A Māori cultural reluctance to present for care, or a systems and quality failure? How we pose the issue, informs our solutions

Nina Scott

Two articles in this edition of the NZMJ address important Māori health topics. One, a Kaupapa Māori-based investigation into inequities in access to antenatal care for young women.1 The other, a Māori health model,2 can be considered an umbrella or overarching framework for thinking about Māori health. Both provide guidance for future direction on action for improving Māori health and achieving equity in health for all New Zealanders.

Health inequities are a problem in all developed countries and are defined as differences which are unnecessary and avoidable, but in addition are considered unfair and unjust.3 Health inequities between Māori and non-Māori New Zealanders are large and pervasive, persist across the lifespan, over time, and surpass inequities by deprivation and geography.4 Similar patterns are seen between Indigenous and non-Indigenous populations in many countries including Australia, the USA, Canada and in Nordic countries.5,6

Without appropriate dialogue, society risks becoming complacent about the tragedy and injustice of inequities. Developing a zero tolerance attitude toward inequities will help ensure that achieving equity becomes a peak societal and health goal. Achieving equity needs to be prioritised before improving overall health for the total population, because, in addition to social justice imperatives, not all methods used to improve health status for the majority of the population will result in a reduction in inequities, and some methods inadvertently increase inequities.

On the other hand, implementing systems changes required to achieve equity will likely improve health for all. For example, developing an equity-focussed, evidence-based, standardised referral to lead maternity care pathway, the need for which is clearly given in the Makowharemahihi article,1 would be expected to contribute toward achieving equity in access between Māori and non-Māori women and also improve access for all women.

The organisation responsible for such systems changes in New Zealand is the Ministry of Health. As the agency responsible for the strategic direction of New Zealand’s health sector, the Ministry of Health holds overall accountability for the quality of healthcare, including ensuring that access, timeliness and quality of health care is equitable for all.

Systems and victim-blaming approaches are two common ways that health inequities are considered or understood. One emphasises the importance of health determinants, including the role of well organised, high quality, equitable health care—and the
other, the responsibility of individual patient behaviours for achieving good health outcomes.

Inequities can be seen as a hallmark for poor-quality, non-standardised care. Variability in care by ethnicity, socioeconomic status, and/or by service, is often the most obvious marker of poor quality along a care pathway or within a healthcare system.

Inequities in prostate cancer mortality between Māori and non-Māori have been blamed on a Māori “cultural reluctance to present for care”. It would have been easy to make the same assumptions in the case of inequities in access to antenatal care between Māori and non-Māori women. However, Makowharemahihi et al, in this edition of the NZMJ, used a systems approach to pinpoint the weakest link in the access to antenatal care pathway which is generating inequities. As expected, there was variable quality of care at this point, with some women receiving high-quality care and others hitting multiple barriers at every turn, resulting in delayed and poorer quality care.

The authors overarching methodology is Kaupapa Māori and although not made explicit, is also consistent with recent thinking on health care quality. Health care quality methods are particularly useful for equity focused systems approaches.

One of the most significant influences in health care quality is philosophy based on the success of manufacturing models, such as lean philosophy based on the Toyota model. In a high-quality system, processes and practices are continually reviewed from a client viewpoint so that problems can be identified and resolved.

The authors focussed on part of a healthcare pathway where inequities were identified, and evaluated processes and practices around that part of the pathway from the point of view of young pregnant Māori women. As a result they have identified an intervention point for improving access to high quality health care early in the life course for children and at an important time in the lives of women and their whanau/family.

Unobstructed throughput and the identification and removal of system bottlenecks are key to quality care, and multiple process steps have been identified as red flag situations, which increase risk for poor-quality care.

Integrated seamless care along the antenatal care pathway between general practitioners and midwives is essential but clearly lacking. It is obviously a bottleneck situation. And it’s not hard to see why, as multiple process steps are required for women to access a midwife/lead maternity carer, including: accessing a phone and the money to use a phone; literacy skills, time and confidence to phone and request care from a list of lead maternity carers (LMCs); and lead maternity carers having space available for new clients. A final important additional process step, which was not assessed by the researchers, is LMCs being willing to accept young Māori clients.

