**Inequitable Access to Healthcare in New Zealand**

**Introduction**

Inequality is defined as the existence of a disparity in degree, size or circumstance. A healthcare system refers to the structure of organization of personnel, resources, and institutions that deliver services of healthcare to target populations. This acts as the populations’ health determinant and is subject to the influence of other social determinants. In an ideal society, inequalities in its healthcare system are nonexistent. However, the world we live in is not ideal. In all nations, there are different social situations for different sections of the populace that result in unfair but preventable differences in health situations (Harris, Cormack and Stanely, 2013). In the end, the differences create disparities in the general well-being and life expectancies among the population. A good healthcare system endeavors to attain fairness in society by providing distribution of healthcare fairly (Kai, 2003). Endeavoring to attain health equity means advocating for all social groups to have equal opportunities of accessing healthcare, with a mind of improving the accessibility situation for those groups who had fewer chances for the same. However, amid the rapid growth of globalization in recent decades, there has been a rapid growth in healthcare system inequalities across all countries including New Zealand.

**The New Zealand healthcare demographic**

In New Zealand, chronic illness is the biggest causer of mortality, morbidity, and inequitable health outcomes. Out of a total of 4.7 million people, 68% European ethnic groups with 15% being Māori making the largest minority followed by Asians and Pacific Islanders at 9% and 7% respectively (Statistics New Zealand, 2017). For these groups, the healthcare access barriers include language barriers; inadequate appropriate information access; institutional racism; variant health system procedures and beliefs; negative attitudes by some health personnel; inadequate culturally sensitive services pertaining to cultural and religious needs; previous negative experiences with social and health services; and fears on health care entitlement (Kai, 2003).

**Reasons for inequalities**

The situation for both the Māori and Pacific people points towards the social determinants of health concept that comprises of four major areas of inequalities; namely discrimination, lifestyle factors, socioeconomic factors and access to healthcare.

**Socio-economic factors**

According to the WHO (2009), indigenous people who were colonized and lost land, as a result, have the worst health status in their own countries. In New Zealand, the trend applies to the Māori and Pacific people who have had longstanding and significant healthcare inequities compared to the Pākehā (Harris, Cormack and Stanely, 2013). In the 1700s the Māori had a higher life expectancy than Britons at 30 years. The onset of imperialism in New Zealand changed this as it came along with diseases like tuberculosis and measles increasing the mortality rates among the Māori. The extent of the imperialism stretched into the culture of the nation as it caused discrimination against the Māori language and regulation of the native’s rights (Oda and Rameka, 2012). This socioeconomic context and loss of land by the Māori led to them having poor health status.

It is important to note the extent of death due to diseases was diminished to the natives who did not lose their lands as compared to those who did. By 1891, their life expectancy had dropped to 23 and 25 years for the women and men respectively with 50% of the deaths being children. The introduction of national healthcare and social welfare schemes in 1938 had the effect of gradually improving the status of the Māori and the Pacific people. Although the life expectancies of the natives are at 77.1 and 73 years for the females and males respectively, it is still far from the 83.9 and 80.3 years for the Pākehā females and males (Ministry of Health 2015).

Over the past four decades, the New Zealand system of healthcare has seen significant restructuring resulting in a system that focused on primary health care and relied on social policies and population health approach to close the health gap. This was a strategic response by the system to the growing healthcare inequalities in the country (Ministry of Health, 2006). Even with the attempts and aspirations to reduce the health gap the Māori and other minorities who have a lower socioeconomic status have much higher chronic disease levels in earlier stages of life making them have a lower life expectancy and higher morbidity (National Health Committee, 2007). They also experience higher instances of injuries and non-communicable diseases.

In the late 70s and early 80s, the regulated economy model utilized in New Zealand invoked subsidies that controlled fluctuations in prices and wages, unemployment rates, as well as state-sponsored mortgage and housing subsidies. However, after 1984 successive governments carried out major reforms to the public’s relationship with the state through state sector reorganization, financial sector deregularization and ceasing industry support (Belich, 2001). The results of these reforms came in the form of privatized major utilities, a tax system that was substantially flattened, regressive consumption tax, income support that is fully targeted, charges to the user for government services like education and health and a shift of the labor market to facilitate flexibility (Dew and Kirkman, 2007). The effect was a substantial increment in socioeconomic inequalities among the aoteroa with the disposable incomes mean equivalent in households having beneficiaries falling significantly. The impact of these socioeconomic changes did not equally impact the Māori and non-Māori.

