**Document to inform discussions to develop a Māori Health Action Plan to implement He Korowai Oranga**

**2020 - 2025**

**Discussion document**

# **Foreword**

***E tipu e rea***

***Ka tipu koe hei tangata***

***Ka ruru e koe ki te tuāuri***

***Hei amonga mōhou ki te pūtake o ngā kōrero e!***

*Te Wī o Te Rangi, Ngai Tamatea*

E ngā tōtara haemata o te wao nui a Tāne, e ngā manu tīoriori, pari kārangaranga o Rongomaraeroa, e ngā mana, e ngā reo, tēnā koutou, tēnā koutou, tēnā tatou katoa!

Tēnā tātau katoa i runga i ngā tini aitua o te wā – te maha o naianei, te tini o nānahi, te mano o neherā. Hāere koutou e ngā mate i runga i te tai awatea; tātou ka whaimuri i te tai ahiahi. Hāere whaka-te-tokerau ki runga i te Ara Wairua, ki Te Rerenga Wairua, ki Te Reinga. E ai ki te kōrero o Toiroa Te Ikariki, “Hāere ki Matahourua, hāere ki Waingaromia, hāere ki oti atu rā e!” Ko koutou ki a koutou; ko tātou i mahue mai nei ki a tatou. Tēnā anō tatou katoa!

He Korowai Oranga, the Māori Health Strategy was originally launched in 2002, and provided a ten-year outlook with an overall aim of whānau ora. The Strategy was then refreshed in 2014, with an expanded aim of pae ora – healthy futures – comprising three key elements: mauri ora – healthy individuals; whānau ora – healthy families; and wai ora – healthy environments. The implementation of the original Strategy was guided by two Māori Health Action Plans, which concluded prior to the refresh of the Strategy in 2014. Now that the Strategy has been refreshed, it is timely to develop the next national Māori Health Action Plan.

He Korowai Oranga continues to set a strong direction for Māori health. Importantly, we are being challenged to do better and to go further. That includes continuing to meet our responsibilities under Te Tiriti o Waitangi, to address and improve substantial health inequities, and to ensure all services for Māori are appropriate and safe. These challenges are substantial and require a strong plan to implement actions and meet expectations. As such, the development of this next Māori Health Action Plan is both critical and necessary. Needless to say, ensuring that the plan is focused on the right things is an important backdrop to the development of this discussion document and the consequential engagement with our Māori health partners, stakeholders and communities.

Nā reira, ki tā te kōrero o Hikairo o Te Māhia, “He manako e koura, e kore ai!” Ko te tikanga o tērā korero, ahakoa e pai ana te moemoeā hei whainga atu, mehemea kāre e whakapau werawera ki te tutuki e kore e tāea. Heoi anō, mā tātou katoa te whakatutukitanga o tēnei māhere hauora Māori, otirā me tōna whainga matua arā te oranga tonutanga o te iwi whānui o Aotearoa nei.

Mauri tū, mauri ohooho, mauri ora!

John Whaanga, Deputy Director-General, Māori Health

# **Acknowledgements**

The Ministry of Health wishes to acknowledge the contributions of all those who have contributed to developing the discussion document to inform a Māori Health Action Plan. In particular, we would like to acknowledge Tā Mason Durie for his generosity of time and wisdom as we seek his insights, and the expertise and insights provided by the Māori Health Action Plan Expert Advisory Group:

* Hingatu Thompson (Chair)
* Matire Hardwood
* Lance Norman
* Tristram Ingham
* Te Pora Thompson-Evans
* Ezekiel Raui
* Suzanne Pitama.

The Ministry would also like to acknowledge Te Tumu Whakarae (District Health Board Māori Managers) for their contribution, support and advice in the development process.

**Contents**

[**Foreword** 2](#_Toc17195704)

[**Acknowledgements** 3](#_Toc17195705)

[**Purpose of this discussion document** 5](#_Toc17195706)

[**Have your say** 5](#_Toc17195707)

[Attending an engagement wānanga 5](#_Toc17195708)

[Complete our online survey 5](#_Toc17195709)

[Make a written submission 6](#_Toc17195710)

[**He Korowai Oranga: the Māori Health Strategy** 7](#_Toc17195711)

[History of implementing He Korowai Oranga: the Māori Health Strategy 7](#_Toc17195712)

[A new approach to Te Tiriti o Waitangi for the health and disability system 8](#_Toc17195713)

[A new Māori Health Action Plan to implement He Korowai Oranga 8](#_Toc17195714)

[**Priority areas for the Māori Health Action Plan** 10](#_Toc17195715)

[Priority area one: Māori / Crown relationships 12](#_Toc17195716)

[Priority area two: Māori health development 14](#_Toc17195717)

[Priority area three: Māori leadership 16](#_Toc17195718)

[Priority area four: Accountability frameworks 18](#_Toc17195719)

[Priority area five: Cross-sector action 20](#_Toc17195720)

[Priority area six: Workforce 22](#_Toc17195721)

[Priority area seven: Quality systems reflect good practice 24](#_Toc17195722)

[Priority area eight: Clear evidence of performance 26](#_Toc17195723)

[**Next steps** 28](#_Toc17195724)

[**Appendix one: Māori Health Action Plan Framework** 29](#_Toc17195725)

[**Appendix two: Summary of issues and priorities raised by Māori through recent Government public engagement** 31](#_Toc17195726)

[**Appendix 3: Key references** 33](#_Toc17195727)

# **Purpose of this discussion document**

This document is to inform discussions in developing a Māori Health Action Plan 2020 - 2025 (the Action Plan) to further implement He Korowai Oranga: the Māori Health Strategy (He Korowai Oranga). Our hope is that this document, along with the Māori Health Action Plan Framework A3 and background information, will provide a strong foundation for discussion on what action needs to be taken to achieve pae ora – healthy futures for Māori.

# **Have your say**

The Māori Health Directorate at the Ministry of Health (the Ministry) is co-ordinating a series of engagement wānanga between 19 August and 31 August 2019. We invite you to share your ideas on the proposed priority areas and what actions can be implemented. You can share your views at the wānanga and/or provide feedback:

* by email
* through an online survey.

The online hub for the Māori Health Action Plan will provide up-to-date information about of the development process, including engagement details. You can find the online hub at:

[www.health.govt.nz/mhap](http://www.health.govt.nz/mhap)

The final Māori Health Action Plan will be released in November 2019.

## Attending an engagement wānanga

Four health sector wānanga have been organised. These will be held in:

* Auckland: Monday 19 August 2019, Holiday Inn Auckland Airport
* Rotorua: Friday 23 August 2019, Sudima Lake Rotorua, 1000 Eruera Street
* Wellington: Wednesday 28 August 2019, Te Papa, Rangimarie room 1
* Christchurch: Friday 29 August 2019, Chateau on the Park, 189 Deans Avenue.

Attendees will include district health boards (DHBs), primary health organisations (PHOs), health providers and health and disability sector workforce, such as clinicians and professionals, and other Māori health organisations.

## Complete our online survey

You can also complete an online survey. To access the survey please go to the online hub at:

[www.health.govt.nz/mhap](http://www.health.govt.nz/mhap)

## Make a written submission

You can make an individual submission or a submission on behalf of an organisation.

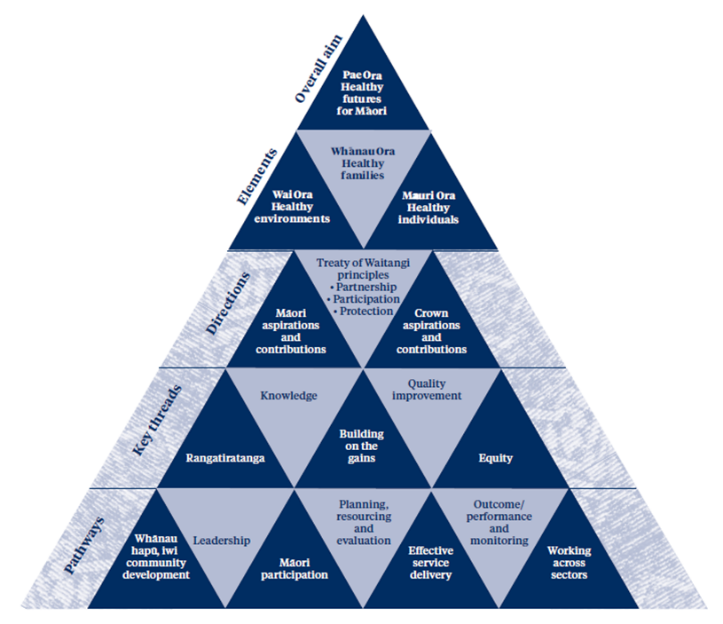
If you make an individual submission, please indicate your interest or involvement in Māori health (for example, as a patient, service provider or whānau of a patient).

