TE PUNANGA ORA
IWI MĀORI PARTNERSHIP BOARD

HAUORA MĀORI PRIORITIES

SUMMARY REPORT

30 September 2024

OUR IWI MĀORI PARTNERSHIP BOARD

Te Punanga Ora Iwi Māori Partnership Board is one of several in Te Manawa Taki region:

He take take maunga, he taketake tangata
Ko Taranaki tō tātou okiokinga
Tū te ao, tū te pō tū kau ana ki te uru
Ōna wai e rere iho ai ki runga ki te whenua
Ki runga ki ngā kāinga, ki runga ki ōna iwi
He puna wai koropupū, he manawa whenua
He puna e heke mai ai te tangata
Kia piki te hauora o Ngā Iwi o Taranaki uri me ngai Māori katoa hei oranga mō te āpōpō
Ensuring our whānau have a culturally healthy future

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INTRODUCTION

Photo: Three Sisters (Rock Formation), Tongapōrutu

Purpose

The purpose of Iwi Māori Partnership Boards (IMPB) under Section 29 of the Pae Ora Act 2022 is described below:

"The purpose of iwi-Māori partnership boards is to represent local Māori perspectives on—

(a) the needs and aspirations of Māori in relation to hauora Māori outcomes; and

(b) how the health sector is performing in relation to those needs and aspirations; and

(c) the design and delivery of services and public health interventions within localities"

In order to achieve this purpose, one of the first pieces of work commissioned by the IMPB was to understand the needs and aspirations of whānau Māori in our community by drawing on available information from the health system (e.g. IMPB profiles prepared by Te Aka Whai Ora, additional data from Te Whatu Ora and PHOs, and the voice of whānau).

How this report is organised

This report is a collation of available and selective (high-level) information from existing reports and whānau engagement results, sorted into a useable form for the IMPB, around three service domains. We needed to find a way to simplify the complexity and scope, and to have key information in one place. We know however that at any time we can and should refer to original source documents. Organising the available information this way was intentional in order for the IMPB to gain a strategic level overview of the situation for whānau in each of the three domains. Te Whatu Ora is currently organised into these three domains nationally and regionally:

- Public and Population Health
- Primary and Community Care
- Hospital and Specialist Services

and below each of these domains are numerous specific services and programmes. This report contains descriptions of services which sit in each domain, to help us as IMPB members to improve and increase our understanding and knowledge of these domains, and what is included (or excluded). The report does not cover every single service or programme from within the health system, but it does reflect the areas of high utilisation (or under-utilisation) by whānau Māori, greatest investment by Te Whatu Ora, and where we as an IMPB can have the greatest impact.

This is not necessarily how we as an IMPB think about health systems or hauora – we would prefer models that operate across the life-course, and which take consideration of the whole whānau - but this is not how our health system has evolved or is organised. In order for us to engage and be effective, we need to understand how each of the above three domains work or do not work for whānau.

This collation of information positions our IMPB to advocate for Māori interests with the relevant national and regional leaders of these three domains. Over time we would hope we can have life-course and whānau-centred dialogue – but for now we work with the system in the way it is organised in order to penetrate and influence the system now.

A note about information sources

Many sources of information were used to produce this report – two volumes of IMPB profiles from Te Aka Whai Ora; additional data requested from Te Whatu Ora on various services; data requested from PHOs; whānau engagement reports; research reports on kaupapa Māori and health services; and expertise of IMPB Board members. We retain the original source documents to enable us to refer back to the original information and analysis provided by the experts who prepared them.

Where we have used that data, we have noted the original source, and those source documents and profiles contain all of the academic references and bibliographies. The IMPB Profiles can be accessed for those wishing to review that information and we have chosen not to repeat it all for that reason. Additionally, experts in the field (e.g. those who developed the IMPB profiles) recognise the data limitations that exist, and these are important for us all to understand. Those data limitations and the positioning of the data was well-described in the profiles. The data supplied is also acknowledged by the system to contain ethnicity errors so likely most of the data under-reports the true situation for Māori.

We ran into some issues with data. Data we received from the health system applies to various time periods – it is not all 2024 current data. Some of the specific data that we requested was not time-stamped to match the data in the IMPB profiles for instance. Some of our data requests were not able to be met at the time of writing. For instance, we

wanted to see more data on numbers of whānau Māori not making it to specialist appointments but did not receive it (we will continue to pursue remaining data). Some information was only available at a national level, reporting NZ results, regional data or Taranaki district data - instead of results just for our IMPB area.

Working with imperfections

This is our first Hauora Māori Priorities report, and we recognise and acknowledge its imperfections – but it provides us with a good start. We expect to get more accurate and current data as the health system moves to tailor data provision to our IMPB area and to get better with ethnicity data and reporting what we want to know. That is the reason our IMPB has made data access and currency a key priority for the future.

We have agreed to work with these imperfections for now – as likely over recent years, the rates, utilisation and outcomes for Māori have not moved much. In fact, it was noticeable to those on our IMPB Board who have worked in the health system for a long time, that not much has changed over the past 3 – 4 decades! Inequities still exist across the health system in all areas. In fact, it is more likely that many areas are now worse off in a post-covid environment.

Again, we chose not to not wait for these imperfections to be fixed before we moved forward – the health of our people TODAY is our priority and waiting for perfect data just is not an option.

As the full Hauora Māori Priorities report is well over 230 pages of information, it is too unwieldly to share publicly, but it is an essential resource for detailed information to support our IMPB purpose and functions that we will continue to refer to over time, until we refresh the information in years to come.

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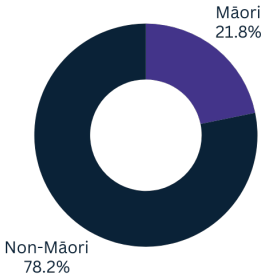
This report is a living document that will be reviewed on a regular basis to include the many voices that are yet to share their experiences that generate or validate priorities for inclusion in this report. Future iterations of this document stand to give visibility to new priorities or reinforce priorities already documented.