Studies show that after implementation of the changes, the inequality gap in employment status, income, education, and housing, between the Māori and non-Māori expanded (Howden-Chapman and Tobias, 2000). These are especially vital aspects as they are important social determinants of health. During this period, the unemployment rates for the Māori grew from levels that were similar to those of non- Māori to triple the levels of the non- Māori. The incomes of Māori households also fell and never recovered (Blakely et al., 2005). It is no coincidence that from the 80s to the 90s, the Māori had higher mortality rates as compared to the non- Māori across all groups of income and that the low-income non- Māori had similar or lower mortality rates compared to high income Māori (Ministry of Health, 2015). Although the gap in life expectancy became narrower over the years, the Māori’s rate of improvement slowed down.

The Pacific Islander is another minority group of people living in New Zealand comprises of seven major ethnicities: Fijian, Samoan, Tongan, Tuvaluan, Niuean, Tokelauan, and Cook Island Māori. The situation of the Islander population also shows similarity to the Māori. Between 1986 and 2004, their unemployment rates rose from a low of 6.6% to a high of 28% in 1991 before gradually declining to 7.4% in 2004. Although this figure is lower than that of the Māori and the Pacific Islanders situation has seen stabilization as new opportunities emerged for them, it has never recovered to the pre-1992 era and they are still over-represented in employment groups of lower pay (Statistic New Zealand, ). At the same time, their healthcare statuses have a lot of similarities to that of the Māori in some situations and lower in others. The ambulatory-sensitive hospitalization rates for the Islanders are lower than the Māori’s indicating that the former used more of the primary care. However, the preventable hospitalization rates for the Pacific Islanders are generally bigger than that of the Māori which is an indication that the population-based interventions have not extensively reached them. Both minorities have greater proportions of persons affected by the relationship between income and mortality compared to the non-Pacific non- Māori population. The main reason for this is the larger distribution of the two minorities’ population in lower income levels.

**Discrimination**

Discrimination has a very close relation to various poor health factors with a clear link being exhibited in the poor health of the Māori and racial discrimination against them. In the nation, Māori experience the highest prevalence of physical and verbal racial discrimination as well as ethnicity based unfair treatment. They also report the highest number of racially discriminatory occurrences with healthcare personnel which makes it clear that the design of the healthcare system in the country negatively affects their health status. A good illustration would be the slower treatment procedures that the minorities receive accompanied by longer waiting times. The doctors are also less likely to refer them to a specialist which is the reason for Hill et al. (2010) findings that although the Māori have a higher chance of contracting cancer, at 9%, they are 77% more likely to lose their lives than the Pākehā.  Apparently like in most OECD countries, the healthcare system is based on equality but lacks equity as there is no room the cultural needs of the minority groups and the unique health perspective that they bring to the fold.

**Accessibility**

Furthermore, due to the feeling that their cultural health perspective is undermined by the dominance of the Pākehā in the sector, the Māori display more resistance towards trusting the system and engaging in the services (Hill et al., 2010). When this is coupled with the other existing obstacles that the minority groups face in the likes of socioeconomic deprivation, it makes healthcare nearly unaffordable for them as well nearly inaccessible. In a survey conducted by the ministry of health, there were over half a million adults in the nation who could not access GP because of cost in 2013 (Ministry of Health, 2015). Other services have varying inaccessibility with mental healthcare being largely outpatient and community based. Lead Maternity Carers are the ones who provide maternity services with three quarters of them having qualified as midwives only (Cumming et al., 2014). Accessibility to dental care is also wanting as the funding offered for the minority communities only allows for full dental care of children while adults can only get limited treatment in cases which are emergencies (Cumming et al., 2014).