If you make a submission on behalf of an organisation, iwi or hapū, please describe its details and its interest in Māori health.

You may email your submission to the Ministry of Health using the following address:

[Māorihealth@health.govt.nz](mailto:Māorihealth@health.govt.nz)

# **He Korowai Oranga: the Māori Health Strategy**

He Korowai Oranga, the Māori Health Strategy has the overall aim of pae ora (healthy futures). With its refresh in 2014, He Korowai Oranga continues to provide a strong platform for Māori health.

The elements, directions, key threads, inverse triangles and pathways of He Korowai Oranga are the health system’s guide to improving Māori health and realising pae ora. The four pathways of He Korowai Oranga guide how the strategy could be implemented. These pathways are:

* supporting whānau, hapū, iwi and community development
* supporting Māori participation at all levels of the health and disability sector
* ensuring effective health service delivery
* working across sectors.

## History of implementing He Korowai Oranga: the Māori Health Strategy

The implementation of He Korowai Oranga is the responsibility of the whole health and disability sector. Implementation was originally supported by Whakatātaka: the Māori Health Action Plan.

Two Māori Health Action Plans were developed to guide the implementation of the original He Korowai Oranga: Whakatātaka Māori Health Action Plan 2002-2005 (Ministry of Health 2002c), and Whakatātaka Tuarua: Māori Health Action Plan 2006-2011 (Minister of Health and Associate Minister of Health 2006).

Whakatātaka was used by the Ministry and District Health Boards (DHBs) to inform planning, resource prioritisation, and service development. Whakatātaka established a firm foundation for the health and disability sector to work towards improved health outcomes for Māori. This included providing direction to DHBs on key actions to be undertaken to implement He Korowai Oranga, improved quality data information, the embedding of whānau ora-based models, and the development of Māori health workforce development and governance.

He Korowai Oranga was refreshed in 2014. In the time since, there has been some progress but there is still much to do. One of the most obvious examples of this is the clear ongoing discrepancy in life expectancy at birth for Māori compared to non-Māori (Ministry of Health 2018c).

## A new approach to Te Tiriti o Waitangi for the health and disability system

Under Te Tiriti o Waitangi (the Treaty of Waitangi) the Ministry of Health, as steward and kaitiaki of the health and disability system (under Article I), has a responsibility to enable Māori to exercise their authority (under Article II) and enable the health system to achieve equity in health and wellness for Māori (Article III) in ways in ways that enable Māori to live and thrive as Māori (the Ritenga Māori Declaration).[[1]](#footnote-1)

These obligations are reflected in the principles of Te Tiriti as they apply to the health and disability sector, specified in the Waitangi Tribunal’s recent Hauora report (Waitangi Tribunal 2019a), they are:

* Tino Rangatiratanga
* Partnership
* Active protection
* Options
* Equity.

This new approach to the health and disability system’s obligations under Te Tiriti will underpin the proposed Action Plan. Within this framework sits achieving equitable health outcomes for Māori and contributing to the Government’s overall aims of wellbeing for all New Zealanders.

## A new Māori Health Action Plan to implement He Korowai Oranga

The Ministry is now engaging with stakeholders to develop a new Māori Health Action Plan. The Action Plan will put He Korowai Oranga into action and adopt the overarching aim of pae ora.

The focus on pae ora encourages everyone in the health and disability sector to work collaboratively, to achieve wellbeing beyond narrow definitions of health, and to provide high-quality, equitable and effective services (Ministry of Health 2018h).

The purpose of a new Action Plan is to enable the health and disability system to respond to Te Tiriti o Waitangi obligations, affirm Māori aspirations, and achieve equitable health outcomes, wellness and wellbeing for iwi, hapū and Māori communities.

Reflecting on these obligations, our past successes and challenges, and common themes from recent Crown / Government engagement with iwi, hapū and whānau, has been integral to developing the proposed approach for this Plan. With an eye to the future, and a five-year implementation time horizon, the draft objectives are:

* acknowledge and enable iwi, hapū and Māori communities to exercise their authority to improve their health and wellbeing
* enable the health and disability system to be fair and sustainable and deliver equitable outcomes for Māori
* address racism and discrimination in all its forms.

The next section outlines the suggested priority areas for a new Action Plan, including:

* the objectives for each area
* the rationale for choosing each area as a priority
* some suggested actions for each priority area
* some suggested measures to monitor progress.

Across the suggested actions, common themes include:

* enabling Māori to make decisions on matters affecting their health and wellbeing
* putting equity for Māori into action
* moving from cultural competency, an understanding and respect for Māori aspirations and preferences, to cultural safety, a focus on addressing privilege, discrimination and racism.

We expect these priority areas and actions will be refreshed after engagement and feedback from Māori and the health and disability sector. The development of this Plan will consider the results of other processes, such as the Health and Disability System Review and the progress of the Public Service Bill.

# **Priority areas for the Māori Health Action Plan**

The development of an Action Plan will draw guidance from aspirations and expectations that whānau, hapū, iwi and Māori communities have shared with Government. Most recently, Māori have provided extensive feedback and advice to Government agencies as part of the Wai 2575 Health Services and Outcomes Kaupapa Inquiry, the Mental Health and Addictions Inquiry, and the development of the Child and Youth Wellbeing Strategy.

“When we participate in hui like this we give a piece of our soul, and we ask that you take care of it.” (Hui participant Mental Health and Addiction Inquiry 2018)

A summary of the main themes from these engagements is attached as Appendix Two. The Ministry has acknowledged the main themes and priorities from those previous engagements with Māori and has used them to guide its thinking.

The Ministry has developed a framework to guide the development of an Action Plan with eight proposed priority areas. These are where the Ministry proposes the health and disability system, alongside iwi, hapū, whānau and Māori communities, prioritise time and resources over the next five years.

The eight priority areas are:

1. **Māori / Crown relationships** - amplify Māori / Crown relationships and meet obligations under Te Tiriti o Waitangi including responding to Wai 2575 findings.
2. **Māori health development** - further develop Māori health capacity and capability through a viable Māori provider network with the resources and authority to provide kaupapa Māori and whānau-centred models of care.
3. **Māori leadership** - increase Māori representation in decision making throughout the health and disability system’s leadership and governance arrangements.
4. **Accountability frameworks** - strengthen expectations for DHBs, PHOs and health and disability Crown entities to meet their obligations under Te Tiriti o Waitangi and account for Māori health equity.
5. **Cross sector action** - ensure national, regional and local joint ventures address the social, economic and behavioural determinants of health.
6. **Workforce** - enable a hauora-competent workforce along with more Māori in the health and disability workforce.
7. **Quality systems reflect good practice** - enhance quality and safety standards and frameworks across the health and disability sector to build capacity and capability to deliver improved health outcomes for Māori.
8. **Clear evidence of performance** - aligned measures and monitoring approaches with increased access to powerful insights to understand the differences in Māori outcomes and the progress being made.

Setting these priorities and associated actions involves an important challenge. The areas need to be specific, relevant and measurable within a five-year timeframe to impact a longer-term horizon. The plan also needs to give the health and disability system and Māori communities the flexibility to develop options for how to deliver on the priorities at local levels. The priority areas also exist within a health and disability system that is already focusing on Māori health outcomes through various action plans and the Government’s overall focus on wellbeing.