NGĀ TANGATA | About the whānau in our IMPB area

Photo: 'Goblin Forest', Te Rere o Kapuni (Dawson Falls)

Demographic trends that the IMPB needs to plan for:

→ Te Punanga Ora rohe is home to just over 27,960 Māori (22% of the total population of 128,410 with 100,450 being non-Māori).



Total Population
128,410

Māori Population
27,960

Non-Māori Population
100,450

Projected Growth: Māori Population in Te Punanga Ora to increase from 22% to 30%.

Investment Growth: Current investment in Kaupapa Māori services must increase alongside this 8% population growth.

49% Māori under 25 years old

VS

26% Non-Māori under 25 years old

→ A significant focus must be on wellbeing, prevention, building capability for leading a healthy lifestyle, increasing school-based services, increasing participation in sports, healthy nutrition, smoking / vaping prevention and cessation.

Younger Population

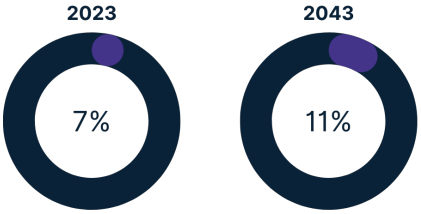
→ This younger population will vastly increase the Māori birth rate over the next 20 years.

This means appropriate maternity/midwifery care is needed to give parents and babies the best start in life. This includes immunisation, enrolment in dental care under 5 and support for early childhood education/Kōhanga Reo.

Older Population

→ Over the next two decades, the Māori population within the IMPB area is projected to be older - by 2043.

65+ years old



This means we need to grow and plan for more aged-care, homecare, falls prevention, rehabilitation, physiotherapy and Kaumātua engagement that encourages regular activity, socialising and healthy eating.

Social determinants have a significant impact on Māori in the rohe

The Institute for Clinical Systems Improvement model of determinants of health and wellbeing, evidence suggests that:

50%

of socio-economic determinants impact your wellbeing (income, education, home, job).

30%

of determinants are health behaviours (eating, smoking, exercise).

20%

of determinants are from health services.

The **Māori** population has **lower rates** of income, job status, home ownership and education across the board so this 50% of "influence" on wellbeing is **severely compromised**.

DIRECT IMPACT

The IMPB can have the greatest DIRECT impact on 50% through promoting healthy behaviours and increased investment in appropriate health services via working with the health system.

INDIRECT IMPACT

The IMPB can have the greatest INDIRECT impact on the other 50% through influencing and advocating with other sectors responsible for job growth, housing and educational achievement. The focus should be on working primarily with MBIE / WINZ, MHUD and Education.

Cultural Factors

41.8%

of Māori in Te Punanga Ora thinks being involved in Māori culture is very/ quite important

46%

of Māori in Te Punanga Ora think spiritually, it is very/quite important.

12.2%

of Māori respondents in Te Punanga Ora reported that being involved in Māori culture was not at all important to them.

In Te Punanga Ora:

almost all Māori in Te Punanga Ora **(97.1%)** had been to a marae, with a majority of those **(51.4%)** having been in the last 12 months.

In 2018:

just under one quarter of Māori **(23.1%)** used te reo Māori regularly in the home, compared to **18.4%** of Māori nationally.

Socio-Economic Factors

Remoteness

Urban

61%

of Māori in Taranaki district live in urban areas.

70%

of non-Māori in Taranaki district live in urban areas.

VS

Rural

40%

of Māori in Taranaki district live in rural.

30%

of non-Māori in Taranaki district live in rural.

Education and Qualifications

Aged over 20 years had achieved a Level 2 Certificate or higher in 2018.

59.8% Māori

72.8% Non-Māori

Transport

Māori are:

3x more likely than non-Māori to be without access to a motor vehicle.

Work

47.4% of Māori aged 15 years and over in Taranaki district were employed full-time in 2018.

15.1% of Māori aged 15 years and over in Taranaki district were employed part-time in 2018.

In 2018, 9.3% of Māori in Taranaki district were unemployed, twice the rate of non-Māori, and Māori were 1.2 times more likely than non-Māori to not be in the labour force.

Income

Māori in Taranaki district are significantly more likely than non-Māori to receive an income of $20,000 or less.

= **36.8%** of Māori.

27.5% of non-Māori.

Digital Enablement

Māori in Taranaki district are:

2.8x more likely than non-Māori to have no access to telecommunications (a functional cellphone, telephone, or the Internet).

Housing

Māori in Taranaki district are less likely than non-Māori to own their home.

In 2018: **68.1%** of Māori aged 20 years and over in Taranaki district lived in a home they did not own/partly own.

In 2018: **39.8%** of Māori in Taranaki district lived in a home that was sometimes or always damp.

Māori in Taranaki district were also twice as likely as non-Māori to live in homes without any source of heating.

Living in an overcrowded home was

2.6x

more common for Māori than non-Māori in Taranaki.

Avoidable deaths that the IMPB can influence to reduce

The life expectancy at birth for Māori born in Taranaki is

77.8 years for females (6.5 years shorter)

75.3 years for males (4.8 years shorter)

The leading avoidable causes of death contributing to the life expectancy gap amount Māori in the region are

- → lung cancer
- → coronary disease
- → diabetes

The age-standardised potentially avoidable death rate

2.1x

higher for Māori compared to non-Māori in Taranaki district in 2014-2018

IMPB PRIORITIES

Rural Health – There are barriers that impact on health-related issues with whānau living rurally. With many of the services based in the urban centres, all major issues originate from difficult access for whānau which include lack of transport, lack of digital connectivity and affordability. Mobile health services, pop up clinics and other methods to support whānau who live rurally need serious consideration to reduce these known barriers.

