



20 September 2019

To the attention of:

Committee Secretariat  
Māori Affairs Committee  
Parliament Buildings  
Wellington  
Phone: 04 817 9520  
[ma@parliament.govt.nz](mailto:ma@parliament.govt.nz)

### **Re: Inquiry into Health Inequities for Māori**

Thank you for the opportunity to make a submission on the Inquiry into Health Inequities for Māori. The inquiry is focusing on cancer care and exploring barriers that Maori experience relating to prevention, screening, diagnosis, treatment, cures, and palliative care. The Maori Affairs Committee opened this inquiry in March 2019. This was after receiving letters from Maori users of the health system expressing concern and identifying shortcomings for Maori seeking cancer care.

***Our interest in this submission is because women's health rights is a core priority for BPW NZ, and influencing more just and equitable policies is an important strategy of this work. We advocate for international instruments that support and improve access to effective health practices for all in creating a rights-based framework where women seek empowerment and wellbeing, including Maori. We also advocate for international best practice to ensure their health and wellbeing, including mental health, as this is a core priority for BPW NZ.***

### **General Comments**

Underpinning this submission is BPW NZ's acknowledgement of the special relationship between Māori and the Crown under the Treaty of Waitangi. Fundamental to the Treaty, are its principles of self-determination, partnership, participation and protection, which have much to offer in promoting the mental health of all New Zealanders, including Māori.

### **BPW NZ Policies**

#### **Breast Cancer Treatment**

**URGE** the Government to ensure that the maximum waiting time between surgery and commencement of radiation treatment for breast cancer patients is within optimum time frames for patients and within twelve (12) weeks, by increasing the funding, training and retention of qualified radiologists and other personnel. (2002)



### **Breast Cancer Treatment Audit**

**URGE** the Minister of Health and the Government to undertake a national audit of treatment of breast cancer throughout NZ, as recommended by the WHO in the 1990s; and that, in order to enhance prevention, attention is given to understanding the reasons for the high death rate of breast cancer in NZ; and that any impediments in relation to obtaining this information, such as the privacy of the individual, be weighed against the welfare of the population generally. **(2003)**

### **Treaty of Waitangi**

THAT BPW NZ recognises that Te Tiriti o Waitangi/The Treaty of Waitangi is New Zealand's founding document. **(2012)**

We refer to the **National Council of Women New Zealand Policy**

That NCW continue to urge the Minister of Health to give priority to positive health promotion and preventive measures, including all possible steps to reduce the incidence of cancer in women, in particular by the promotion of regular cervical smears and of breast examination at no cost to the individual. **1987.**

### **World Health Organisation WHO**

The key mission of WHO's work in cancer control is to promote national cancer control policies, plans and programmes that are harmonized with strategies for noncommunicable diseases and other related health concerns. Our core functions are to set norms and standards for cancer control including the development of evidence-based prevention, early diagnosis, screening, treatment and palliative care programmes as well as to promote monitoring and evaluation through registries and research that are tailored to the local disease burden and available resources.

Our submission will focus on the terms of reference for this inquiry:

### **Collating existing statistics and evidence regarding Maori cancer health and identifying significant inequalities.**

On average, Maori live 7-9 years less (depending on lifestyle and living conditions) than non-Maori and are 2.5 times more likely to die from diseases that can be addressed through health care. There are persistent disparities in access and quality of health care for Maori that have maintained and in some case worsened inequity of outcome. We need to address the broader social determinants of health that influence the levels of health advantage and disadvantage between individuals and population groups in New Zealand and which contribute to poor health outcomes. In some areas of New Zealand where Maori live in large numbers, a significant percentage are classified as being the most socio-economically deprived (NZ Dep. 9&10).



At 2013 Census (the latest one available), 78% of Maori adults did not own their own home and 38% Maori tamariki (0-14years) were living in crowded households. In recent years, there have been a significant number without satisfactory accommodation – living in motels, garages, cars etc. It has been recognised that poor health is contributed to be poor living conditions, over-crowded poorly ventilated and non-insulated housing. Families living in these conditions are often receiving low incomes (either from low wage employment or from unemployment/other benefits), have poor nutrition, limited transport options and have received inadequate education.

Reducing smoking prevalence is an important factor, to reduce smoking related harm which includes not only cancer but asthma and cardiovascular disease (CVD). Statistics that indicate the relevance of cancer within Maori and recorded in DHB Maori Health Plans are not current and relate to the 2013 Census because the 2018 Census figures are not yet available. Existing statistics indicate that smoking prevalence in the Maori population has fallen however smoking prevalence among Maori is more than double than that of the general population and that smoking prevalence among Maori women aged 20-50 years in more than 40%.

### **Studying the higher incidence rate Maori experience with specific cancers compared to non-Maori.**

Avoidable mortalities – lung cancer in both male and female Maori and breast and cervical cancer in female Maori.