An A3 representation of the priority areas and the associated suggested actions and measures is attached as Appendix one. This A3 also shows how the eight priority areas for action align with Te Tiriti o Waitangi and with He Korowai Oranga. This is a draft framework that we will be using to facilitate discussions throughout the engagement process.

## Priority area one**: Māori / Crown relationships**

#### Objective

Amplify Māori / Crown relationships and meet obligations under Te Tiriti o Waitangi including responding to Wai 2575 findings.

#### Rationale

Te Tiriti o Waitangi provides an imperative to acknowledge, protect and promote the health of Māori. In Whaiora: Māori Health Development (1994), Tā Mason Durie stated:

“Māori health development is essentially about Māori defining their own priorities for health and then weaving a course to realise their collective aspirations” (Durie, 1994).

The Ministry and DHBs have relationships with Māori advisory groups and Iwi Relationship Boards but it is not clear how effective Māori-Crown relationships have been in realising Māori health aspirations.

On 1 July 2019, the Waitangi Tribunal released its findings and recommendations on Stage One of the Kaupapa Inquiry in the report Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. In relation to primary care the Tribunal found that the legislative, strategy and policy framework, funding arrangements, way health entities are held to account, and the partnership that the Crown has with Māori are not Treaty-compliant. This has contributed to serious and persistent health inequities for Māori.

Effective Māori-Crown relationships include understanding the rights, interests and perspectives of Māori meaningfully engaging and building relationships with iwi, hapū and Māori communities, and embedding Māori and Te Tiriti o Waitangi perspectives into policy, programmes and services.

Investing in Māori health within a Te Tiriti o Waitangi framework can guide responsiveness at all levels of the health and disability system. This includes inclusive policy design and creating greater opportunity for collaborative service innovation, devolution of resources and increased Māori decision-making.

#### Suggested actions

* The Ministry will continue to adopt a collaborative approach throughout the remainder of the Wai 2575 inquiry.
* Design with Māori the Māori Health Action Plan and broader initiatives (Wai 2575 finding).
* The Ministry, in its stewardship role, will reset its Māori-Crown relationships to ensure it is clear and consistent, including looking at the effectiveness of different partnership approaches and identifying what approaches might be possible in different situations (Wai 2575 finding).
* Explore the possibility of a stand-alone Māori health authority (Wai 2575 finding).

#### Suggested measures

* Number and type of partnership agreements between Māori and the Ministry, and DHBs.
* Levels of satisfaction with Māori-Crown partnership arrangements.
* (Others to be determined).

## Priority area two: Māori health development

#### Objective

Further develop Māori health capacity and capability through a viable Māori provider network with the resources and authority to provide kaupapa Māori and whānau-centred models of care.

#### Rationale

He Korowai Oranga supports approaches to health and wellbeing that use Māori strengths and assets to develop Māori-led initiatives tailored to meet Māori health needs. This includes Māori models of health and wellbeing, rongoā (traditional healing), and innovation. These are referred to as ‘kaupapa Māori’ models of care. Whānau-centred approaches sit at the core of kaupapa Māori models, being culturally-grounded and holistic, focused on improving the wellbeing of whānau and addressing individual needs within a whānau and community context.

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

Alongside kaupapa Māori services, Māori have looked to the rest of the health and disability system to offer culturally appropriate and safe whānau-centred services. As many Māori continue to receive most of their health care from mainstream services, effort is required to ensure that mainstream services work effectively for Māori through the provision of whānau-centred care.

In recent engagement around achieving equity in health outcomes for Māori and other groups, community-based Māori providers were at the forefront of those who asked for:

* resources and support to tailor whānau-centred services that focus on addressing the whole-of-life issues and needs
* a move away from commissioning systems and funding formulas that reinforce existing service patterns and are biased towards a Western medical world view
* Government commitment to collaborative and constructive actions, jointly owned by Māori and the Crown, to develop solutions that work for them.

#### Suggested actions

* Support the kaupapa Māori and whānau centred approaches proposed in other sector actions plans.
* Continue to strengthen and promote successful kaupapa Māori services that are focused on achieving whānau ora through the Māori Health Development Scheme and Te Ao Auahatanga Hauora Māori.
* Ensure that all health sector contracting documents incorporate references to the Treaty and health equity for Māori (Wai 2575 finding).
* Develop a fair methodology for assessing historical underfunding of Māori PHOs (Wai 2575 finding).
* Commissioning organisations to adopt fair and sustainable approaches to contracting for kaupapa Māori and whānau-centred / whānau ora services.

#### Suggested measures

* Availability and type of kaupapa Māori and whānau centred services.
* Number of Māori utilising kaupapa Māori and whānau centred / whānau ora services.
* (Others to be determined).

## Priority area three: Māori leadership

#### Objective

Increase Māori representation in decision-making throughout the health and disability system’s leadership and governance arrangements.

#### Rationale

Delivering system change will require strong sector leadership. It is imperative that our governance and leadership arrangements support change while also providing a high level of transparency and accountability.

Research indicates when indigenous peoples make their own decisions, they consistently out-perform external decision makers on matters as diverse as natural resource management, economic development, healthcare, and social service provision (Cornell and Kalt 1998).

While Māori participation in the health and disability sector has increased significantly, there is an ongoing need to ensure Māori are, and remain, well represented in key leadership and strategic decision-making roles. Achieving this requires Māori participating meaningfully and effectively in decision making fora – for example, as members of a DHB board or as participants on other statutory or advisory committees. The New Zealand Public Health and Disability Act 2000 (the Act) stipulates a desire to have greater participation by Māori in the health and disability sector with a view to improving Māori health outcomes and reducing health disparities between Māori and other population groups.

The Act also states that DHBs should endeavour to ensure Māori membership of a DHB board is proportional to the number of Māori in the DHB’s resident population and, in any event, ensure there are at least two Māori members of the board. Having proportional representation on DHB boards contributes to DHBs’ ability to adequately respond to the health needs of their regions’ Māori population.

These arrangements require adequate support and investment to be successful and increase capacity of Māori to take up leadership roles while supporting capability building.

#### Suggested actions

* Monitor and report on Māori representation on DHB boards and committees as mandated under the Act.
* Develop a method for monitoring Māori representation on PHO boards and amongst PHO chief executives.
* Invest in building Māori leadership and governance capability and capacity.

#### Suggested measures

* Percentage of Māori DHB board members compared to the district’s population.
* Percentage of Māori board members on PHO boards compared to the district’s population.
* (Others to be determined).

## Priority area four: Accountability frameworks

#### Objective

Strengthen expectations for DHBs, PHOs and health and disability Crown entities to meet their obligations under Te Tiriti o Waitangi and account for Māori health equity.

#### Rationale

The New Zealand Public Health and Disability Act 2000 (the Act) sets out the objectives of District Health Boards (DHBs), one of which is to reduce health disparities by improving health outcomes for Māori and other population groups. It also sets out DHBs’ obligations under the Treaty of Waitangi. DHBs need to consider He Korowai Oranga in their planning, to meet their statutory objectives and functions for Māori health.

Health and wellness exist in a complex system. To a certain extent, they depend on factors a health and disability system can control, but they are also impacted by the various social, economic and behavioural determinants of health. In the almost two decades since the Act explicitly made removing inequalities an objective of DHBs, we have made some progress but there is still much to do. Māori health status remains unequal with non-Māori across almost all chronic and infectious diseases as well as injuries (Ministry of Health 2015).

Despite greater Crown awareness of Māori health issues in more recent years, several Tribunals have also continued to note the continuing poor health outcomes for Māori into recent times and the persistent disparities between Māori and non-Māori, which the Tribunal Ko Aotearoa Tenei report described as a ‘modern Māori health crisis’. The Tauranga Moana Tribunal also found that persistent disparity between Māori and non-Māori health outcomes ‘indicates a failure of active protection by the Crown’ and this failure was a breach of the principle of active protection’ (Crocker 2018).

Accountability and monitoring levers within the health and disability system are key to achieving health equity for Māori, and equity needs to be embedded in all aspects of the system’s accountability framework, from long-term strategic planning to short-term key performance indicators.

