Te Ohu Rata o Aotearoa, Māori Medical Practitioners Association (Te ORA)

Te ORA is a professional body representing Māori medical students and doctors working as clinicians, researchers and teachers. We have approximately 340 active members; therefore Te ORA represents the majority of the Māori medical workforce in New Zealand.

Te ORA does not deliver health services but seeks to provide support services to its membership such as: annual Hui-ā-Tau and Reo Wānanga (Te ORA and Te Oranga). We also try to find specialist training opportunities for our membership and advocate strongly in all areas of Māori health.

Te ORA has international networks which include formal collaborations agreements with the Medical Deans of Australia and New Zealand (including the Leaders in Indigenous Medical Education network), and Health Workforce NZ. Te ORA also works closely with the Australian Indigenous Doctors’ Association (AIDA) and more recently with the National Aboriginal Community Controlled Health Organisation (NACCHO).

Thank you for the opportunity to provide feedback on the draft update of the NZ Health Strategy. We commend the Minister on the decision to update the existing Strategy. We have used the consultation submission form to frame our feedback as follows.
Challenges and opportunities

The Strategy reflects a range of challenges and opportunities that are relevant to New Zealand’s health system. Some of these are outlined in I. Future Direction on pages 5–7.

1. Are there any additional or different challenges or opportunities that should be part of the background for the Strategy?
Health Inequities

While addressing inequalities in the health system is broadly captured within the draft Strategy we suggest that addressing inequalities is such a fundamental issue (both in terms of health outcomes and delivering on the Treaty relationship) that it needs to be more specifically referenced in the background as a particular challenge.

Health inequities are a challenge which many have called a ‘wicked problem’. Although health inequities have multiple causes, solving them, or achieving equity does not require overly complex solutions. The good news (and thus the opportunity) is that we know much about how to achieve equity in outcomes. Several key principles should guide efforts to remove inequities.

First, the Ministry should look to reveal inequities by reporting all performance data stratified according to parameters of equity e.g. ethnicity, socioeconomic status. Change cannot occur if the health system believes that health care is optimal and that inequities are society’s problem.

Second, the Ministry must track outcomes that matter to patients, such as quality of life and the ability to function. To reach adequate outcomes, we must talk to patients and their whānau in order to meet their needs and aspirations. Evidence supports the fact that successful health services tailor care to patients, their whānau and communities. Patient centered care, as defined in the IOM’s seminal *Crossing the Quality Chasm* report is a widely accepted dimension of quality, and one that is explicitly recognised in our NZ Triple Aim in ‘Experience of Care’. (1,2) Patient centered care is described as “providing care that is respectful of and responsive to the individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. This must specifically be a goal for Māori and other population groups for whom the health system presently does very poorly in this dimension.

Third, we encourage the Ministry to align incentives to remove inequities and address social factors. A business case to achieve equity motivates and sustains improvement. Health organisations are more likely to implement interventions to improve equity if those efforts are paid for. The health system has largely been silent with regard to creating incentives explicitly to remove inequities. We should pilot interventions that specifically provide incentives for achieving equity and reward both high levels of quality and achieving steps towards equity.

Finally, payment systems should support approaches to public health that create healthy communities, provide equitable population health and primary care, and prevent costly hospitalisations.

Examples of where inequities have been eliminated exist across all sectors. The consistent application of learnings from equity success stories will require government leadership and the setting of clear expectations. Those expectations must be made explicit in our national health strategy.
The future we want

The statement on page 8 of I. Future Direction seeks to capture the future we want for our health system:

So that all New Zealanders live well, stay well, get well, we will be people-powered, providing services closer to home, designed for value and high performance, and working as one team in a smart system.

2. Does the statement capture what you want from New Zealand’s health system? What would you change or suggest instead?

The statement does not fully capture what we want from NZ’s health system. There are inconsistencies within this document and between this draft strategy and other Ministry publications such as He Korowai Oranga: Māori Health Strategy 2014 and Equity of Health Care for Māori: A Framework both of which were published only last year. The draft strategy is persistently tolerant of inequity, and remains virtually silent on actions and behaviours to address equity as a crosscutting dimension of quality.

Despite labouring the point that the health system performs well for most people, the draft strategy then largely ignores the issue of those that the health system performs most poorly for. This makes the term ‘all New Zealanders’ problematic for Māori as Treaty partners with the Crown because ‘all’ in this context actually means ‘most’ and Māori are over-represented in the group for whom the health system does not consistently perform well. Māori are largely an afterthought of this Strategy.