Maori males – most frequent cancers are lung cancer followed by liver cancer

Non-Maori males – most frequent cancers are lung cancer followed by colorectal cancer

Maori females – lung cancer followed by breast cancer

Non-Maori females – breast cancer followed by lung then colorectal cancer

### **Identifying the specific sets of issues experienced by Maori health service users**

Whanau and culture are important to Maori wellbeing. Connectiveness through whakapapa, the ability to speak te reo and participate in tikanga Maori, as well as being able to access Maori cultural domains, such as marae, are fundamental to a secure cultural identity so that Maori might live like Maori.

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

As with other indigenous populations, Maori hold a view of health as being holistic and recognises the relationships between people's physical wellbeing, their whanau and social



connections, spirituality and the wider physical and social environment as important determinants of wellbeing. This is further supported by being able to lead healthy lifestyles. This is further supported by being able to lead healthy lifestyles. Cultural identity has also been positively associated with improved health and wellbeing outcomes for Maori, .....and reduced depression, whereas experiences of racism were associated with poor wellbeing outcomes, increased depression and higher suicide attempts.

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

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

There has been a call for support and funding for matauranga Maori and kaupapa Maori services which have been seen as lacking in the health system, and that investing in research on rongoa Maori (traditional Maori medicine) would provide an evidence base in relation to their use.

Discussion has highlighted a “monocultural design bias” that has contributed to Maori inequities in health and has considered how we can create a system that responds to diversity and we could respond more to diversity and measure more we might measure the impact for Maori health outcomes.

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

Maori have reported that they are less likely than non-Maori to being offered a choice of appointment times, and to be understood about specialist appointments for co-morbidity needing to be collated so that only one visit is required. Maori adults and children are more than twice as likely not to have collected prescription medications because of cost, than non-Maori adults and children. In the survey, 22% of rangitahi (youth) Maori were unable to access the care they needed and significantly less than non-Maori. Evidence has shown that across the life course, engagement with the health system increases advantages for non-Maori and disadvantages Maori. Where Maori are access health services, they do not always receive optimal care which includes suboptimal prescribing and over-prescribing,



poor communication between professionals and Maori patients, delays in treatment and surgical interventions and longer hospital stays after acute admissions.

**Investigating and critiquing the lower engagement rate for Maori with prevention, early detection, screening programmes, treatment and medication.**

Statistics held by DHBs indicate that wahine Maori have a lower rate of screening for both breast and cervical cancers, than the general population. The previous government had National Targets of 80% for the general population, but in both breast and cervical cancers, the wahine Maori screening rate was approximately 67%. It is important to improve early detection and early intervention for both forms of cancer as they are treatable in the early stages and important to prevent the invasive form of the disease. Promotional programmes used have failed to encourage wahine Maori to lift the screening rates, whereas promotional programmes to Pacific women have resulted in a higher uptake of screening.

Churches have been effective in assisting with this promotion to Pacifica women. Where there are health centres based on marae, there is a higher incidence of screening as they are able to connect with wahine Maori that live in that vicinity but there are not enough of these to reach the wider population. It is recognised that there is a cultural reluctance for some women (not only Maori) to undertake cervical screening so it hoped that the planned vaginal screening will be undertaken by those women who feel uncomfortable with cervical screening. Vaginal screening can be done by individuals in their own home and returned to health professionals to test for early stages of cervical cancer which would then indicate the need for the more complete cervical screening.

PHO's should have a dedicated cervical screening co-ordinator and work with their GPs to support the establishment of a cervical screening champion who will be responsible for actions to improve cervical screening and to offer free smears for priority women including wahine Maori. Women who are over-due for their 3-yearly smears to be targeted for recall, invite, engagement and smear-taking activity.

Breast cancer is the second leading cause of cancer mortality for wahine Maori, with the National Screening Unit recommending breast screening to identify breast cancer early, enable earlier treatment and reduce breast cancer morbidity and mortality. Maori are one of the priority groups for the national BreastScreen Aotearoa programme. Data matching with Primary Care practices allows for identification of women who are not enrolled in the BSA programme and also provides updated contact details for women who are enrolled but may have moved or changed their telephone numbers. Barriers need to be addressed which impede access and uptake of breast screening. There needs to be detailed invitation and recall processes designed to improve appointment processes, patient monitoring and follow-up. These include letters, texts, phone calls and home visiting. The previous national target for a mammogram was 70% with wahine Maori achieving 63.5%.