WHĀNAU VOICE | General Feedback

Photo: Taranaki Beach, Taranaki

Whānau Voice

Te Punanga Ora drew on existing engagement evidence with whānau provided by partners and also known prior work that Iwi Māori organisations and partners (including Te Punanga Ora's predecessor Te Whare Punanga Kōrero who had been working alongside the former Taranaki DHB since 1993). The evidence included information from Te Kawau Maro, Tui Ora and from the former Taranaki DHB's Health Equity Assessment project – which although an older report, reflects issues still faced by whānau today. The equity case studies included focus groups and key informant interviews including whānau – and their voice is still highly apparent in the results.

Populations affected by inequities

The most prevalent inequities reported in the Health Equity Assessments (HEA) were ethnic, geographic and socioeconomic, which were identified in every case study. Each HEA highlighted inequities for Māori populations. People living in higher deprivation, in South Taranaki, rural areas, and greater geographical distances from health services were commonly identified as experiencing inequities.

Advantaged population groups

The six case studies commonly identified Pākehā, high socio-economic groups and people living close to health services, particularly those residing in New Plymouth, as the populations most advantaged in health service and programme delivery. Across all case studies non-Māori, specifically New Zealand Pākehā, were viewed as advantaged. The way in which health services and programmes are delivered was consistently viewed as most culturally appropriate for Pākehā, based on mono-cultural, Western, bio-medical understandings of health.

Delivery of health services by a predominantly non-Māori/Pākehā workforce was commonly highlighted. Pākehā were reported to be more likely to engage with health services, feel more comfortable doing so and less likely to experience racism in their experiences in the health system. Pākehā were also described as having preferential access to the determinants of health including education, employment, income, housing, health literacy and deprivation. Other mechanisms of advantage identified for Pākehā were preferential access to healthcare, faster pathways to health care, higher hospitalisation rates, and benefitting from health care configuration that advantages those with access to transport and other resources to attend appointments.

Higher socio-economic population groups were regarded as advantaged in all of the case studies, due to having greater financial resources to enable access to public health services and programmes; being more likely to be employed with good incomes, and in working arrangements with fewer challenges to attending appointments; living in wealthier areas with less deprivation; having access to their own transport; being more highly educated with higher literacy; placing greater value on preventative health and engagement with services; and having a better ability to pay for private health care.

Geographic populations residing closer to health services, particularly those living in New Plymouth, were identified as advantaged groups in all case studies.

Drivers of inequities

Socio-economic disadvantage All of the HEA case studies identified socio-economic disadvantage as a key contributor to health inequities. Factors such as living in poverty and being more likely to have lower education levels, resulting in higher health literacy demands, were commonly highlighted as key equity considerations. Socio-economic deprivation relating to housing was frequently cited as contributing to unfair health outcomes, most commonly in relation to poor quality of housing and being more likely to live in rental properties and associated transiency. More transient groups were highlighted as 'slipping through the gaps' of the health system due to regular changes of home address.

The intersecting nature of socio-economic disadvantage with living in more affordable rural areas and identifying as Māori was commonly noted in the reports. A key socio-economic consideration highlighted across the HEA was the significant financial pressures on low-income groups that results in a number of more immediate life stresses (such as being time poor, having existing financial debts, difficulty paying for basic everyday needs and additional social problems) and results in health not being a high priority. Working conditions for people on low incomes were commonly identified as a contributor to inequities due to difficulty accessing flexible time off work to attend appointments.

Lack of cultural safety

All case studies highlighted a lack of culturally safe practice to appropriately meet the needs of Māori. Delivery was commonly described as culturally inappropriate, with staff delivering services lacking adequate awareness and understanding of the cultural needs of Māori populations. Māori consumers commonly drew attention to the cultural disconnect they experienced when engaging with health services. Western, bio-medical health model. All case studies drew attention to inequities in health resulting from a health system that is designed to meet the needs of non-Māori, particularly Pākehā populations, by being based on a Western, bio-medical model of health. The Western-based medical model of health was commonly recognised as being culturally inappropriate for Māori, particularly the compartmentalising of health issues, in contrast to a holistic approach to hauora in Te Ao Māori.

The mono-cultural design of well-meaning services and programmes was reported to increase inequities by benefitting non-Māori groups, while failing to adequately meet the needs of Māori. Māori were reported as having few opportunities to input into how services and programmes were planned and whānau were not viewed as 'being at the centre of planning'.

Racism and discrimination

Racism within the health system was commonly highlighted. Fear, by Māori, of racially discriminatory treatment towards Māori was frequently reported, with negative past experiences and mistrust of health service staff and the broader health system commonly cited. Associated fear and anxiety with engaging with health services due to discriminatory practices was reported in two of the HEA. Racism was described as institutionalised in the health system, resulting in a lack of confidence amongst Māori in the quality of care they would receive.

Geographic disadvantage

Geographic barriers were emphasised in all case studies, commonly highlighting the disadvantage experienced by populations living greater distances from health services, particularly those living in South Taranaki and more rural areas. The concentration of health services in New Plymouth was frequently cited as an equity issue due to differential access to health care.

Māori were reported as being more likely to live further away from health services. The location of health services was viewed as an important equity consideration, and mobile services that did reach geographically remote areas were thought to service these groups better. Fewer or no services available, such as a lack of general practices and 'after hours' doctors, was a common example of geographic disadvantage. The intersecting nature between socio-economic and geographic disadvantage were commonly referred to as compounding equity issues. Transport barriers Each case study drew attention to transport barriers experienced by health consumers, with particular emphasis given to the practical barrier a lack of transport presents for lower socioeconomic groups. The cost of travel was considered an additional disadvantage for people living further away from services. The costs associated with travel included having access to a private vehicle and financial means to cover the costs of the vehicle warrant of fitness, registration and petrol; lack of access to public transport and lack of money to afford the bus. The case studies commonly viewed transport as a challenge to achieve equitable access to the benefits of health services and programmes.