Conclusion

 A good healthcare system endeavors to attain fairness in society by providing distribution of healthcare fairly. However, there has been a rapid growth in healthcare system inequalities across all countries including New Zealand. For both the Māori and Pacific people the inequalities are largely due to four major areas; namely discrimination, lifestyle factors, socioeconomic factors and access to healthcare. These are the reasons for the existing healthcare inequalities that affect the different minority subgroups in New Zealand which impede the ability of the groups to access and extensively utilize health care. Nevertheless the implementation of the intervention methods discussed in the review of literature will go a long way in improving the accessibility, affordability and utilization of health services by the minority groups and therefore the reduce the disparities of the system.

**The New Zealand healthcare system**

**Introduction**

The Māori who are New Zealand’s indigenous people came to the islands from eastern Polynesia around 700 to 1200 years ago (Anderson et al., 2006). The first documentation of the natives contact with Europeans was in 1769 during the historical expedition by James Cook that triggered the start of the colonization of the islands by the British. In 1840, the Māori through their chiefs accepted an alliance with her Majesty's Empire by signing the Treaty of Waitangi which was written in both Māori and English. At the time, there were 100,000 Māori and 2000 settlers and the treaty aimed to safeguard the rights and protections of the natives. The two different versions of the treaty exhibited substantive differences resulting in different obligations and rights interpretations for the different concerned parties. In the end, the promises that were the basis for the formation of the treaty were not kept (ANDERSON et al, 2006). As of the turn of the 20th century, the Māori like any other indigenous populace in the world had become a minority under colonization.

They lost most of their land that had heavy negative effects on their ability to produce food and they were immersed in abject poverty, discrimination and marginalization. The demographic situation on the Island changed with around 800000 settlers by far outnumbering the 40000 or so natives in 1901. As indigenous people of New Zealand, the best instrument the Māori could have used to keep and protect their rights was the treaty of Waitangi (ANDERSON et al, 2006). The longstanding disparities in the health status of the non-Māori and Māori population show that the health rights of the natives were not protected as the treaty dictated. In the 70s, the treaty started receiving greater awareness. This was due to the growing frustration by the Māori and their aspirations to get equity in the health system. The result was the recognition of the treaty as a fundamental point in the Māori -government relationship. However,   the treaty is yet to be incorporated in social policy legislation and there still exists a substantive gap between its acceptance and translating its aims into real healthcare status gains for the Māori.

**The structure of the healthcare system**

In New Zealand, the healthcare system comprises of a mix private and public owned institutions offering a wide scope of health services that have undergone radical reshaping in the last 4 decades. The 80s saw Area Health Board entities on regional levels offer bulk hospital funding with their services excluding primary healthcare. Crown Health Enterprises came into being in the 90s (Barnett, Smith and Cumming, 2009). These were state-owned hospitals and firms that were set up and worked with Regional Health Authorities to offer services that also encompassed primary healthcare. At the end of the millennium, the restructuring focused on the government side of the system with DHBs now integrating hospitals into bodies that offer funding. Populations now rely on DHBs to provide, plan, manage and fund health care services including primary care, aged care, and public health as well as non-governmental health services by Māori and Pacific providers. The DHBs rely on Primary Health Organizations (PHOs) to fund primary health care provision (Barnett, Smith and Cumming, 2009). Many of the PHOs were started between 2002 and 2005 and are tasked with working with the local populations with the aim of reducing inequalities in the health sector through the improvement of service provision and accessibility. The idea was to shift the allocation of primary healthcare share from a fee-to-service endowments package at the specialist level to a main funding of the PHOs through capitation model (Barnett, Smith and Cumming, 2009).

**Implication of the Waitangi Treaty in the strategy**

The first time the government developed a Strategic Objective for Māori health improvement and to reduce the health inequality was in the 1993 legislation. This formed the basis for most of the growth and development health initiatives for the Māori in the decade (Manatu Hauora, 2017). It spurred the review of the Ministry of Health’s internal structures which recommended the formation of the Māori Health Group whose manager would report to the Deputy-General directly. Over the years different legislations and internal restructurings have come in place at the ministry but the Māori Health Branch was maintained and even grew into a directorate. During this time it increased in size to reflect the much broader line of management across other business units it has today. The Māori capacity and Capability Plan released by the ministry internally in 2001 is the reason for a lot of the development of the Te Kete Hauora. The plan sought to reinforce Māori workforce and management capacity while developing the awareness and knowledge on Māori healthcare issues across the ministry by focusing on the needs of Māori health (Kiro, 2000). In the end, it started the draft consultation of the Māori health strategy or He Korowai Oranga with its themes being key aspects of the strategy (King and Turia, 2002).