Initiatives that are underpinned by equity invariably lead to improved health for all. But initiatives that are designed without an adequate equity focus frequently create, maintain or reinforce inequities.

The Treaty relationships laid out in the draft Strategy comment on the need to ‘reduce’ rather than ‘eliminate’ the inequity in health outcomes appears to accept some remaining level of inequity. Such an approach is inconsistent with setting an expectation of equity and is not in keeping with the Ministry publications noted above.

This focus on ‘reducing’ inequities rather than ‘removing’ inequities highlights inconsistencies with the overall aims of the draft Strategy. On one hand it is a strategy for ‘all New Zealanders’ equally, yet it is acceptable for the health system to continue to operate unevenly at the expense of ‘some New Zealanders’. Inequities are not acceptable and the strategy must be clear that inequity cannot be tolerated.

Our vision is for a health strategy that encourages and requires providers to focus on equity as well as improving the health of the total population. This will only become a reality if there is a mind-set change across the entire system so that a focus on equity becomes the norm rather than the exception or a footnote.

For example, it is well established that despite higher levels of need, Māori are less likely to access health services than non-Māori. Analysis of prescription data shows that, even when need is accounted for, Māori are less likely to be prescribed many...
medications including those to treat and prevent cardiovascular disease, diabetes and other conditions. This phenomenon is recognised worldwide and has been named ‘the inverse care law’, where those who have the greatest need for health services have the lowest access to those services. (3)

Some would argue that ‘all New Zealanders’ has an implicit focus on equity. However, any such implicit focus has only worked for the unfairly advantaged population groups, not Māori or other groups that experience disadvantage, and there is no reason to believe that it will work to deliver health equity in the future.

There must be an explicit and crosscutting focus on equity in order to change the status quo.

A set of eight principles is proposed to guide the New Zealand health system. These principles are listed on page 9 of I. Future Direction and page 31 of II. Roadmap of Actions.

Do you think that these are the right principles for the New Zealand health system? Will these be helpful to guide us to implement the Strategy?

Tiriti o Waitangi

Recognition of ‘the special relationship between Māori and the Crown under the Treaty of Waitangi’ is proposed as one of the refreshed principles upon which the Strategy is built.

However this is the only reference to the Treaty in the draft Strategy. This gives the impression that the statement is ‘lip service’ and that there a lack of intention to practically reflect this relationship or a lack of understanding about how this might be achieved.

This is disappointing, particularly as much of the Strategy, and particularly the strategic themes that underlie it, are entirely consistent with the Treaty relationship or have the potential to greatly enhance that relationship.

Reference to the Treaty relationship should be made in relation to each of the strategic themes, noting how various aspects of each theme build that relationship.

Identifying the Treaty relationship in each of the strategic themes would also help to identify where the strategy is likely to fall short in meeting the Crown’s treaty obligations.

For example, although we shouldn’t only be striving for equity but rather working towards achieving it, the goal under ‘Value and High Performance’ of ‘striving for equity of health outcomes for all New Zealand populations’ is a goal that is consistent with the Treaty relationship. This is because the Treaty relationship is founded on the basis of equity between Māori and other New Zealand citizens. It should therefore be acknowledged that such a theme is entirely consistent with the Treaty relationship if achieving equity is our major goal.
The aspiration of what the health system will look like in 10 years’ time as a result of this strategic theme is ‘that there has been a clear lift in health outcomes’ for Māori and other disadvantaged groups. A similar approach is repeated throughout the draft strategy – i.e. what is being aimed for is a ‘reduction’ in or an ‘improvement’ in the health status of disadvantaged groups (without an explicit expectation of equity). These goals assume that some level of inequity for Māori (and other groups) will persist and that this is acceptable.

This is not consistent with the principles of the Treaty, in particular the Treaty principle of equality.

To comply with the Treaty of Waitangi the New Zealand Health Strategy must consistently expect equity of health outcomes between Māori and other New Zealanders – not simply that the current inequity is ‘less bad’.

The Crown’s obligation is to actively protect Māori interests rather than to accept a lesser standard simply because equity is seen as difficult to achieve. What the health system should aspire look like in 10 years’ time is one with equitable health outcomes and care for all population groups.