Under representation of Māori in workforce

Two thirds of the case studies emphasised the lack of Māori staff delivering health services and suggested this contributes to a culturally inappropriate and incompetent health system for Māori consumers. Some of the case studies described the staff delivering services and programmes for Māori as not appropriate and suggested that Māori providers may be preferred by some consumers.

Lack of community and family networks

Two thirds of the case studies noted the barriers faced by groups who lack the appropriate supports to successfully access and engage with the health system. Groups who are not well connected to health and social services and community supports were considered to face additional barriers to participating in health services and programmes. Examples given were groups who had a lack of access to assistance to navigate the health system, lack of social connections and whānau support, and low engagement and existing relationships with services, such as general practices. Lack of access to telephone The practical barrier lower socio-economic groups' experience of accessing health services by telephone was also highlighted. A lack of credit on mobile phones was commonly reported as

an access issue for lower income groups. A lack of internet was also noted in some HEA as a barrier to accessing information on health information and services.

Solutions / Pathways for Promoting Equity

Pathways for promoting equity Thirteen pathways for promoting health equity were commonly identified across the HEA case studies.

1. **Equity focused planning:** All HEA cases recommended planning that prioritises achieving health equity. Health equity needs to be at the centre of routine planning and consideration given to how programmes and services are going to redress health inequities. Resources should be allocated to approaches that will meet the needs of the most disadvantaged groups. Therefore, if programmes and services cannot demonstrate a positive impact on inequities, action must be taken to divest from that programme or service or plan and action changes to specifically address inequities.
2. **Increase the Māori workforce:** A common recommendation across the HEAs was to increase the number of Māori staff working in health, and for 'by Māori, for Māori' approaches to promote equitable outcomes for Māori health consumers. Suggestions included supporting more Māori to enter the workforce through scholarships and cadetships, and more recruitment of Māori staff to work in the services.
3. **Cross sector collaboration and service integration:** A key strategy for promoting equity across the HEA was to undertake greater collaboration with other services and sectors. It was commonly noted that many of the opportunities for promoting health equity, particularly for Māori, will be achieved by working alongside other stakeholders, such as Māori community service providers, primary health organisations, general practices and early childhood centres.
4. **Patient-centred services:** Attention was brought to the need to integrate services that have mutual audiences, such as children or women, to work together to meet the needs of service users and their whānau. This approach, it was noted, would enable health services to put patients at the centre of planning and could take a life-course approach to health services.
5. **Cultural safety:** A significant area requiring improvement was a clear need for a more culturally competent health workforce and culturally safe practices. Building the capacity of existing staff to deliver services that are culturally safe for Māori was commonly highlighted to demand organisational attention. Consumer voice consistently emphasised the need for the people working within in the services who interface with the public to be more culturally safe in their practice. Recommendations included marae-based cultural responsiveness training, so as to develop staff skills, awareness and understanding of Te Ao Māori.
6. **Kaupapa Māori services:** The need for culturally appropriate delivery to meet the needs and aspirations of Māori was also a common recommendation. Fundamental to addressing inequities for Māori is the provision of programmes and services that are culturally meaningful and appropriate for whānau. Recommendations commonly focused both on ensuring mainstream services were delivered in a way that better understands and responds to the needs of Māori, as well as recommending that Māori providers have a greater role in the delivery of kaupapa Māori services.
7. **Additional resources in South Taranaki:** Additional resourcing of services and programmes is needed in South Taranaki. Promoting equitable access to the benefits of health services and programmes for people living in South Taranaki was championed in the case studies. Extending the reach of services to areas in South Taranaki (including Coastal Taranaki), as well as allocating additional resources to existing services and programmes, was proposed.
8. **Equity data reporting and monitoring:** A key recommendation for planning to address health inequities is the continuous monitoring of inequity data. It was commonly suggested that inequity data should be routinely reported by ethnicity, geographic location, age and socio-economic deprivation and that it is regularly reviewed, shared and drawn upon to inform planning.
9. **Use of Te Reo Māori:** The case studies maintained that the use of Te Reo Māori should be integrated more strongly into health service and programme delivery. Consistently raised by consumers - correct pronunciation and increased use is important to Māori and contributes to promoting health and wellbeing.
10. **Addressing telephone barriers:** A practical suggestion for achieving equitable access to health services and programmes was to address the barriers that low socio-economic groups regularly face when attempting to contact the health system. A lack of phone credit was a common contributing equity issue for low-income groups, and it was suggested that health services ensure all groups can have free communication access. Suggested actions included promoting the 0800 numbers available more widely and establishing a free 0800 phone number for consumers to contact any health service in Taranaki from a mobile phone.

11. **Health promotion and communications:** The need for equity-focused targeted communications and health promotion was highlighted. There were reported gaps in health promotion activities and planned wide-spread communications which highlighted opportunities for collaborative approaches. The need to undertake health promotion activities to reach Māori audiences through existing groups and events was commonly noted. Communication strategies were suggested in a number of HEA that have a specific equity emphasis, involve a range of stakeholders and incorporate a diverse range of communication forums, including social media.
12. **Community-based kaiawhina with transport support:** The important role of community-based kaiawhina to support Māori whānau to engage with health services was commonly reflected across the case studies. Appropriate, community-based support to assist whānau to navigate health services as suggested. This role was suggested for both child health services (such as community oral health), as well as for wāhine Māori (finding a midwife and breast screening). Importantly, the role of the kaiawhina was commonly linked to the provision of transport for health consumers. Other community-based roles were suggested such as nurse-led community health clinics and training community members to become health workers in the community.
13. **Consumer participation:** To ensure health services and programmes are meeting the needs of consumers, greater participation of consumers is required in planning. This includes routinely collecting feedback from health consumers, both those using the services and 24 those not engaging, to inform future planning.