**Current position of the legislature**

The New Zealand Public Health and Disability Act 2000 contains a number of significant laws in relation to Māori health. The underlying factor of all of these Māori related laws is the requirement by DHBs to develop and maintain processes enabling the Māori to engage in and bestow strategies concerned with the improvement of their health. The imposition of these requirements is in respect and recognition of the Waitangi Treaty articles with the goal of Māori health status improvement (Manatu Haaurora, 2017). The act stipulates the objectives of the DHBs include health disparity reduction through the improved health outcomes of the affected population groups like the Māori. It also purposes to reduce and possibly alleviate health outcome differences among the various groups of the population. The implementation of the New Zealand Public Health and Disability Act is improved by the strategic guidance and direction provided by the Māori Health Strategy and the New Zealand Health Strategy (King and Turia, 2002). There is an acknowledgment of the Crown’s special relationship with the Māori under the Waitangi Treaty under the New Zealand Health Strategy.

**The Ministry’s position**

In its attempt to fulfill the health and disability needs of the Māori, the He Korowai Oranga utilizes three key articles as its basis. These three articles are the Treaty of Waitangi articles which are articulated as Governance; Maori control; and Self-determination and Equity. The idea driving the utilization of these articles is the notion that even though it is the responsibility of the government on the population’s behalf to provide healthcare, the needs of the Māori in terms of healthcare and disability can only be met by the inclusion of the whole sector. The governance article articulates the development of strategies to aid in appropriate gains in healthcare and disability services through collaboration with Māori communities (Manatu Haurora, 2017). Basically, it advocates for the involvement of Maori in the development and implementation of health policies. Maori control and self-determination advocates for the involvement of the Māori in all of the sector’s levels starting with planning, decision-making, development and finally delivery of disability and health services. The last article of equity requires the safeguarding of the cultural values, concepts, and practices of Māori while ensuring they get access to the same level if not better healthcare services. The adoption of these articles resulted in the advancement of disease control and health promotion in Māori communities through the establishment of initiatives like the Māori led providers.

**Māori health care services**

Crengle (2000) recognized two philosophies that were vital to primary Māori healthcare services. These were positive Māori development promotion and utilization of Māori models of health.  These healthcare service providers based their development and delivery of healthcare services on Māori cultural processes as a means that support self-sufficiency. They identify the key issues affecting their target population and utilize a scope of strategies that specifically target the issues. These include proactive community inclusion in the delivery and planning of the services; considerably large-scale mobile clinic services; subsidized health care; and employment of Māori as the primary staff as they have better access to Māori consumers and understand their issues. In the end, these Māori service providers in healthcare articulate all the three basic articles of the Waitangi Treaty and are able to properly address the needs of the Māori which would go a long way in addressing the issues of healthcare inequalities in the nation (Ellison-Loschmann and Pearce, 2006).

Even if there has been an exponential growth in the number of Māori health providers over the years, it does not mean that it has been smooth sailing for them. They face a myriad of challenges including inadequate primary health data that is reliable, a small Māori workforce in healthcare and a short contract period that necessitate extensive renegotiations almost annually. Their specialization to deal with a Māori populace that is in high need of health services means an increased cost of operation. Thus if significant gains are to come about from the utilization of the providers, it is necessary for the funders to consider this (Kiro, 2000).

**Conclusion**

The adoption of the Waitangi Treaty in healthcare policies regarding Māori and their healthcare status went a long way in improving their status and reducing the disparity existing between them and other groups. Adoption of the three articles was especially significant as it resulted in many positive changes for Māori healthcare model. Although there is little evidence on the effectiveness of the strategy, it is clear from the literature review that the opposite is true; reduced participation, protection and partnering with Māori results in poor health outcomes for them which does not align with the Treaty of Waitangi.

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