#### Suggested actions

* Embed Te Tiriti in all documents that make up the primary health system (Wai 2575 finding).
* Embed achieving equitable health outcomes in all documents that make up the primary health and disability system (Wai 2575 finding).
* Strengthen accountability mechanisms and processes which affect Māori in the primary health and disability sector (Wai 2575 finding).
* DHBs and PHOs prepare and make available their annual Māori health plans (Wai 2575 finding).

#### Suggested measures

* Numbers of DHBs and Crown entities meeting equity and Treaty commitments in their accountability documents.
* Number of PHOs with published plans to deliver effective services to Māori and reports on progress.
* (Others to be determined).

## Priority area five: Cross-sector action

#### Objective

Ensure national, regional and local joint ventures address the social, economic and behavioural determinants of health.

#### Rationale

Improvements in Māori health will lead to improvements in other areas of life, and vice-versa. For example, higher educational achievement and good-quality employment often improve health outcomes. Poor health can also adversely affect people’s education, employment opportunities, and socio-economic status. Currently, Māori experience a lower-quality of living over a range of measures, as evidenced below.

Wellbeing measures are used to show how people feel about their lives. Figure 2 shows that a much lower percentage of Māori have high wellbeing within most of the domains when compared to the entire New Zealand population, particularly in areas such as housing, civic engagement and governance.

**Figure 2: Difference in probability of having a high score within the Living Standards 9 domains for wellbeing for Māori compared to the NZ Population**

While health and disability services contribute to health outcomes, figure 2 indicates the need to address the broader determinants of health for Māori and increase the general quality of life. Providing Māori with warm, dry homes would have vast and long-standing effects on Māori health, as it would likely decrease rates of rheumatic fever, respiratory diseases, and other common ailments. Addressing Māori health without addressing the root causes of poor health narrows the capacity of the system to respond to Māori unwellness and limits the effect the health and disability system can have in improving heath equity for Māori.

An example of good integrated service delivery includes new approaches to the disability support system, addressed in Enabling Good Lives. This initiative will give disabled Māori and their families increased choice and control over the support they receive and has required Government agencies to work together differently, for example by integrating funding and contracts.

#### Suggested actions

* Continue to engage and contribute to broader Government Priorities requiring cross-agency collaboration, including improving child and youth wellbeing and mental health and wellbeing.
* Continue to develop local initiatives that bring together iwi, hapū, DHBs and other social agencies and organisations at the local level.
* Work with cross-sector experts to use the evidence on the burden of disease for Māori to design and evaluate interventions.

#### Suggested measures

* Number of DHBs that are part of local joint ventures with Māori, local government and other groups.
* (Others to be determined).

## Priority area six: Workforce

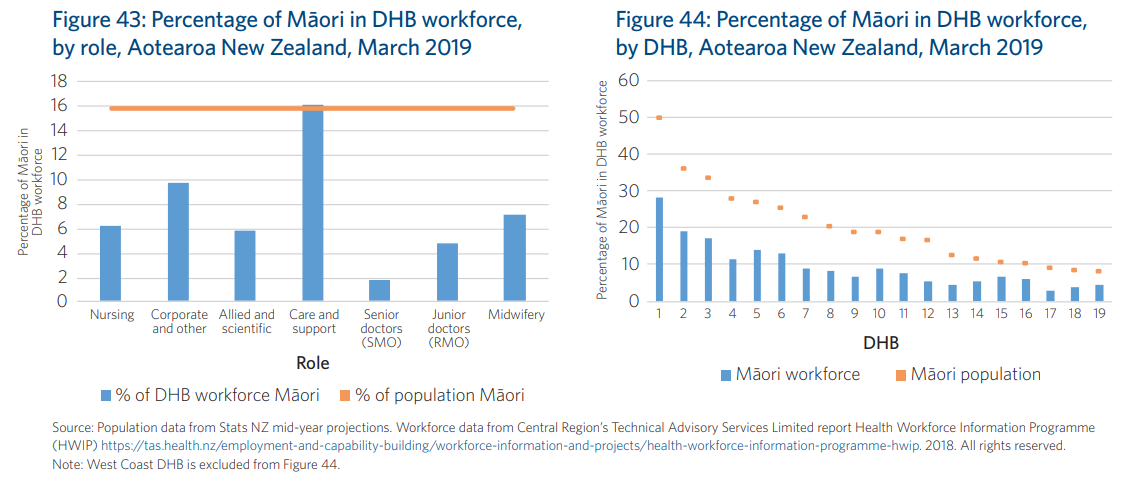
#### Objective

Enable a hauora-competent workforce along with more Māori in the health and disability workforce.

#### Rationale

Over the past few decades, significant efforts have been made to build the Māori health workforce. These efforts have involved establishing scholarships and leadership programmes, as well as several Māori workforce development organisations.

The Māori health workforce has grown steadily. Despite this gradual increase, there is a long way to go to achieve population parity. Recent data published by the Health Quality and Safety Commission, using DHB employed workforce data, shows this gap across professions and across DHBs (HQSC 2019).



Addressing the under-representation of indigenous health professionals is recognised internationally as being an integral component of the overall response to addressing indigenous health inequities (Curtis, Wikaire, Stokes and Reid 2012).

The Māori population is projected to increase at a faster rate than the non-Māori population. Sustained efforts to grow the Māori health workforce are needed to ensure it can meet the higher demand from a larger Māori population.

Equally important is the need to build a culturally-competent and culturally safe health and disability workforce. This necessitates assessing racism and discrimination in all its forms. Moving from cultural competence to achieving cultural safety is fundamentally about eliminating racism and discrimination.

Evidence suggests that treatment is differentiated when Māori access services. For example, Māori children receive sub-optimal asthma control, which is clear from the higher levels of prescriptions for reliever medications, without any preventer prescribed, which may contribute to the 30 percent higher rate of hospitalisation for asthma for Māori children compared with non-Māori children. Communication is another key issue. Compared with non-Māori, Māori adults consistently respond less-positively to questions about the experience of communication with hospital staff and doctors.

Creating a culturally safe and competent health and disability workforce is the responsibility of, and a priority for, the entire health and disability system.

#### Suggested actions

* Implement the Budget 2019 Māori Health Workforce Development Package.
* Embed cultural safety within training and continuing professional education requirements for clinicians.
* Conduct research to measure Māori experience of working in the health and disability sector.
* Focus on Māori promotion and retention.
* Provide developmental opportunities in tikanga and te reo Māori.
* Establish policies across DHBs that strengthen cultural safety for all staff.

#### Suggested measures

* The number and percentage of Māori across health and disability workforce groups.
* The number and percentage of Māori in professional leadership and management roles.
* Increased levels of Māori workforce satisfaction.
* DHBs with implemented cultural competence policies.
* Number of health workforce members who are te reo Māori speakers.
* (Others to be determined).

## Priority area seven: Quality systems reflect good practice

#### Objective

Enhance quality and safety standards and frameworks across the health and disability sector to build capacity and capability to deliver improved health outcomes for Māori.

#### Rationale

The health system needs to improve its quality and safety standards and frameworks to better guide the sector and workforce to achieve health equity for Māori and deliver whānau-centred care. It is the Ministry’s responsibility (supported by Health Quality and Safety Commission and the Health Disability Commissioner) to support the sector to promote the safe provision of health and disability services, enable the establishment of consistent and reasonable standards for providing services, and encourage providers to take responsibility for providing culturally-responsive and appropriate services for Māori.

Māori are engaging far less frequently with the health system than their non-Māori counterparts, and their engagements are often shorter and do not adequately address the issues at hand. This is evidenced by the higher reported level of unmet need for primary care and pharmaceuticals reported in the New Zealand Health Survey (Ministry of Health 2019c), higher rates of ambulatory sensitive hospitalisations (Ministry of Health 2019d), and inequitable differences in cancer survivability (Teng et. al. 2016).

Encouraging a quality and culturally-safe system will ensure the sector is aligning with the priorities of He Korowai Oranga, through supporting the Māori and Crown aspirations for Māori health. This will, in turn, create a more effective health and disability system that is responsive to the needs of Māori.