PUBLIC & POPULATION HEALTH

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Photo: Beachside, Ngāmotu (New Plymouth)

Causes of death (and early death) for Māori in the rohe

- The leading avoidable causes of death contributing to the life expectancy gap among Māori are lung cancer, coronary/ heart disease and diabetes, followed by COPD. The focus needs to be on:
    - Ensuring those with these conditions are diagnosed, and supported to manage with medication, exercise and social / whānau supports, and that we prevent or mitigate deterioration or early death.
    - Ensuring those "at risk" of developing these diseases (e.g. pre-diabetic) are caught early, diagnosed and supported to prevent onset of disease.
- **Life expectancy:** The life expectancy at birth for Māori born in Taranaki between 2018-2022 is 77.8 years for females and 75.3 years for males. Māori life expectancy in Te Punanga Ora is 6.5 years shorter for Māori females and 4.8 years shorter for Māori males, compared to non-Māori in Te Punanga Ora.
- The leading **avoidable causes of death** contributing to the life expectancy gap among Māori in the region are lung cancer (0.9 years), coronary disease (0.8 years) and diabetes (0.6 years).
- The leading **causes of death** for Māori in Taranaki district in 2014-2018 were **ischaemic heart disease, lung cancer, chronic obstructive pulmonary disease (COPD), diabetes and cerebrovascular disease.**
- The leading causes of death for Māori females were ischaemic heart disease, lung cancer, COPD, breast cancer and diabetes. For Māori males the leading causes were ischaemic heart disease, lung cancer, COPD, diabetes, and suicide.
- Leading causes of avoidable deaths are as above and can be prevented through high quality health care and public health interventions (prevention).
- The age-standardised **potentially avoidable death rate** (177 deaths each year per 100,000 people) was 2.1 times higher for Māori compared to non-Māori in Taranaki district in 2014-2018. This equates to an average of 22 avoidable deaths each year in Māori females aged 0-74 years, and 31 in Māori males in Taranaki district.

Preventable conditions influenced by lifestyle factors

- The leading avoidable causes of death contributing to the life expectancy gap among Māori in the Te Punanga Ora region are lung cancer (0.9 years), coronary/ heart disease (0.8 years) and diabetes (0.6 years). The focus needs to be on:
    - Ensuring those with these conditions are diagnosed, and supported to manage with medication, exercise and social / whānau supports, and that we prevent or mitigate deterioration or early death
    - Ensuring those "at risk" of developing these diseases (e.g. pre-diabetic) are caught early, diagnosed and supported to prevent onset of disease
- Between 2017 and 2021, 78.6% of Māori (aged ≥15 years) in Taranaki were overweight or obese
- Roughly 1,482 Māori (820 women and 662 men) aged ≥25 years in Taranaki had diabetes in 2022.
- In 2022, 1,262 Māori (≥20 years) in Taranaki were identified as having gout, which affected more Māori men (n=925) than women (n=337).

Screening

- Lung cancer was the most common cancer registered for Māori females, while prostate cancer was the most common cancer registered for Māori men in Taranaki.
- An average of 81 Māori register with cancer each year in Taranaki.
- In Taranaki in 2023, 55.0% of eligible Māori women aged 45 to 69 years had been screened for breast cancer compared to 71.0% for non-Māori women
- For cervical cancer, 62.9% of eligible Māori aged 25 to 69 years in Taranaki in 2023 were up to date with their cervical screening, compared to 78.7% of non-Māori.
- For bowel cancer, 46.9% of the eligible Māori population in Taranaki as at June 2023 had been screened, compared to 61.5% of non-Māori.

IMPB PRIORITIES FOR PUBLIC AND POPULATION HEALTH

- → Te Punanga Ora agree to the Governments 5 priorities of "modifiable behaviours" alcohol use, smoking/vaping, diet, exercise and social cohesion.
- → **Health promotion:** Health promotion messaging needs to be localised and delivered by local people. There is a need for a comprehensive end-to-end health promotion approach over the life-course with language and styles that work for Māori, so they connect and understand the health system
- → **Emergency preparedness:** This is a priority including availability of Emergency services especially for rural areas. Helping whānau be better informed about available services would be a key element of a localised health promotion campaign
- → **Mobile screening units:** These need to be used to share across the region and screen for bowel, breast and lung cancer
- → **HPV vaccinations:** Our IMPB supports this and wishes to see an increase in awareness and promotion for girls and boys in our rohe
- → **Family Harm:** is a key social determinant of health (harm causes mental health and illness) and is an indicator of the pressures of poverty, deprivation and colonisation). We see this as a priority determinant to partner with whānau, hapū and Iwi, and other sectors
- → **Alcohol, vaping and gambling:** Te Punanga Ora IMPB want to be more active and advocate on the regulations on controlling outlets for alcohol, vaping and gambling

PRIMARY & COMMUNITY CARE

Photo: Te Rere o Kapuni (Dawson Falls), Te Papakura o Taranaki

Maternity and Child Health

- In 2022, only two thirds (66.1%) of Māori babies in Taranaki were enrolled with a primary care provider by the time they were three months old, compared to 92.5% of non-Māori babies
- 3,123 pēpi were born in Taranaki in 2019, 554 (36.3%) were Māori, which is greater than the national percentage at 27.4%.
- Between 2018 and 2022, 7.5% of Māori babies in Taranaki district had low birthweight (<2,500g) and 2.2% had high birthweight (>4,500g).
- Māori babies were 1.1 times more likely than non-Māori to be born prematurelyIn Taranaki, Māori immunisation rates were lower than non-Māori at every milestone age. At 18 months of age, less than half of Māori were fully vaccinated (compared to over 70% of non-Māori), which is especially concerning for diseases such as measles for which both vaccine doses are due before 18 months.
- Between July 2022 to June 2023 in Taranaki district, there were 571 potentially avoidable hospitalisations in Māori children aged one month to 14 years.
- The rate of potentially avoidable hospitalisations was 1.2 times higher for Māori children than non-Māori children.
- There are very stark inequities in immunisation coverage especially for Māori. In Taranaki district, between April 2023 and March 2024:
    - Only 47.5% are immunised at 6 months of age
    - Just over 60% are fully immunised at 8 months of age
    - The coverage rate climbs to 71.2% by 12 months – but then drops back down to almost 51.3% at 18 months
    - At 5 years, 69.3% of Māori children are immunised before school age, leaving 30.7% (almost 1/3) not immunised (compared to non-Māori non-Pacific at 81.0%)

