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## New Zealand's bold strategy for reducing health disparities

New Zealand's programme *Whānau Ora* takes a new approach to improving the health of the Māori population: putting communities in the driver's seat. But will it work? Ted Alcorn reports.

"Social inequalities in health are not a footnote to the problems of health; they are the problems of health", said Michael Marmot, Chair of the UN's Commission on Social Determinants of Health, at a symposium on health equity in July in Auckland, New Zealand. His audience had reason to listen. New Zealand is characterised by some of the largest health disparities between Indigenous and non-native populations in the world.

A sixth of New Zealand's population are descendants of Māoris and are afflicted by higher rates of disease than are the non-Māori population, receive treatment later and of lower quality, and have poorer outcomes. The disparities crop up in nearly every indicator and throughout the life cycle. Incidences of many types of cancer are three to four times higher for Māori, and their survival rates are lower. Incidence of rheumatic fever in children is more than 20 times higher than in people of European descent. 22% of European-descended New Zealanders were identified as

smokers in 2009 compared with 46% of Māori people. And although the disparity in life expectancy between Māori and non-Māori people has fallen since the 1950s, when it exceeded 15 years, the gap widened in the early 1990s and has remained steady since then (figure). The life expectancy of Māori New Zealanders is roughly 8 years shorter than those of their non-Māori counterparts.

**"Māori want self-determination. Māori want to be able to provide health services their way: by Māori, for Māori..."**

Poverty undoubtedly plays a part. According to New Zealand's Deprivation Index (a composite of indicators including income, education, and mobility), 75% of Māori people fell in the poorer half of the distribution in 2006, and 24% were in the lowest decile. But disparities persist even within comparable income groups, and they are gravest among the poor.

Teresa Wall, deputy director-general of the Māori Health Directorate at the Ministry of Health, says that the health system has been complicit in propagating these inequalities. Especially over the past 20 years, the disparities largely indicate improvements in the health of non-Māori that have not been matched by equal progress in the Māori population. Wall says that is because public health interventions designed for the general population and delivered through mainstream service providers often failed to take into account the barriers that might prevent Māori from accessing them. The country's smoking cessation programme was exemplary of this. "It was well-evidenced, well-resourced, but we were surprised to see that actually as it was rolling out, it was increasing the inequalities between Māori and non-Māori. Because what that programme didn't do was it didn't design smoking cessation to accommodate different population groups...It ignored the fact that smoking is hugely socially determined."

There is widespread awareness of the disparities and the government has integrated the rhetoric of equality into many of its policies. New Zealand's district health boards, which are the main mechanisms for delivering health care in the country, are explicitly mandated by the New Zealand Health and Disability Act to work to reduce health disparities. Additionally, public health care funding is linked to the deprivation index as a way of channelling additional resources to underserved groups.

But measuring disparities is much easier than reducing them, says Dale Bramley, Chief Executive Officer of the Waitemata District Health Board, the largest in the country, providing health care to 550 000 Aucklanders.

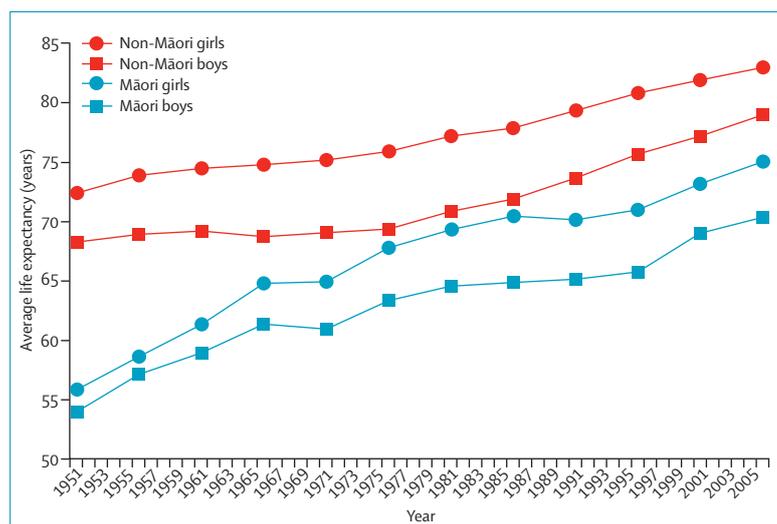


Figure: Average life expectancy at birth for Māori and non-Māori girls and boys between 1951–2005  
Source: New Zealand Government.