As demonstrated by the authors, early and appropriate access to antenatal care is important for its positive impact on outcomes for mother and child. Timeliness is crucial as initial contact with health services is an opportunity for first trimester screening, lifestyle interventions including diet and smoking cessation, and navigation to an LMC or hospital care. The authors cite longstanding knowledge of inequities in
early access to antenatal care for young women. In light of such a clear need, this is an important piece of work, but it is concerning that it has taken so long for a study such as this to be done. Developing a high quality equitable antenatal care pathway should be a priority for any government.

Resolving quality issues identified through this research will require leadership and resourcing and the full, timely support of the Ministry of Health. Following on from the Kaupapa Māori methodology and quality improvement methods used to inform the study, the same methodology and quality improvement philosophy should be used to inform the development of solutions. Kaupapa Māori methodology speaks to the need for Māori leadership, expertise and involvement in solution development, implementation and monitoring. A high-quality, Kaupapa Māori antenatal care pathway would work for Māori women at least as well as for non-Māori women. It would also be standardised, user-friendly, simple, easy-to-follow and continuously monitored.

The methodology and methods employed for this research could be used to identify points of intervention along other critical health care pathways for Māori and also contribute toward achieving an equitable health system in New Zealand and help improve the quality of health care for all New Zealanders.

Māori models of health provide important frameworks for thinking about Māori health at systems and individual levels and can be used for teaching purposes with health professionals from many disciplines. Encounters with a variety of health professionals are par for the course during a journey through health care.

In the ideal scenario, health professionals at every point along every health care journey would be culturally safe and non-racist. Further, at the system level, policymakers and maintainers at every level of health care would develop equity-focused policies and practices aimed at improving Māori health alongside achieving equity and improving health for all New Zealanders.

The article by Pitama, Huria and Lacey—also in the current edition of the NZMJ—gives an overview of the updated Meihana model, which provides a guide for health professionals on the clinical assessment process for Māori patients. Drawing on two established models—Te Whare Tapa Wha (the four cornerstones of health), and the Calgary-Cambridge model—a key strength of the updated Meihana model is that it goes beyond its foundation models to include sociopolitical determinants of health such as racism and the role of high-quality health services. Another strength is its focus on high quality ethnicity data to inform continuous quality monitoring.

The Meihana model helps practitioners understand a Māori model of health, determinants of Māori health and causes of inequities in health between Māori and non-Māori. Its use could theoretically contribute toward improving Māori health, achieving equity in health, and improving health for all. Learning’s from the model could be enacted at clinician to patient and whānau interactions, and at the wider systems level.

Racism at the personal and systems levels is a recognised determinant of health in New Zealand. Evidence shows that experience of racism has a negative effect on health and that Māori are more likely to experience interpersonal racism than non-Māori.
Training health professionals could hypothetically reduce the frequency and severity of interpersonal racism experienced by Māori. Institutionalised, or systems level racism is a powerful determinant of health that goes beyond interpersonal situations. The Meihana model could contribute toward decreasing institutional racism by improving health professionals understandings of Māori health, health inequities and health determinants, so that when they contribute to organisational changes, they focus on Māori health needs and rights in an evidence based way and may be less likely to support health initiatives which result in poor outcomes for Māori and/or increase inequities.

More directive guidance on the responsibilities of health professionals to address inequities and ways of doing that effectively, both at the interpersonal level with patients and whānau and at the systems level would strengthen the model. However, the updated Meihana model incorporates a broad understanding of Māori health and in the right hands, could be a very useful teaching tool, for a range of health professionals and in a variety of settings.

I, for one, plan on incorporating the updated Meihana model into my interprofessional teaching practice.

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Author information: Nina Scott, Public Health Physician, Te Puna Oranga, Māori Strategy Unit, Waikato DHB, Hamilton—and Māori Academic Coordinator, Rural Health Inter-professional Immersion Programme, University of Auckland

Correspondence: Nina Scott. Email: nscott.waikato@gmail.com

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