IMPB PRIORITIES FOR MATERNAL CHILD HEALTH

- → **Strengthen focus of service design on Hapūtanga journey:** The hapūtanga journey should include a whānau inclusive approach and practitioners upskilling and applying a cultural lens over this approach. This should include strengthening the relationships between Midwives, Well Child Tamariki Ora (WCTO) Nurses and GPs, to provide a wraparound service throughout the hapūtanga journey.
- → **Workforce:** Increase Māori midwifery workforce as Hapū māmā are unable to access a midwife due to limited Māori midwives – and this situation will worsen as the young population grows
- → **Midwifery funding model:** Address the funding models of midwife visits being capped so they can adapt to meet the needs of each whānau
- → **Before school checks:** Work with WCTO with Before School Checks (B4SC) when there is a failed hearing and needs referral to Audiologist to advocate for reduced wait times.
- → Increase access to tools and equipment that support new māmā whilst in maternity care i.e breast pumps in rooms.
- → **Immunisation:** Invest and prioritise pop-up vaccination clinics around the region. Re-engage with and resource Covid-trained community vaccinators to support immunisation efforts and build relationships with employers to utilise the community vaccinators. Te Whatu Ora to report on $50m investment in Māori immunisation and impacts on rates in IMPB area and data on tracking immunisation in schools in particular

Child and Youth Oral Health

- In 2021, in Taranaki district, 87.4% of Māori children aged 0-4 years were enrolled with community oral health services, compared to 96.9% of non- Māori children.
- Of those children who were examined, 68.3% of Māori 5-year-olds had decayed teeth (1.7 times the rate for non-Māori 5-year-olds).
- Of those children who were examined, 66.2% of Māori 5-year-olds had decayed teeth (2.1 times the rate for non-Māori 5-year-olds).

- More Māori children at school age five had decayed teeth than non-Māori and non-Pacific children within Taranaki district, midland region providers, and New Zealand as a whole. Within Taranaki district, 33.8% of all Māori children at school age five did not have decayed teeth, i.e., were caries free.

Oral Health

— Child oral health data shows a far greater proportion of tamariki Māori have dental disease and their experience of this disease is more severe. As a result, a greater proportion of tamariki Māori are admitted to hospital for treatment of this dental disease.

— Rangatahi Māori (13-18 years old) have poorer oral health service utilisation rates compared to non-Māori youth, and from the age of 18 years have higher rates of unmet oral health disease and are more likely to delay treatment due to cost.

— Pending adult dental data requested from Te Whatu Ora.

IMPB PRIORITIES FOR ORAL HEALTH

→ **Access:** Dental and oral health is a major priority. The only access for schools is a mobile bus that services the Taranaki region on rotation. More mobile dental services going into rural communities regularly is a priority

→ **Importance of oral health:** Increase awareness and education amongst tamariki and their whānau by highlighting impacts on children's teeth later in life if teeth are not cared for throughout their younger years

→ **Adult dental:** Adult dental health requires ongoing education and addressing affordability issues by making dental care more accessible for those on low-incomes

→ **Rangatahi:** Rangatahi aged up to 18 years are entitled to care – but the focus is on schools and not on those no longer at school before age 18. More awareness is needed for those rangatahi that they can still access oral health services for free – and be more proactive to look at opportunities to locate Rangatahi not in school (sports grounds, youth hubs, work places).

Primary Mental Health and Addictions

- Between 2017 and 2022, 14.2% of Māori respondents (≥15 years) in Taranaki had a K10 score of ≥12, indicating high or very high levels of psychological distress.
- According to the Suicide Web tool, there were approximately 19 confirmed or suspected deaths in 2022 in Taranaki.
- Māori were 40% less likely to receive regular medication compared to non-Māori. Medication is not the only treatment for depression, but this large ethnic difference in the rate of receiving antidepressant medication raises questions about access to and receipt of appropriate depression treatment for Māori in Taranaki district.

IMPB PRIORITIES FOR PRIMARY MENTAL HEALTH & ADDICTIONS

→ **Tamariki resilience:** Develop and deliver specific education for children to build and strengthen their individual resilience as they grow.

→ **Mental Health Crises:** There are concerns that response times to crisis situations are too slow and this needs to be addressed. Due to potential delays, there should be an investment in educating and teaching whānau about how to deal with crisis situations. Whānau should also have information about where they can refer whānau and the pathways for mental health support in the community.

→ **Community mental health and addiction:** Increase in resourcing programmes for whānau using community-based models to address primary mental health and addiction within whānau. A good example are programmes and models that Te Rau Ora have run in the Taranaki District with proven success in the past.

→ **Suicide postvention:** Specific services are needed to support whānau dealing with postvention suicide.

Primary Care - GP Services

— As at August 2024, there were 20,323 Māori enrolled in primary care in Taranaki. Based on the last Māori population figures (2023) which showed 27,960 Māori in Taranaki - this would appear to indicate that around 7,600 Māori (27%) are not enrolled or are enrolled in another area.

— An absence of enrolment in primary care can be a barrier to whānau accessing prescriptions, referrals for specialist assessments and NASC services for home support or aged care.

— Data from the PHO indicates that over 5,800 enrolled Māori patients (around 29%) have not visited the practice in the last 12 months – even though the PHO / practices have received capitation funding to provide care for those patients.