#### Suggested actions

* Support work underway that has implications for improving the sector's responsiveness to Māori, such as the review of Health and Disability Services Standards.
* Establish an approach to address racism and discrimination and long-term system planning to address its impact on core quality and safety policy, systems and frameworks.
* Support the adoption of holistic whānau-centred approaches across the health and disability system.
* As policies, standards and frameworks come up for review, ensure that they are updated and reflective of the health and disability system's obligations to Māori.
* Establish more comprehensive measurements of Māori trust and engagement with the system.

#### Suggested measures

* Number of regulated providers meeting standards for providing health and disability services to Māori.
* Increased trust and confidence by Māori in the system.
* (Others to be determined).

## Priority area eight: Clear evidence of performance

#### Objective

Aligned measures and monitoring approaches with increased access to powerful insights to understand the differences in Māori outcomes and the progress being made.

#### Rationale

Quality health data is a key asset for Māori development. This will enable Māori individuals, whānau, hapū and iwi to make the best decisions to support their communities in the ways that meet their development needs and aspirations. Progress towards pae ora will require enabling Māori to have greater access, governance and capability to better use data that is relevant.

Data must also be better collected, analysed, and utilised by the Ministry, DHBs, providers, and across wider sectors, to respond to inequities for Māori. Indigenous data sovereignty is supported by international policy, including the United Nations Declaration on the Rights of Indigenous Peoples, and the WHO Commission on the Social Determinants of Health.

In considering the challenges posed in achieving equitable health outcomes for Māori, it is essential to understand where equity gaps exist and along what dimensions. Detailed, disaggregated and reliable data and analytics over time are critical for policy development, service design and monitoring progress. Aggregated data can hide variability and can lead to decisions that, while improving overall average performance, leave significant disparities between individuals and groups.

Currently, service utilisation analytics is the most prolific and up-to-date in the health and disability system. Data focusing on outcomes or at family/community level is rarer and often takes longer to become available.

#### Suggested actions

* Implement the 2017 Ethnicity Data Protocols.
* Collect Iwi data as part of the National Health Index.
* Support the work of StatsNZ to create a comprehensive view of wellbeing, and to design a Treaty-based Māori approach to data governance across the official data system.
* Design a primary health research agenda with Māori experts (Wai 2575 finding).
* Collect, report-on and make available robust quantitative and qualitative primary care data and information relevant to Māori health outcomes (Wai 2575 finding).
* Publicly report-against measures specific to Māori health outcomes (Wai 2575 finding).
* Develop a plan for enabling individual, whānau, hapū, iwi, and community access to their health and disability data.
* Continue to invest in the development of Māori health provider analytical capability.

#### Suggested measures

* Māori with access to their own health data through online patient portals.
* Māori providers with access to analytical tools to analyse their own data and data held nationally.
* Māori provider satisfaction with access to data held nationally.
* (Others to be determined).

# **Next steps**

Following engagement, the Ministry will synthesise the information and insights collected through the wānanga, the online survey and the email address. Feedback captured during engagement will shape what the final Action Plan looks like. The Ministry will continue to work alongside the Expert Advisory Group and engage with Māori and the health and disability sector to develop the Action Plan, before Cabinet consideration and release in November 2019.

The online hub on the Ministry’s website will be a central point for stakeholders and the general public to access information about this process. The website will act as a hub for documents before, between, and following health sector wānanga, ensuring stakeholders have oversight of our process.

The online hub can be found at:

[www.health.govt.nz/mhap](http://www.health.govt.nz/mhap)

# **Appendix one: Māori Health Action Plan Framework**



# **Appendix two: Summary of issues and priorities raised by Māori through recent Government public engagement**

|  |  |  |  |
| --- | --- | --- | --- |
| Te Tiriti o Waitangi   * Te Tiriti o Waitangi should be the foundation for all of our work * Recognise Māori indigeneity and affirm indigenous rights * Adopt tikanga Māori frameworks to reflect the practical commitment to Te Tiriti o Waitangi * The New Zealand Public Health and Disability Act 2000 is not strong enough to ensure that te Tiriti principles are met * Terminology used in the health sector needs to better reflect current understandings and implementation of te Tiriti * Many Māori have expressed a preference to use an articles-based vs. principle based approach to te Tiriti | | | |
| Article 1 (Ko te Tuatahi Kāwanatanga)  *Requires a stewardship or kaitiakitanga approach informed by morals, values and ethics* | **Article 2 (Ko te Tuarua Tino Rangatiratanga)**  *Provides the right for Māori to live on Māori terms & according to Māori philosophies, practices and values* | **Article 3 (Ko te Tuatoru Ōritetanga)**  *Provides for the same rights and privileges of citizenship* | **Declaration – Whakapuakitanga Rītenga Māori**  *Ritenga Māori are framed by te ao Māori, enacted through tikanga and encapsulated within mātauranga Māori* |
| Māori in Governance and Leadership   * Lack of genuine partnership under the articles of te Tiriti. * The Crown does not adequately partner with Māori (in the health sector, and more broadly). * There has not been adequate attention paid to Māori interests in the design and implementation of health services. * Give Māori a seat at the table to determine how services are designed, commissioned, delivered and evaluated. * Improve and develop Māori participation and representation across the sector at a governance level. This includes shared power and decision-making between the Crown and Māori and the influence of funding and contracting arrangements on the distribution of decision-making power. * Develop stronger iwi / Māori partnerships with DHBs. * Support Māori leadership development. | **Rangatiratanga and mana motuhake**   * Māori whānau, hapū and iwi want to exercise tino rangatiratanga and mana motuhake. * Māori want shared decision-making power. * Trust Māori in their ability to know and to deliver what works for Māori. * Improved outcomes for Māori must be driven and delivered by Māori. * Involve Māori communities at all stages of policy design and implementation. * All Māori, including tamariki and rangatahi, have a right to be included in the decision-making process. * Tamariki and rangatahi are the leaders of today and the future – they are the champions of Pae Ora. We need to invest in their development and value their voice. | **Equity of access to services and equity of health outcome**   * There is tension between universal and community approaches to the provision of services. * There is a lack of flexibility in the current system to meet the diverse health needs of Māori. * Health professionals should act within the system to connect people to the services available to them. * Cost of GP services acts as a barrier to Māori accessing primary care. * There is strong evidence that Māori do not always receive optimal quality of care and that this impacts on health outcomes. * More adult Māori wait longer than three months for an appointment to see a specialist compared to non-Māori. * Racism has been identified as a factor in the quality of care Māori receive and as a broader determinant of health. | **Mana Māori**   * Affirm indigeneity and the importance of Māori culture. * Incorporate core Māori values, such as manākitanga, whānaungatanga, and kaitiakitanga into the way the system operates. * Align Government policy with tikanga Māori. * Allow for whakawhānaungatanga in new environments to encourage relationship development and Māori engagement with services. |
| Māori are the solution   * Māori have a sense of urgency to make changes to the health and disability system. * Health and disability services need to be strengths-based, not deficit-based. * Recognise tamariki and rangatahi Māori as taonga. * Whānau tino ora – ask *‘what matters to whānau?*’ not *‘what’s the matter with whānau?’* | **Invest in our Māori health workforce.**   * A diverse and representative health workforce that understands the importance of achieving health equity. * There is a lack of diversity in the current workforce. Māori make up 3% of the medical workforce and 11% of the industry group Health Care and Social Assistance (Stats NZ, Census 2013). * Māori health workforce challenges are centred on the capacity and capability of the Māori workforce and attracting and retaining Māori health professionals to work in rural areas. * There is insufficient investment in building the Māori health workforce. * Pay parity issues between health professionals working for Māori providers and those working for mainstream providers are a challenge for recruitment and retention. | **Addressing colonisation and racism**   * At the heart of Māori un-wellness is colonisation, intergenerational trauma, institutional racism, unconscious bias, and a western model of wellbeing. * Research shows Māori are significantly more likely to experience discrimination than the New Zealand European population. * Start from a place of restoration. Acknowledge and address the historic and present injustice experienced by Māori, and start to heal the intergenerational mamae (pain). * Recognise the impact of cultural alienation and generational deprivation. * Develop the cultural competency and responsiveness of the health and disability system. | **Whānau centred models of care**   * The system is set-up for individual engagement and doesn’t offer a platform for whānau engagement * Focus on whānau wellbeing. * The current system does not recognise the diverse realities of Māori whānau, hapū and iwi * The current system fails to promote the autonomy of whānau. * Struggles to design services around whānau and take services to whānau, to ensure tamariki are able to connect to their whakapapa and culture. * Whānau ora approaches should be funded as business-as-usual. |
| Funding partnerships   * Improved outcomes for Māori will require a greater level of and more streamlined investment into Māori health. * Contracting arrangements are inflexible and low-trust. This does not support innovation. * Māori providers are scrutinised more. The Crown must start from a position of trust. * Distribute resources to empower Māori. * Fund Māori providers at the level required to provide equitable care for their populations. * Funding should be longer-term and focus on achieving outcomes rather than outputs. * Fund preventative services rather than secondary services. * Critically review services, rather than continuing to fund the same thing. * A number of Māori providers have expressed a desire to see separate or distinct Māori-led funding and commissioning models. | | | **Mātauranga Māori**   * Mātauranga Māori plays an important role in the shaping of contextual, cultural and ideological approaches and in the understanding of health and wellbeing for Māori. * Interventions based in Mātauranga Māori are proven to deliver better health outcomes for Māori communities. * Return to kaupapa Māori services systems and practices. * Māori want the flexibility to develop and deliver services, ‘by Māori, for Māori’. * Support Māori research, particularly research being done ‘by Māori for Māori’. |
| Accountability   * The Government should be accountable to Māori. * Need a two-way accountability arrangement between funders and providers. * Our policies need to be bigger than the Government of the day. * Take action on some of the major systemic issues that have typically been considered “too hard” or “too big” to address. | | | **THIS PAPER DOES NOT REFLECT**  **GOVERNMENT POLICY** |
| Data, information sharing and technology   * Quality health data collection provides the knowledge base for investment, service planning and data sharing. * Concerns have been raised about data quality including inconsistent collection of ethnicity data. * There are issues of data sovereignty and governance, described as the inherent rights and interests of Māori in the collection, ownership and use of Māori data. This includes ensuring appropriate structures, mechanisms and instruments through which Māori can exercise control over Māori data. * Lack of national primary care database means that it is very difficult to monitor many outcomes in primary care. | | |

# **Appendix 3: Key references**

Acheson D. 1998. *Independent Inquiry into Inequalities in Health Report*. London: The Stationery Office. URL: [www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report](http://www.gov.uk/government/publications/independent-inquiry-into-inequalities-in-health-report) (accessed 3 September 2018).

Aday LA, Fleming GV, Anderson R. 1984. *Access to Medical Care in the US: Who have it, who don’t*. Chicago: Pluribus.

Alper J, National Academies of Sciences, Engineering, and Medicine (US), Roundtable on Population Health Improvement. 2016. *Metrics that Matter for Population Health Action: Workshop summary*. Washington, DC: National Academies Press. DOI 10.17226/21899 (accessed 25 July 2018).

Auckland UniServices Limited. 2018. *Variation in medicines use by ethnicity: a comparison between 2006/7 and 2012/13: Final report*. URL: https://www.pharmac.govt.nz/assets/2018-01-19-Variation-in-medicines-use-by-ethnicity-Final-Report.pdf (accessed 11 September 2018).

Black D. 1980. *Inequalities in Health: Report of a research working group*. London: Department of Health and Social Security.

Braveman P. 1998. Monitoring equity in health: A policy oriented approach in low and middle income countries. *Equity Initiative Paper* 3. Geneva: World Health Organization. 92 pp. (WHO/CHS/HSS/98.1).

Braveman P. 2006. Health disparities and health equity: Concepts and measurements. *Annual Review of Public Health* 27:167–94.

Braveman P. 2014. What are health disparities and health equity? We need to be clear. *Public Health Reports* 129(1\_suppl2): 5–8.

Braveman P, Gruskin S. 2003. Defining equity in health. *Journal of Epidemiology and Community Health* 57(4): 254–8.

Braveman P, Tarimo E, Creese A. et al. 1996. *Equity in Health and Health Care: A WHO/SIDA initiative*. Geneva: World Health Organization.

Came H, Doole C, McKenna B, et al. 2018. Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *Social Science and Medicine* 199: 132–9.

Came H, McCreanor T, Doole C, et al. 2016. The New Zealand Health Strategy 2016: Whither health equity? *The New Zealand Medical Journal* 129(1447). URL: [www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1447-16-december-2016/7107](http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2016/vol-129-no-1447-16-december-2016/7107) (accessed 25 July 2018).

Came H, McCreanor T, Doole C, et al. 2017. Realising the rhetoric: Refreshing public health providers’ efforts to honour Te Tiriti o Waitangi in New Zealand. *Ethnicity and Health* 22(2): 105–18.

Chin MH, King PT, Jones RG, et al. 2018. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy*. URL: [www.ncbi.nlm.nih.gov/pubmed/29961558](http://www.ncbi.nlm.nih.gov/pubmed/29961558) (accessed 26 July 2018).

Clark D. 2018. *Minister's 2019/20 Letter of Expectations.* Retrieved 6 June 2019 from Ministry of Health: [https://nsfl.health.govt.nz/dhb-planning-package/201920-planning-package/supplementary-information-201920-planning-guidelines-1 (20](https://nsfl.health.govt.nz/dhb-planning-package/201920-planning-package/supplementary-information-201920-planning-guidelines-1%20(20) December)

Coleman JS. 1988. Social capital in the creation of human capital. *American Journal of Sociology* 94: S95–S120.

Cornell S. Kalt J. 1998. *Sovereignty and nation-building: the development challenge in indian country today*. <https://hpaied.org/sites/default/files/publications/PRS98-25.pdf>

Crocker T. 2018. *Māori Health Services and Outcomes Inquiry (Wai 2575) Pre-casebook Discussion Paper: Part 1.* Wellington: Waitangi Tribunal Unit.

Culyer AJ, Wagstaff A. 1993. Equity and equality in health and health care. *Journal of Health Economics* 12(4): 431–57.

Cunningham C. 1995. *He Taura Tieke: Measuring effective health services for Māori*. Wellington, New Zealand: Ministry of Health.

Curtis E. Wikaire E. Stokes K. Reid P. 2012. *Addressing health workforce inequities: a literature review exploring ‘best’ practice for recruitment into tertiary health programmes*. International Journal for Equity in Health. Volume 11, Article 13.

Daniels N. 2006. Equity and population health: toward a broader bioethics agenda. *Hastings Center Report* 36(4): 22–35. URL: [www.ncbi.nlm.nih.gov/pubmed/16898358](http://www.ncbi.nlm.nih.gov/pubmed/16898358) (accessed 2 September 2018).

Department of the Prime Minister and Cabinet. 2019. *Child and Youth Wellbeing Strategy*. Retrieved 25 March 2019 from Department of the Prime Minister and Cabinet: https://dpmc.govt.nz/our-programmes/child-and-youth-wellbeing-strategy

Durie M. 1993. *The CHI Model: A culturally appropriate auditing model: Guidelines for public health services*. Wellington, New Zealand: Public Health Commission.

Durie M. 1994. *Whaiora: Māori health development.* Auckland: Oxford University Press.

Durie M. 1998a. The Hui Taumata Matauranga: Progress and platforms for Māori educational achievement. In Durie M. 1998. *Nga Kahui Pou Launching Māori Futures*. Wellington: Huia.

Durie M. 1998b. *Whaiora: Māori health development*. 2nd ed. Auckland: Oxford University Press.

Frontier Economics. 2010. *Estimating the Costs of Health Inequalities: A report prepared for the Marmot Review*. London: Frontier Economics. URL: [www.instituteofhealthequity.org/file-manager/FSHLrelateddocs/overall-costs-fshl.pdf](http://www.instituteofhealthequity.org/file-manager/FSHLrelateddocs/overall-costs-fshl.pdf) (accessed 25 July 2018).