"The analysis is good here and a lot of information has been produced over the years, but a lot of it tends to be... descriptive. There's a lot less evidence about the effectiveness of interventions to reduce inequalities."

Some observers have concluded that reducing health disparities will first require that Māori communities be empowered to address their problems directly. One of them is Jean Te Huia, a Māori midwife who has been on the front lines of providing care in the city of Hastings for 20 years. "Māori want self-determination. Māori want to be able to provide health services their way: by Māori, for Māori. And I believe that's the only way we can address the disparities in the Māori population. Until that happens, we'll just continue to mop up the mess—basically, to put a band-aid over the wound."

Mason Durie, a professor of psychiatry at Massey University, Palmerston North, who has spent his career working to improve Māori health, has come to the same conclusion. He says that although disparities in health outcomes are often the most stark, the underlying problems lie in other areas, particularly housing, education, and employment. These factors contribute to disparities by fostering illness, delaying care seeking, and discouraging good adherence to treatment. "Quite often the thing that gets pointed at is the health sector, when really the determinants of inequalities in health are largely outside the health sector—the health sector just picks up the pieces. And a different approach is required to make the next level of progress."

Whānau Ora might be that approach. In 2008, on the invitation of Minister and co-leader of the Māori Party Tariana Turia, Durie chaired a taskforce to define the initiative. They proposed the creation of a new institution to bring the fragmented social services for Māori under a single roof. Providers and patients will be reoriented to give more attention to preventive medicine and health promotion, and wellbeing will be addressed holistically for families

(whānau, in the Māori language) rather than individuals. Although improving Māori health is Whānau Ora's primary goal, it puts equal emphasis on economic security, self-management, community cohesion, and participation in Māori culture and the wider world.

In many respects, Whānau Ora asks Māori communities to develop solutions themselves. "It's a programme that shifts the focus from identifying a pathology to building capability", says Durie, "and we have not emphasised that enough. We've gotten better at fixing up problems and doing crisis-interventions, but haven't done so well at being able to identify strengths and build on those strengths."

Funding for the programme was announced in June, 2010, though the amount—NZ\$134 million over 4 years in the 2010 budget and an additional \$30 million in 2011—was far less than the \$1 billion originally proposed. Providers who have begun implementing the programme remain optimistic. "We're very much trailblazing on this", says Martin Steinmann, Whānau Ora project leader of a primary health-care organisation in Tauranga. His staff are integrating their community-based and clinical services, developing information technologies to streamline communication between providers, and soliciting feedback from families about their needs and ways to address them. "Basically we've been given a terms of reference and really it's a blank piece of paper. It's potentially turned our contracting-with-the-state model and how we interact with whānau and the individuals on its head. So it's quite exciting."

Critics of the programme contend that it lacks clear benchmarks by which to monitor its performance; one of them is Kelvin Davis, a member of the opposition Labour Party and their Associate Spokesperson for Māori Affairs. "They've just gone for this big broad policy that's set up to fail because it actually isn't specific enough or targeted enough", he told *The Lancet*, "and as a result we won't be able to

measure whether it's been all that effective. Which is a real pity, because we all want it to be successful."

Minister Turia strongly disputes that claim. "Whānau Ora has been tightly linked to a focus on outcomes; outcomes which are derived, owned and developed by whānau. How each whānau expects to achieve outcomes will be determined by them to fit their own unique set of circumstances." Although conceding that this flexible approach is less well defined than would be a one-size-fits-all policy, she is confident that the indicators that communities ultimately develop will be sufficient to monitor performance.

Debate over this point suggests a deeper truth. Progress towards some of the programme's central goals are difficult to measure. And because many of its objectives will take years if not decades to achieve, it may prove impossible to attribute changes directly to Whānau Ora.

For some reasoned sceptics, the programme is still a risk worth taking. Tony Blakely, director of the Health Inequalities Research Programme at the University of Otago, says that all his experience working in public health tells him that a programme as devolved as Whānau Ora will end in failure. But he also concedes that the decision to move forward should belong to the Māori people, and says they might ultimately prove his instincts wrong. "Well-respected Māori leaders in our community throw it straight back at liberal white guys like me and say, 'Well, what you've done in the past has not worked particularly well. So we're going to talk to people in our communities, and we're going to actually shape stuff for our community. Give us space, give us funding, and watch us work.'"

The outcome of their efforts—whether Whānau Ora fails to eliminate the disparities, or proves to be a new model for improving the health of marginalised groups everywhere—will be of interest to all.

Ted Alcorn