IMPB PRIORITIES FOR PRIMARY CARE – GP SERVICES

→ **Long-Term Conditions:** The IMPB supports the Government's priorities of focusing on key pathologies: CVD, diabetes, respiratory disease, and mental health

→ **Delivery models for primary care:** Explore different models of primary care that can ensure access and better options for whānau. Community Hubs throughout the rohe specifically for after hours and weekends delivery is an example. These hubs would act as a one stop shop providing several health services. Other models to explore include a dual approach of Nurse Practitioner led health clinics with telehealth; sole Nurse-led care with GP consults utilising medical students in their practicum year. These proposed solutions will help to help mitigate the shortage of GPs and wait times for appointments, while reducing use of secondary health/specialists.

→ **Workforce:** Develop a local mentorship programme within the current regional Nursing network to support aspiring Nurse Practitioners.

Pharmacy

— Large inequities continue with accessing medicine. In NZ, Māori remain overall much less likely to access dispensed medicine than non-Māori, despite their health need being higher with chronic conditions like diabetes, heart disease, respiratory conditions like asthma and COPD. In 2012/13 gaps in medicines dispensing's meant there were in effect 608,800 lost opportunities for Māori to access medicines, with in total 1,126,280 pharmaceutical treatments that Māori did not receive. The additional challenge is that even where a medicine is prescribed, some whānau are not collecting the prescription.

— Pending data on prescribing from the PHO.

IMPB PRIORITIES FOR PHARMACY

→ **Use of medications:** Health promotion campaign around proper medication use by whānau toi ensure medications have the full beneficial effect

→ Pharmac actively engaging with Te Punanga Ora to understand where medication funding and supply is needed and then supported to make application to the funding pool available

→ Include access to Māori Pharmacists to provide support and education on medications.

Rongoā / Traditional Healing

— In 2018, 13.1% of Māori in Te Punanga Ora had taken part in traditional healing or massage in the past 12 months, compared to 12.3% of Māori nationally.

IMPB PRIORITIES FOR RONGOĀ

→ **Expansion:** More investment into Kaupapa Māori and Mātauranga approaches to promote, access and deliver Rongoā as a form of traditional healing.

Needs Assessment and Service Coordination (NASC), Home Care and Aged Residential Care (ARC)

- The number of Contact Assessments (CA) assessments for Māori within Taranaki decreased from 2020 to 2024 (from 91 in 2020 to 0 in 2024
- The number of home care assessments fell from 91 in 2020 to 41 in 2024.
- The number of Contact Assessments and Home Care assessments have also fallen at a national level, both for Māori and non-Māori, although the number of assessments of both types completed for Māori remains consistently lower than non-Māori.
- The number of first Long Term Care Facilities assessments for Māori within Taranaki decreased from 2020 to 2024, falling from 25 assessments in 2020 to 11 assessments in 2024.
- The number of first Long Term Care Facilities assessments have also fallen at a national level, both for Māori and non-Māori, although the number of assessments completed for Māori remains consistently lower than non-Māori.
- As of April 2024, there were 93 (.09%) Māori out of a total of 1,028 in Aged Residential Care facilities in the Taranaki District.

IMPB PRIORITIES FOR NASC / HOME CARE

- **Home support services:** Current home support services are not considered to meet the need of whānau in Taranaki. This need will increase with the growing number of Kaumātua over the next 20 years. The model is inflexible and not enough kaupapa Māori approaches taken to assessment or those providing the home support. There is need to bring services to communities through mobile services and home visiting so Kaumātua can stay in their homes as long as possible. There needs to be more Kaupapa Māori models of in-home care services specifically for Kaumatua. There also needs to be easier access to services including transport, food and cost of living.
- **Tangata whaikaha:** There is a need to actively advocate for more suitable services for our Tangata whaikaha whānau which includes addressing long term mobility issues. Continue to build on the relationship with ACC to support all our whānau with their needs including Tangata Whaikaha.

Other Community Care Priorities:

Te Punanga Ora have also identified other community health priorities.

- **Audiology:** Prioritise access to audiology and hearing tests for all ages
- **Tane ora services:** Community services and programmes developed and dedicated to the health and well being of Tane health.

HOSPITAL & SPECIALIST SERVICES

Photo: Wilkies Pools, Te Papakura o Taranaki

Hospitalisation Rates

- Māori adults in Taranaki were more likely to be hospitalised across the board:
    - 73% more likely to be admitted for circulatory system diseases (including heart disease and stroke).
    - 71% more likely to have a coronary artery bypass and graft.
    - Heart failure admission rates were 5.0 times as high for Māori.
    - Stroke admission rates were 86% higher for Māori than for non-Māori.
    - Hypertensive diseases admissions were 2.8 times as high.
    - Chronic rheumatic heart disease were 5.0 times as high for Māori.
    - Māori under 75 years were 4.0 times as likely to die from circulatory system diseases with an average of 810 hospitalised from circulatory diseases.
    - The rate of hospitalisations for gout was almost 8 times as high for Māori.
    - Between 2020 and 2023, Māori in Taranaki were 1.7 times more likely than non-Māori to be hospitalised for circulatory system diseases. This includes hospitalisations from conditions such as rheumatic fever, high blood pressure, ischemic heart disease, strokes, and other forms of heart disease.
    - Between July 2022 to June 2023 in Taranaki, there were 571 potentially avoidable hospitalisations in Māori children aged one month to 14 years.
    - The rate of potentially avoidable hospitalisations was 1.2 times higher for Māori children than non-Māori children.
    - Māori were 1.6 times more likely than non-Māori with diabetes to be hospitalised for renal failure (1.3 times for Māori women and 1.6 times for Māori men).
    - COPD hospitalisations were 3.8 times higher for Māori women, and 2.2 times higher for Māori men, compared to non-Māori women and men in Taranaki.
    - Asthma hospitalisation rates were higher for Māori than for non-Māori in each age group.