There is also a distinct lack of reference to the Treaty relationship in the Roadmap section of the draft Strategy. This is despite the Roadmap noting that the principles should guide decision-making around the redesign of services and outcomes to be expected. The example of how the design of training for health workers and board members should reflect the Treaty relationship principle once more gives the impression of tokenism as none of the five year goals or specific actions set out in the Roadmap, nor the actions listed, are guided by the Treaty relationship or make any mention of this.

It is difficult to expect decision makers within the health system to appreciate how the guiding principle of the Treaty relationship should influence decisions and service redesign if the Strategy and Roadmap themselves do not lead by example.

### Five strategic themes

The Strategy proposes five strategic themes to focus action – people-powered, closer to home, value and high performance, one team and smart system (I. Future Direction, from page 10).

4 Do these five themes provide the right focus for action? Do the sections ‘What great might look like in 10 years’ provide enough clarity and stretch to guide us?
In keeping with previous, health equity should be explicitly woven throughout any strategic themes of the NZ Health Survey.

The five themes above should support the creation of healthy communities, provision of equitable population health and primary care, and prevention of costly potentially avoidable hospitalisations. However, the focus appears to be on primary, secondary and tertiary health care services. The lack of planning for the key population health challenges New Zealand will face (such as climate change, increasing cost and complexity of medical care etc.) is concerning. (4,5)

Notable for its absence is a strategic theme on ‘prevention’.

Roadmap of Actions

II. Roadmap of Actions has 20 areas for action over the next five years.

5 Are these the most important action areas to guide change in each strategic theme? Are there other actions that would be better at helping us reach our desired future?

Road Map

The Roadmap is a critical part of the draft Strategy as it provides the focus on the tasks that need to be undertaken to meet the goals of the draft Strategy. The Roadmap notes that the actions listed within it ‘signal their importance for the future of New Zealand’s health system’.

As it is currently drafted, it is difficult to trace the linkages between the actions listed in the Roadmap, the 5 year vision of the Roadmap, the 10 year vision of the draft Strategy, and the principles that underlie the Strategy.

For example, the draft Strategy states that ‘Māori and Pacific health models, such as Whānau Ora and the Pacific Fonofale model, are used to provide effective and accessible care responsive to their communities’ is a vision for health services in 10 years’ time. However the 5 year outcomes listed in the Roadmap make no mention of using these models, and nor do the immediate actions listed in the Roadmap.

There will not be optimal development of Māori and Pacific health models as a way to provide effective and accessible health care in the next 10 years if steps leading towards this are not identified as a priority in the short to medium term.

Similarly the vision for value and high performance in 10 years’ time notes ‘a clear lift in health outcomes experienced by population groups previously disadvantaged’. Exactly what would constitute an acceptable ‘lift’ in health outcomes is not clear; the expectation ought to be one of equitable outcomes in keeping with an expectation of equity. Furthermore, it is impossible to identify the elements of the Roadmap that will lead to realising this vision. The earlier steps are phrased in such a way that there is no clear connection to the 10 year vision of the health system.
Health Equity

The Roadmap must paint a picture of health equity for Māori and other groups that experience inequality by including the discussion of the health needs and aspirations of Māori for each section. In doing so the Roadmaps should also meaningfully reference The Treaty of Waitangi as our founding document.

A commitment to health equity must be explicit across all action areas within each strategic theme. Actions explicitly focussed on Māori health must be comprehensively developed and all other actions require a strengthened focus on Māori health to align with He Korowai Oranga: Māori Health Strategy 2014 and the Ministry publication, Equity of Health Care for Māori: A Framework.

Specific Comments

The entirety of the Roadmap requires a comprehensive review from a Māori health and health equity perspective. These specific comments do not address all of the actions but highlight some of the shortcomings of the actions listed, which are for the most part too high level, and fail to adequately consider the needs of Māori and other population groups that experience inequity in the present health system.

Action 6: A great start for children, families and whānau.

This action should be expanded to explicitly include the youth population. More support is required for pregnant women who smoke to have a smokefree pregnancy and motherhood. Smoking during pregnancy is one of the most important causes of avoidable illness and death for unborn children, infants and their mothers in New Zealand. It is clear that pregnant women are not currently getting the services and help they need to be smokefree.