Harrop A. 2012. *The Coalition and Universalism: Cuts, targeting and the future of welfare*. London: The Fabian Society. URL: <https://fabians.org.uk/wp-content/uploads/2012/01/The-Coalition-and-Universalism.pdf> (accessed 25 July 2018).

Hart JT. 1971. The inverse care law. *The Lancet* 297: 405–12.

HQSC. 2017. *Health Equity*. URL: [www.hqsc.govt.nz/our-programmes/other-topics/new-projects/health-equity/](http://www.hqsc.govt.nz/our-programmes/other-topics/new-projects/health-equity/) (accessed 25 July 2018).

HQSC. 2018. *A Window on the Quality of New Zealand’s Health Care 2018*. Wellington: Health Quality and Safety Commission. URL: [www.hqsc.govt.nz/assets/Health-Quality-Evaluation/Windows\_Document/Window-Jun-2018.pdf](http://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/Windows_Document/Window-Jun-2018.pdf) (accessed 25 July 2018).

HQSC. 2019. *A Window on the Quality of New Zealand’s Health Care 2019*. Wellington: Health Quality and Safety Commission.

Hill S, Sarfati D, Blakely, T, et al. 2009. Ethnicity and cancer treatment in New Zealand: Do Māori patients get a worse deal? *Journal of Epidemiology & Community Health* 63(Suppl 2), 13.

Hill S, Sarfati D, Blakely T, et al. 2010. Survival disparities in indigenous and non-indigenous New Zealanders with colon cancer: The role of patient comorbidity, treatment and health service factors. *Journal of Epidemiology & Community Health* 64(2) 117–23. URL: <https://jech.bmj.com/content/jech/64/2/117.full.pdf> (accessed 25 July 2018).

Howden-Chapman P, Tobias M (eds). 2000. *Social Inequalities in Health – New Zealand 1999*. Wellington: Ministry of Health.

Institute of Health Equity. 2018. *About Our Work:* *Monitoring and evaluating progress*. URL: [www.instituteofhealthequity.org/about-our-work/monitoring-and-evaluating-progress](http://www.instituteofhealthequity.org/about-our-work/monitoring-and-evaluating-progress) (accessed 1 August 2018).

Jones C P. 2000. Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health* 90(8), 1212–1215. doi:10.2105/ajph.90.8.1212.

Kawachi I, Subramanian SV, Almeida-Filho N. 2002. A glossary for health inequalities. *Journal of Epidemiology & Community Health* 56(9) 647–52. URL: <https://jech.bmj.com/content/jech/56/9/647.full.pdf> (accessed 25 July 2018).

Lange R. 1999. *May the People Live: A history of Māori health development 1900–1920*. Auckland: Auckland University Press.

LaViest TA. 2005. *Minority Populations and Health: An introduction to health disparities in the United States*. Jossey-Bass.

Mahler H. 1981. The meaning of health for all by the year 2000. *World Health Forum* 2(1) 5–22.

Marmot M. 1986. Does stress cause heart attacks? *Postgraduate Medical Journal* 62(729): 683–6.

Marmot M. 2010. *Fair Society, Healthy Lives: The Marmot Review: Strategic review of health inequalities in England post-2010*. London: The Marmot Review.

Marmot M. 2016. Health inequality and the causes of the causes. *2016 Boyer Lectures: Fair Australia: Social justice and the health gap.* URL: www.abc.net.au/radionational/programs/boyerlectures/series/2016-boyer-lectures/7802472 (accessed 25 July 2018).

Marmot M, Rose G, Shipley M, et al. 1978. Employment grade and coronary heart disease in British civil servants. *Journal of Epidemiology and Community Health* 32(4): 244–9.

Mills C, Reid P, Vaithianathan R. 2012. The cost of child health inequities in Aotearoa New Zealand: A preliminary scoping study. *BMC Public Health* 12(1): 384. URL: <https://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-12-384> (accessed 1 August 2018).

Minister of Health and Associate Minister of Health. 2006. *Whakatātaka Tuarua: Māori Health Action Plan 2006–2011.* Wellington. Ministry of Health

Ministry of Health. 2002a. *He Korowai Oranga: Māori Health Strategy*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/mhs-english.pdf](http://www.health.govt.nz/system/files/documents/publications/mhs-english.pdf) (accessed 25 July 2018).

Ministry of Health. 2002b. *Reducing Inequalities in Health*. URL: [www.health.govt.nz/publication/reducing-inequalities-health](http://www.health.govt.nz/publication/reducing-inequalities-health) (accessed 24 July 2017).

Ministry of Health. 2002c. *Whakatātaka: Māori Health Action Plan 2002–2005*. Wellington. Ministry of Health.

Ministry of Health. 20o4. *A Health Equity Assessment Tool (Equity Lens) for Tackling Inequalities in Health*. URL: [www.health.govt.nz/publication/health-equity-assessment-tool-equity-lens-tackling-inequalities-health](http://www.health.govt.nz/publication/health-equity-assessment-tool-equity-lens-tackling-inequalities-health) (accessed 24 July 2018).

Ministry of Health. 2007. *Whānau Ora Health Impact Assessment*. Wellington, New Zealand: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf](http://www.health.govt.nz/system/files/documents/publications/whanau-ora-hia-2007.pdf) (accessed 2 August 2018).

Ministry of Health. 2011. *Targeting Immunisation: Increased immunisation*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/publications/targeting-immunisation-health-target.pdf](http://www.health.govt.nz/system/files/documents/publications/targeting-immunisation-health-target.pdf) (accessed 25 July 2018).

Ministry of Health. 2015. *Tatau Kahukura: Māori Health Chart Book 2015* (3rd edition). Wellington: Ministry of Health.

Ministry of Health. 2016. *New Zealand Health Strategy: Future direction.* Wellington: Ministry of Health.

Ministry of Health. 2017. *Statement of Strategic Intentions 2017–2021.* Wellington: Ministry of Health.

Ministry of Health. 2018a. *Rheumatic Fever*. URL: [www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever](http://www.health.govt.nz/our-work/diseases-and-conditions/rheumatic-fever) (accessed 25 July 2018).

Ministry of Health. 2018b. *System Level Measures Framework*. URL [www.health.govt.nz/new-zealand-health-system/system-level-measures-framework](http://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework) (accessed 25 July 2018).

Ministry of Health. 2018c. *Life Expectancy*. Retrieved 22 March 2019 from Ministry of Health: https://www.health.govt.nz/our-work/populations/Māori-health/tatau-kahukura-Māori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/life-expectancy

Ministry of Health. 2018d. *Annual Report for the year ended 30 June 2018.* Wellington: Ministry of Health.

Ministry of Health. 2018e. *Changes to the Ministry’s Second-tier Structure.* Retrieved 25 March 2019 from Ministry of Health: https://www.health.govt.nz/about-ministry/leadership-ministry/executive-leadership-team/changes-ministrys-second-tier-structure

Ministry of Health. 2018f. *Achieving Equity in Health Outcomes: Highlights of important national and international papers.* Wellington: Ministry of Health.

Ministry of Health. 2018g. *Wai 2575 Health Services and Outcomes Kaupapa Inquiry*. Retrieved 25 March 2019 from Ministry of Health: https://www.health.govt.nz/our-work/populations/Māori-health/wai-2575-health-services-and-outcomes-kaupapa-inquiry

Ministry of Health. 2018h. *He Korowai Oranga*. Retrieved 25 March 2019 from Ministry of Health: https://www.health.govt.nz/our-work/populations/Māori-health/he-korowai-oranga

Ministry of Health. 2018i. *Health and Independence Report 2017. The Director-General of Health’s Annual Report on the State of Public Health.* Wellington: Ministry of Health.

Ministry of Health. 2018j. *System Level Measures Framework*. Retrieved 25 March 2019 from Ministry of Health: https://www.health.govt.nz/new-zealand-health-system/system-level-measures-framework

Ministry of Health. 2018k. *Results Based Accountability*. Retrieved 25 March 2019 from Ministry of Health: https://www.health.govt.nz/about-ministry/what-we-do/streamlined-contracting/results-based-accountability

Ministry of Health, ThinkPlace. 2017. *Exploring Why Young Māori Women Smoke: Taking a new approach to understanding the experiences of people in our communities*. Wellington: Ministry of Health. URL: [www.health.govt.nz/system/files/documents/pages/exploring-why-young-Māori-women-smoke-final-10oct2017.pdf](http://www.health.govt.nz/system/files/documents/pages/exploring-why-young-Māori-women-smoke-final-10oct2017.pdf) (accessed 25 July 2018).

Ministry of Health. 2019a. *Operational Policy Framework 2019/20.* Retrieved 22 March 2019 from Nationwide Service Framework Library: <https://nsfl.health.govt.nz/accountability/operational-policy-framework-0/operational-policy-framework-201920>

Ministry of Health. 2019b. *Achieving Equity in Health Outcomes: Summary of a discovery process*. Wellington: Ministry of Health.

Ministry of Health. 2019c. *Annual Update of Key Results 2017/18: New Zealand Health Survey* Retrieved 15 August 2019 from Ministry of Health: <https://www.health.govt.nz/publication/annual-update-key-results-2017-18-new-zealand-health-survey>

Ministry of Health. 2019d. *Ambulatory sensitive (avoidable) hospital admissions*. Retrieved 15 August 2019 from Nationwide Service Framework Library: <https://nsfl.health.govt.nz/accountability/performance-and-monitoring/data-quarterly-reports-and-reporting/ambulatory-sensitive>

Mooney G. 1983. Equity in health care: Confronting the confusion. *Effective Health Care* 1(4): 179–85.

Office for Disability Issues. 2016. *New Zealand Disability Strategy 2016–2026.* Wellington: Ministry for Social Development.

Office of Disease Prevention and Health Promotion (US). 2018. HealthyPeople.gov. URL: www.healthypeople.gov (accessed 2 August 2018).

Office of Health Equity. 2015. *Portrait of Promise: The California statewide plan to promote health and mental health equity: Report to the legislature and the people of California by the Office of Health Equity. California Department of Public Health, August 2015*. Sacramento, CA: Office of Health Equity, California Department of Public Health. URL: [www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH\_OHE\_Disparity\_Report\_Final%20(2).pdf](http://www.cdph.ca.gov/Programs/OHE/CDPH%20Document%20Library/Accessible-CDPH_OHE_Disparity_Report_Final%20(2).pdf) (accessed 1 August 2018).

OHCHR. 2008. The right to health. Fact Sheet 31. Office of the United Nations High Commissioner for Human Rights. URL: [www.ohchr.org/Documents/Publications/Factsheet31.pdf](http://www.ohchr.org/Documents/Publications/Factsheet31.pdf) (accessed 25 July 2018).

PHARMAC. 2018. *Medicine Access Equity: Draft problem definition and scope discussion paper*. Wellington: Pharmaceutical Management Agency (PHARMAC).

Poynter M, Hamblin R, Shuker C, et al. 2017. *Quality Improvement: No quality without equity?* Wellington: Health, Quality & Safety Commission. URL: [www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality\_improvement\_-\_no\_quality\_without\_equity.pdf](http://www.hqsc.govt.nz/assets/Other-Topics/Equity/Quality_improvement_-_no_quality_without_equity.pdf) (accessed 25 July 2018).

Ramsden I. 2002. *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. Doctoral dissertation, Nursing, Massey University.

Rawls J. 2001. *Justice as Fairness: A restatement*. Harvard University Press.

Reid P, Paine SJ, Curtis E, et al. 2017. Achieving health equity in Aotearoa: Strengthening responsiveness to Māori in health research. *The New Zealand Medical Journal* 130(1465): 96–103.

Reid P, Robson B. 2007.Understanding health inequities. In Robson B, Harris R. (eds). *Hauora: Māori Standards of Health IV. A study of the years* 2000–*2005.* 3–10.

Sapolsky RM, Mott GE. 1987. Social subordinance in wild baboons is associated with suppressed high density lipoprotein-cholesterol concentrations: The possible role of chronic social stress. *Endocrinology* 121(5): 1605–10.

Schneider E, Sarnak D, Squires D, et al. 2017. *Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care*. The Commonwealth Fund.

Tager IB, Weiss ST, Muñoz A, et al. 1983. Longitudinal study of the effects of maternal smoking on pulmonary function in children. *New England Journal of Medicine* 309(12): 699–703.

Te Puni Kōkiri. 2019. *Whānau Ora*. Retrieved 25 March 2019, from Te Puni Kōkiri: https://www.tpk.govt.nz/en/whakamahia/whanau-ora

Te Rōpū Rangahau Hauora a Eru Pōmare. 1980. *Hauora: Māori standards of health*. Wellington: Wellington School of Medicine.

Teng AM. Atkinson J. Disney G. et al. 2016. *Ethnic inequalities in cancer incidence and mortality: census-linked cohort studies with 87 million years of person-time follow-up*. BMC Cancer 16(1):755.

The Treasury. 2018a. *Our Living Standards Framework*. URL: <https://treasury.govt.nz/information-and-services/nz-economy/living-standards/our-living-standards-framework> (accessed 25 July 2018).

The Treasury. 2018b. Tim Ng talking with NBR’s Grant Walker about the wellbeing budget*.* URL: <https://treasury.govt.nz/news-and-events/news/tim-ng-talking-nbrs-grant-walker-about-wellbeing-budget> (accessed 25 July 2018).

Turia T. 2014. *Launch of He Korowai Oranga: Māori Health Strategy*. URL: [www.beehive.govt.nz/speech/launch-he-korowai-oranga-–-māori-health-strategy](http://www.beehive.govt.nz/speech/launch-he-korowai-oranga-–-māori-health-strategy) (accessed 1 August 2018).

Waitangi Tribunal. 2019a. *HAUORA: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry*. Wellington. Waitangi Tribunal

Waitangi Tribunal. 2019b. *Health Services and Outcomes Inquiry*. Retrieved 6 May 2019 from Waitangi Tribunal: <https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry>

Wehipeihana N, Were L, Goodwin D, et al. 2018. *Addressing the Challenges of Young Māori Women Who Smoke: A developmental evaluation of the phase two demonstration project. Evaluation Report.* Wellington: Ministry of Health.

Wellesley Institute. 2016. *International Review of Health Equity Strategies*. Toronto: Wellesley Institute. URL: [www.wellesleyinstitute.com/wp-content/uploads/2016/07/International-Review-of-Health-Equity-Strategies.pdf](http://www.wellesleyinstitute.com/wp-content/uploads/2016/07/International-Review-of-Health-Equity-Strategies.pdf) (accessed 25 July 2018).

Whitehead M. 1991. The concepts and principles of equity in health. *Health Promotion International* 6(3): 217–28. URL: <https://doi.org/10.1093/heapro/6.3.217> (accessed 2 September 2018).

Wilkinson RG. 1992a. Income distribution and life expectancy. *British Medical Journal* 304(6820): 165–8.

Wilkinson RG. 1992b. National mortality rates: the impact of inequality? *American Journal of Public Health* 82(8): 1082–4.

Woodward A, Kawachi I. 2000. Why reduce health inequalities? *Journal of Epidemiology and Community Health* 54(12): 923.

WHO. 1978. *Declaration of Alma-Ata*. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978. World Health Organization. URL: [www.who.int/publications/almaata\_declaration\_en.pdf](http://www.who.int/publications/almaata_declaration_en.pdf) (accessed 25 July 2018).

WHO. 2011. *Rio Political Declaration on Social Determinants of Health*. World Conference on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011. World Health Organization. URL: <http://cmdss2011.org/site/wp-content/uploads/2011/10/Rio-Political-Declaration-on-SDH-20111021.pdf> (accessed 25 July 2018).

WHO. 2019. *Health System: Equity*. Retrieved 22 March 2019, from WHO: https://www.who.int/healthsystems/topics/equity/en/

1. The Ritenga Māori declaration (often commonly referred to as the ‘fourth article’) was drafted in te reo Māori and read out during discussions with rangatira concerning Te Tiriti o Waitangi. It provided for the protection of religious freedom and the protection of traditional spirituality and knowledge. [↑](#footnote-ref-1)