Emergency Department Presentations

New Zealand EDs uses the Australasian triage scale which has five triage categories; triage category 1 patients are very urgent, while triage category 5 patients are less urgent.

- In 2023, Māori represented 23.6% (n= 10,376) of all ED presentations in Te Punanga Ora and 24.3% in the Taranaki district.
- In 2023, Māori were presented more acutely in ED (Triage category 1) than non-Māori when considering population sizes, represented 32.6% of all ED presentations with Triage category 1 in Te Punanga Ora. This is similar to the wider Taranaki district with Māori represented 32.5% of all ED presentations with Triage category 1.
- There were 29.9% ED presentations at **Hawera** ED with triage category 1 that are associated with Māori in Te Punanga Ora IMPB area.
- There were 28.1% ED presentations at **Taranaki Base** ED with triage category 1 that are associated with Māori in Te Punanga Ora IMPB area and 27.7% of presentations with triage category 1 that were associated with Māori that have a Taranaki domicile.
- There were 39.5% ED presentations at **Hawera** ED with triage category 1 that are associated with Māori in Te Punanga Ora IMPB area and 40.4% of presentations with triage category 1 that were associated with Māori that have a Taranaki domicile.

Wait Lists

- As at July 2024, there are 401 patients currently on cataract waitlists in the Taranaki district. Of those, 29 are Māori representing 14.0% of the total number of patients in the waitlists.
- Further data pending.

First Specialists' Assessments

Health New Zealand - Te Whatu Ora Taranaki offers First Specialist Assessments (FSAs) for 20 Specialist Services.

- In January to June 2022, a total of 12,635 (42 unknown ethnicity, 2,313 Māori and 10,280 non-Māori) referrals were made to hospital Specialist Services in Taranaki.
- Of these referrals 11,582 were accepted and 1,050 referrals were declined (six unknown ethnicity, 185 Māori and 859 non-Māori).
- While the number of referrals for all ethnicities have remained consistent between 2017-2021, the number of referrals declined for non-Māori has increased gradually with the number of declined for Māori remaining relatively unchanged.
- Māori are overrepresented in three of the 20 Specialist Services in Taranaki. These specialties are Paediatric Medical, Dental and Dermatology (32%, 28.4% and 26.6% respectively). When comparing did not attend rates for FSAs by ethnicity for the period of January 2022 to June 2022, Māori make up more than 40% of the DNAs for FSAs in nine of the twenty Specialist Services.

Outpatient Care

- In 2023, 11.5% of first specialist medical appointments and 19.1% of first surgical appointments for Māori were missed. This contrasts to only 3.1% of medical and 6.8% of surgical first specialists appointments missed for non-Māori in Te Punanga Ora.
- Māori are significantly more likely to miss out on receiving their first specialist appointment (3.7 times for medical and 2.8 times for surgical). This adds further delays for Māori in accessing the operations and medical treatment they require and contributes to poorer health outcomes.

IMPB PRIORITIES FOR HOSPITAL & SPECIALIST SERVICES

- → The IMPB supports the Government's health targets, shorter ED wait times, faster cancer treatment, shorter wait times for FSA's and shorter wait time for Planned Care.
- → **Discharge and referral pathways:** The IMPB needs access to data to understand referral pathways when exiting hospital care specifically the choice of referring to Māori providers post-discharge.
- → **Renal care:** Addressing the renal unit access and referral times.
- → **Outpatient clinics:** Increased presence and availability of Specialists down in South Taranaki.
- → **Ambulance and emergencies:** Concerns about the long wait times for ambulances and the need to invest in the workforce and resources to service the large geographical area. It is also unclear where responsibility lies for delays in emergency transfers from Hawera ED to Waikato hospital ED. More resources should be provided for community paramedics
- → **Accessing specialists:** Support the Government's priority to reduce the delays in getting specialist assessments and care

MĀORI WORKFORCE

Photo: Lake Mangamahoe, Ngāmotu (New Plymouth)

Māori Workforce

- The Medical Council conducts an annual survey looking at the percentage of Māori Doctors within each region. The graph below presents the top 10 regions by percent of Māori doctors for the 2024 year. The Taranaki District has 420 doctors of which 20 are Māori, reaching 5.1% for the region. There remains a significant gap to reach a workforce representative of the regions Māori population.
- the proportion of Māori compared to non-Māori workforce as significantly low or non-existent across the various professions. The exception is midwifery where Māori make up 20% of the midwifery workforce and are well represented in HNZ
- There is significant increase in Māori workforce numbers across Nursing, Dental/Oral Health professions, Midwifery, Sonographers and moderate growth seen in some of the allied health professions such as Pharmacy, Radiology Anaesthetic Technicians.
- The largest workforce growth areas nationally are Māori dental hygienists/therapists, Māori dentists, and Māori midwifes
- 5%, well below meeting the representative figure of 17% - 18% total Māori population.
- Dental hygienists and midwifery both forecast positive increases in workforce growth, however the increase as a percentage of the total workforce is minimal at 2% and 4.5% respectively
- Priority Māori workforces for consideration include Doctors in particular GP's; Mental health workforce and an in particular increase in senior mental health clinicians; Nurse practitioners, prescribers; Pharmacists and Midwives.

IMPB PRIORITIES FOR WORKFORCE

- Workforce planning: Te Punanga Ora is keen to participate in a region-wide Māori workforce strategy with other IMPBs.
- Invest in the wider health workforce including:
  - Dental and Oral health practitioners
  - Paramedics
  - Māori midwives
  - Health Promoters
  - Specialists
  - GP's and Nurse Practitioners
  - Mental health and addictions workforce

NOTES

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Back Photo: Arial view of Mount Taranaki
Cover Photos: Mount Taranaki

TE PUNANGA ORA

KO TŌ MANAWA KO TAKU MANAWA