Recommendations:

a. Including the following action; ‘Ensure pregnant and postnatal women who smoke are supported to be smokefree by providing ready and free access to nicotine replacement therapy and support to quit services.’

b. Developing a Health Target measuring the percentage of hospitalised pregnant women who smoke who are provided with cessation support.

Data for the smokefree pregnancy hospital target could be readily accessible with the new Maternity Information System and this must be mandated.

Action 13 revised as follows:

Action 13:

Improve governance and decision-making processes across the system, through a focus on equity, capability, innovation and best practice, in order to achieve equity and improve overall outcomes.

c. * Review governance arrangements across the system, including those of the Ministry of
Health and ministerial advisory committees.

d. Develop and implement a regular review of DHB governance performance.
e. Require DHBs and governance bodies to self-audit against the Ministry of Health tool, *Equity of Health Care for Māori: A Framework*

**Action 14 revised as follows:**

**Action 14:**

The Ministry of Health will work with leaders in the system to improve the cohesion of the health system, including by clarifying roles and responsibilities/accountabilities, **including for achieving health equity** across the system as part of the planning and implementation of the Strategy.

a. * The Ministry will review its structures, processes and culture to ensure it is well positioned for its stewardship role in the system and its leadership role in implementing the Strategy, including ensuring good-quality policy, a **strong equity focus** and legislative/regulatory advice, and monitoring of performance by equity parameters e.g. **ethnicity**.

b. DHBs will carry out their roles and responsibilities at national, regional and local levels, including any changes to these as a result of implementation of the Strategy.

**Turning strategy into action**

6 What sort of approaches do you think will best support the ongoing development of the Roadmap of Actions? Do you have ideas for tracking and reporting of progress?

There should be mandated equity focussed reporting, ensuring that targets can only be counted as being met if it is met for Māori and other demographic groups that experience health inequities. There is a growing call for equity focussed health reporting. An approach that mandates equity focussed reporting will best support an ongoing focus on achieving health equity.

Currently, service providers can reach health targets for ‘all New Zealanders’ while failing to reach the same target for Māori. For example, a provider may ensure that 80.9% of New Zealand Europeans access a service, but only 61.5% of Māori, resulting in a total population result that nearly reaches an 80% target.

Thus data can be reported either in an equity focussed or total population manner. Both methods send very different messages to the reader; for one, equity is the focus, the other; equity is not the focus.

There is anecdotal evidence that providers are cherry picking the easiest to recruit (NZ European women) for cervical screening, and actively stopping trying to recruit Māori women (because it takes more effort), in order to ensure to reach the total population target of 80%.  

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Any other matters

7 Are there any other comments you want to make as part of your submission?

We would like to see the Ministry demonstrate leadership regarding a stronger accountability focus on health services to achieve health equity. Currently, it seems that many organisations view health equity goals as optional extras despite statutory obligations under the NZ Health and Disability Act 2000. The currently proposed focus serves to absolve the health and disability sector from its responsibilities toward improving health for ‘all New Zealanders’.

Additionally we would like to see acknowledgement of the ‘special role’ of the Māori health workforce as detailed below:

- The role of the Māori health workforce is much more than just an advocacy role, and certainly more than a symbolic role as a “visible reminder that Māori are represented as health practitioners”. There is limited explanation of the additional responsibilities that our health system places on Māori health practitioners. For example, Māori health improvement is the responsibility of the health system, not just that of Māori health practitioners. However, Māori health practitioners are expected (both by their own communities as well as by non-Māori) to work over and above their professional obligations in order to mitigate the negative impacts of the inequities that Māori patients experience with respect to health determinants and the access to resources needed to improve their health outcomes.

- Additionally, despite Ministry of Health documented discourse around obligations to the principles of the Treaty of Waitangi, Māori health practitioners have held disproportionately less power and influence at governance and policy level within the health sector. This current situation has not redressed the historical imbalance (which precluded a genuine Treaty partnership), and instead has privileged those belonging to the dominant culture at the expense of Māori and other minority groups.

- The Strategy must acknowledge and respond to the additional expectations placed on Māori health practitioners by ensuring that the health system supports and maintains their additional training and ongoing cultural and other professional development needs.

- In addition, it is imperative that the Strategy focuses on the non-Māori health workforce and the role of the health system in ensuring that the health workforce is high quality, culturally competent, health literate and therefore fit-for-purpose to meet the needs of the Māori population and all population groups within New Zealand.
References:


