

Reducing health inequalities for Maori

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I'd like to acknowledge the traditional owners of this land. It's great to be here in very warm Perth, and I don't think I'm the indigenous woman that John referred to. I want to suggest that there are three reasons why health systems consider developing a diverse health workforce, and in particular, an indigenous workforce. As a mechanism for addressing health disparities, improving cultural appropriateness in health care delivery, and of itself, increasing the participation of indigenous people in the business of health, or more broadly, enabling them to participate in the economy and the benefits that accrue to their health.

Life expectancy at birth is a key summary indicator of health—fatal health outcomes, the survival experience of the population. The New Zealand data is sourced from the same report, the New Zealand Social Report. The Australian data is perhaps not really comparable, because it's from two different sources, but I think the point is that Maori compared to non-Maori have a lower life expectancy, as do indigenous Australians compared to non-indigenous Australians. And I haven't looked more broadly at other indigenous populations for exactly the same reason, that data is not easily comparable across countries, because of the different way in which they collect their data. However, it can be said that for all population groups they do less well than the non-indigenous population group in their country.

This data is all cause mortality rates for one to 74 year olds by sex, by ethnicity—and as you can see, there has been improvement over time, for both the non-Maori and the Maori population, but the rate of improvement for Maori has not been as great. This is male cancer mortality rates and male cancer registration rates. Now, when we look at these, we see that Maori males with cancer have a greater risk of dying from their cancer than their non-Maori counterparts. For example, if you look at liver the liver cancer registration was three times that of non-Maori males, and the liver cancer mortality rate was over three and a half times that of non-Maori males. If you look at prostate, the prostate cancer registration was significantly lower for Maori. However, Maori males have a significantly higher mortality rate; it's almost twice that of non-Maori. Similarly, for female cancer. So the case mortality for Maori is higher than for non-Maori females, Maori with cancer have a greater risk of dying from their cancer than their non-Maori counterparts.

While I have only included cancer data for consideration, for nearly all other disease types, Maori are less likely to do as well as the non-Maori population in New Zealand. I have not included any Australian comparative data, but according to the Australian Human Rights Commission, chronic diseases, and in particular, cardiovascular disease, are the biggest single killers of indigenous peoples in Australia and in an area where the indigenous and non-indigenous health quality gap is most apparent. So we know that there is a significant gap.

So quite rightly, attention is focussed on improving the way in which the system operates. Indigenous, and more broadly, health care workforce initiatives that increase the diversity of the workforce, are frequently cited as necessary to improve the care of indigenous peoples. Certainly in the United States, the Institute of Medicine Review of Health Services found that health care professionals who belonged to minority groups were more likely to serve those populations. This rationale also, to some extent, underpins New Zealand workforce programs that seeks to increase the number of Maori in the Maori health workforce, and has

certainly formed, along with greater choice, the basis for developing health providers owned and delivered by Maori people.

However, it is interesting that most of the dialogue is often focussed on the patient, health professional resemblance, and that access to quality health care appears to be only dependant on the engagement of the relationship, not the products or the outcomes of the activities for which the relationship is formed. So given the attention in New Zealand and the justification for having affirmative actions, how large is the Maori health workforce compared to the non-Maori health workforce? And really, how realistic is the expectation that this workforce will achieve, where the whole of the system has—systematically failed. So in 2004, there were 234 Maori doctors and they were about 2.6% of the total medical workforce. There has been some growth, in 2008 there are 94 more. For nurses—3003 nurses in 2005, which is about 7.5% of the total nursing workforce. There has been an actual increase in 2008, but given the growth in the non-Maori nursing population, the percentage has remained pretty stable.

Main employment settings for Maori active medical practitioners, in 2006 and 2008, show that they're predominantly in public hospitals and private practice. And as we've heard from Robyn and John, the difficulty in getting practitioners, or health professionals to work in all areas, is particularly similar in New Zealand. We certainly don't have the remoteness that you have to cope with, but we still tend to have a mal distribution of the workforce.

So Maori health and disability providers, who have been an important part of the New Zealand system for about 20 years, starting very small—they're still pretty small—they're approximately 272, but that's probably an over-estimation and partly because there's no clear definition of what they might be. So payments to the Maori health providers sector in 2009 was 202 million, out of a budget of 12 billion. Of these providers, there are approximately 56 general practices; 12 primary health care organisations; and the rest are either niche providers, like Rongoa traditional healers, or providers who have a broader range of public health contracts, things like: smoking cessation, gambling, mental health and addiction services, and many of them have other social service contracts. All Maori health providers operate primarily in the primary care sector. None own or operate any secondary care facilities.

So coupled with the small numbers of health professionals and the small number of Maori health providers, none of which provide the full range of health care, it is unrealistic to say that they will reduce or address Maori health disparities. I suspect that you can make the same comparison to the Australian situation. They are likely to improve care to those that they serve, but as one in eight Maori—rather seven in eight, use mainstream provider services, their ability to shift the inequalities related to health care are really limited.

So hence, the importance of mainstream care—and I'm not sure whether you use that terminology "mainstream," but I suppose it's the non-indigenous health care or it's the great big bucket or the great big truck as opposed to the little truck—and so, cultural appropriate care is about the way in which mainstream begins to deliver its health services. And again, the focus in this space is on the interaction between the health care professional and the patient. However, this framework designed by Bittencourt et al expands cultural competence or culturally appropriate care, to include organisational interventions, structural interventions and clinical cultural competence interventions. It's a much more sophisticated way of ensuring that culturally appropriate care is embedded across the health system within health organisations, and informs the health professional/patient relationship.

Lastly, participation is an important focus. Much has been said over the last decades about the rights and duty of people to participate in the design and delivery of their health care. Certainly, in '78 with the Declaration of Alma-Ata, Article 4, it was pretty unequivocal about that. The 1986 Ottawa Charter states that, "Health promotion is the process of enabling people to increase control over and to improve their health." In New Zealand, three principles derived from the Treaty of Waitangi by the Royal Commission on Social Policy, have been used to inform governments' interaction. The principles are partnership between Maori and the government and its agencies, participation by Maori and protection of Maori interests. In the New Zealand Public Health and Disability Act 2000, there is a Treaty of Waitangi statement, and it requires the funder, District Health Boards, to ensure Maori participation in decision-making, and in the delivery of health and disability services. Lastly, workforce diversity is seldom mentioned as a good of itself, that is, for the sake of distributive justice if jobs in the health professions are considered good, to be equally distributed.

One of the issues for New Zealand in growing an indigenous health workforce is that not enough Maori children leave college with sufficient science to enable them to successfully train to be a health professional, and this is the biggest impediment. For Australia, indigenous peoples' educational attainment is improving. Between 2001 and 2006, the proportion of indigenous peoples aged 15 years and over, who had completed Year 12, increased from 20-23%. Education has always been shown to be positively associated with reductions in the rates of long-term health conditions, particularly heart disease and diet-related illness. Education of itself is an important health determinant. Education improves one's chances of employment, earning ability, owning your own home, social mobility and better health.

This shows the neighbourhood deprivation distribution of Maori and non-Maori, 2006. So if all things were equal, you would expect that 10% of both Maori and the non-Maori population would reside in each decile but this is not the case. About 67% of the Maori population is at the most deprived end of the scale, while the non-Maori population is located—is spread more evenly, but with a greater number located at the least deprived end. This explains the poorer social outcomes for Maori compared to non-Maori, and is largely driven by the unequal distribution of the goods and services available to the New Zealand population.

In the spirit level, why more equal societies almost always do better, Richard Wilkinson and Kate Pickett argued that there are pernicious effects that inequality has on societies: eroding trust, increasing anxiety and illness and encouraging excessive consumption. They also argue that in countries that are more equal, everyone benefits. There are economy-wide benefits to be achieved from improving the quality of the life of indigenous people here and in New Zealand. It implies an improved quality of life for indigenous people, a reduction in the burden of disease and improvement in the ability of indigenous people to share in economic prosperity.

I said I would cover these three rationale[sic], but in finishing this presentation, I would suggest that participation, culturally appropriate health care in addressing health disparities, is a more logical order of the themes. Finding lasting and durable solutions requires the participation of indigenous people in partnership with mainstream to reduce health disparities. For all the reasons that I have shown, they cannot be made responsible for solving problems which are a result of the ways in which society has discriminated against them or precluded them from the goods and services of their countries.

There are no easy solutions. This is not a sprint. This is a marathon, and we all have a role to play in solving this complex issue. And lastly, this requires understanding and addressing across the whole range of domains, the root causes, and in doing so, it is useful to reflect on this quote from Hillary Graham, a social epidemiologist. "How well and how long one lives is powerfully shaped by one's place in social hierarchies."

Thank you.