One barrier identified in both cervical screening and breast screening recalls is the frequent movement of Maori (and Pacific) families from the recorded address/landline to either a different address in the district or to another DHB area. Many families live in rental accommodation without security of longevity of tenure. Some families live in garages/cars and not enrolled in a General Practice but rely on Emergency Departments when health care is required. When women are located, often on a mobile phone, transport can be offered if this is the barrier. Where cost is a barrier, further offers/options need to be investigated. Any promotional programmes should not only focus on women, but include the men of the family to encourage their female family members to be screened for both breast and cervical cancers, reminding the women how important they are to the family.

Promotion of BreastScreen through Maori Women's Welfare League, Poukai, Marae, Hapu and Iwi events and other events where high numbers of priority women will attend.

DHBs have had past targets to meet, to encourage GPs to discuss smoking cessation and to advise on available programmes to assist with this. These are no longer administered. There are programmes based on past national targets to persuade pregnant women to stop smoking as it affects the health of the unborn child, and later the baby/child once born. This is followed up to maintain a smoke free environment when they return home, hoping the women persuade male and other family members to also give up smoking. Midwives are an active part of this as their services are still active for 6 weeks following the birth. Support is continued through Well Child Tamariki Ora Providers (Plunket, Raukura Hauora o Tainui, etc.) Support is also offered to mother and other family members through specialist stop smoking services available in each health district.

Vaping has been seen as a way to encourage everyone to give up smoking tobacco with the Ministry of Health developing policy around this, but recent information from the USA in particular has indicated a number of deaths associated with vaping, with further research being undertaken to find out what components are causing the deaths.

### **Looking at the role primary and health professionals play in improving cancer survival rates for Maori**

Increase Maori participation in primary care and improve PHO enrolment rates. Primary care is the point of continuity of health providing services from disease prevention and management through to palliative care. This will improve access to primary care services that will reduce the health disparities between Maori and non-Maori.

Education about the various services available to assist with better management of lifestyle and improved health literacy about the causes of cancer are responsibilities that are delegated through PHOs to primary care whether that is to be provided by General Practices



or Maori Health providers. Much has been written within this submission about the importance of primary and health officials role in improving cancer survival rates for Maori.

**Researching how to best design, develop, and roll out an early detection and/or wellbeing programme**

Improve Maori enrolment in PHOs – develop key messages and promotional material targeted at improving Maori enrolment in a PHO and General Practice. Work with Maori community health service providers to raise awareness of the importance and benefits of enrolment and the promotion of available services for the early detection of cancers and a comprehensive wellbeing programme. Good nutrition and regular exercise/physical activity, reducing smoking prevalence and obesity, improving CVD risk management, would contribute significantly to reducing the leading causes of mortality. Early identification, support and management to develop a supportive care model with clinical nurse specialists, community nursing and primary care. Life expectancy for Maori has been improving but not at a faster rate than the general population – the gap between Maori and non-Maori is still 7-9 years, depending on living conditions and lifestyle.

**Identifying where whanau ‘touch’ the system to find ‘moments of impact’ where bias (unconscious or deliberate) consistently occurs.**

There has been a call for more Maori and community led services, with a tension between national approaches and community-led and driven approaches in health care services, that constrained local flexibility and innovation to meet the unique and diverse needs of Maori. It has also been expressed by many that central to the pursuit of health equity is recognition and honouring of te Tiriti o Waitangi and tackling racism in the system.

Maori are almost 10 times more likely to experience multiple forms of discrimination than the New Zealand European population. In addition to racial discrimination, Maori report institutional racism, including different access to health care services and opportunities. Health professionals have been witnessed as having implicit bias, which perpetuates and maintains power imbalances in the system and impacts on the quality of care Maori receive. However, eliminating racism needs to be a goal for wider social service agencies whose services contributed to poorer Maori health outcomes. Eliminating racism is everyone’s responsibility from those working in administration to service delivery and leadership and governance, and this needs to be both personal and organisational performance plans. There needs to be a stronger research evidence base identifying and assessing programmes and interventions that are effective in addressing the frequency and impact of racism on health outcomes for Maori.



### **Exploring a conceptual best practice whanau-centric model of cancer care.**

There has been historic underfunding of Maori providers of services. Maori providers were not funded to the level that allowed delivery of holistic services consistent with Maori models of practice and recognising the complexity of circumstances of their client base. The contracting arrangements lacked the flexibility to allow for innovation in service delivery. Contracts awarded to Maori providers did not allow for pay equity and did not recognise the dual clinical/technical and cultural competencies of Maori practitioners and health workers. For a conceptual best practice whanau-centric model of cancer care, the model will need to be adequately funded to deliver holistic services. There were 14 Maori PHOs – now only 4 - Nga Mataapuna, National Hauhora Coalition, Ngati Porou Hauora Charitable Trust, Ore Toa PHO. There was historic inadequate support from the Crown.

(Maori) Health Funding – In 2017-18 PHOs received \$907 million in capitation funding. \$167 million went to Maori patients enrolled in both Maori and non-Maori PHOs. The four remaining Maori PHOs received \$28.7 million and based on the number enrolled in those organisations, \$10.17 million was spent on Maori patients of PHOs. Maori health providers get 1.86% of Vote Health. Increases in health spending each year are not always matched by increases in spending on Maori health providers.

To be effective, there needs to be increased and adequate funding to deliver best practice whanau-centric model of cancer care. Along with this funding, there needs to be an increase in the diversity of health workforce, attracting a Maori workforce to community care is challenging especially in rural areas, and the lack of pay parity between health professionals working for Maori providers and those working for mainstream providers is a challenge for recruitment and retention. There needs to be increased government investment in building the Maori health workforce but also investment and training is required to ensure the non-Maori workforce is skilled and competent to work with Maori whanau and communities. It has been suggested that there is a need for dedicated Maori enrolment targets across all health training programmes and specific targets for health employers. Appropriate training for Maori health providers is lacking, as is support and investment in matauranga Maori and kaupapa Maori in the health workforce.

There is an untrained work force amongst family caregivers who have traditionally been expected to care for aged and terminally ill family members, including those who have cancer, rather than placement in residential care homes/villages/hospices. Because they have usually developed an empathy for their patients, it would be a great opportunity for these care-givers to be offered training opportunities and once Family Funded Care is introduced in 2020, be contracted officially into the Maori health workforce and continue on this professional pathway through a Maori health service provider.



Most commonly Maori health service providers are iwi or Maori owned and community based, Maori governed and deeply rooted in Maori values and cultural practices. They provide services to predominantly high-needs communities. They are uniquely placed to deliver on Maori aspirations and concepts of health and wellbeing alongside the delivery of treatment and care. One difficulty exists where they are prejudiced by the DHB model in providing kaupapa Maori models of care across multiple DHB districts.

The Whanau Ora model has had success in improving outcomes – with an overarching aim of “best outcomes for Maori”. The key strengths of this programme are that it is culturally anchored, whanau centred and strengths based, and its flexibility has enabled prioritised funding of services to progress issues of greatest importance for whanau. This is a successful model of care, to support whanau to provide care and support to their members in the treatment and management of health care and for long term healthcare support. It is important to restore trusted relationships between whanau and practitioners that recognise and acknowledge the role of whanau in determining their own health needs, and a need to build the health literacy of whanau to empower them to be more involved in decisions about their own health care.

### **Recommendations:**

That government look at possibly a mobile health bus that goes with a spread of specialist into the most deprived communities. Let's start looking at taking our services into the communities.

Education awareness - more TV ads. More engagement on the marae taking the message out to the communities.

Making visits more affordable by either subsidising transport to get to attend Doctors' visits.

### **Conclusions**

We would like to see better data collection that also has a gender lens component to it along with health professional going more into the community to look at a best practice model that better reaches our Maori communities and has the identification of early detection as part of the routine services provided.

Work with Maori community health service providers to raise awareness of the importance and benefits of enrolment and the promotion of available services for the early detection of cancers and a comprehensive wellbeing programme. Good nutrition and regular exercise/physical activity, reducing smoking prevalence and obesity, improving CVD risk management, would contribute significantly to reducing the leading causes of mortality. Early identification, support and management to develop a supportive care model with clinical nurse specialists, community nursing and primary care.



BPW NZ welcomes the opportunity to speak to this submission, to provide advice to this select committee and to advance women's rights in New Zealand.

### **Our Organisation**

BPW NZ is an affiliate of BPW International. BPW International is one of the most influential international networks of business and professional women with affiliates in 95 countries in five continents and a diverse membership of 28,000.

Our organisation's aims are to link professional and business women throughout the world, to provide support, to lobby for change and to promote the ongoing advancement of women. We work for equal opportunities and status for all women in economic, civil and political life and the removal of discrimination in all countries. We promote our aims and organise our operating structure without distinction as to race, language or religion.

### **International Status**

BPW International has General Consultative Status at the United Nations through the UN Economic & Social Council (ECOSOC). This enables BPW International to appoint official representatives to UN agencies worldwide and to accredit members to attend specific UN meetings.

BPW New Zealand speaks strongly for women in international forums and works hard in relation to the advancement to the status of women.

We request the New Zealand Government to consider the noted recommendations on further steps that can be taken to improve our human rights situation and offer advice and guidance on effective implementation.

Thank you for the opportunity to provide our suggestions and we hope that our comments are of use to you.

On behalf of  
New Zealand Federation of Business and Professional Women Inc.

Hellen Swales  
President  
027 528 6799  
[President@bpwnz.org.nz](mailto:President@bpwnz.org.nz)

Dr Barbara Bedeschi-Lewando  
Vice President, Issues  
021 288 1010  
[vpissues@bpwnz.org.nz](mailto:vpissues@bpwnz.org.nz)