed strategies to increase the numbers of doctors through a new Waikato Medical School and offering $22,500 student loan forgiveness for nurses and midwives in return for a bonding arrangement. However, the equity gap for Māori is that more are needed as new entrants to midwifery and nursing to even think about accessing student loan support.

The broader health workforce also needs further training and understanding of Māori health inequities; Te Tiriti o Waitangi obligations; the need to develop stronger relationships with Iwi and Māori health providers (to provide more options to Māori patients and whānau) and to be more aware of their own unconscious biases toward Māori. Hospital and specialist services therefore need to actively invest in this work for their broader health workforce. It is more than the typical “one day Treaty workshop” or Marae visit or learning a karakia. If anything, those activities are a ‘tick the box’ approach and do not demonstrate a real commitment to create deep and lasting change and improvement to practice. It is about creating a deeper understanding of oneself and one’s own identity and beliefs; and then to apply that learning to their practice when working with Māori patients and whānau; when planning and delivering health care with Iwi; and when making investment and prioritisation decisions. Teaching non-Māori staff the cultural practices of Māori is not the answer. Facilitating them to address their own biases, attitudes, and behaviours towards all peoples of different ethnicities to their own, is more important and effective.

TE PAE ORANGA
RUAHINE | TARARUA

info@tepaeoranga.org.nz