



CPAG 2023 Policy Brief on Māori child health

Pathways towards health equity for tamariki Māori

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VISION

All tamariki will grow up surrounded by loving, thriving whānau within supportive communities where there are resources, opportunities and systems to enable them to live self-determined lives and futures.

CPAG acknowledges that tamariki Māori and whānau have unique rights as tangata whenua, affirmed within He Whakaputanga and Te Tiriti o Waitangi. The significant inequities in well-being outcomes and child poverty for tamariki Māori are the result of ongoing colonisation, systemic racism and neglect. Reducing child poverty in Aotearoa requires our country to address the inequitable distribution of power and resources that prevents Māori from flourishing.

ISSUES

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Colonisation of Aotearoa was not the peaceful meeting of two peoples to build a new nation as equals. Instead, colonising Europeans systematically appropriated almost all Māori resources, destroying much Māori culture, including political systems. European models of government and management were imposed that favoured the colonising population by design and application.¹

The effects of this on Māori were catastrophic and persist to today,² in part because systems and resource redistribution – everything from education³ to the criminal justice system⁴ to home loan approvals⁵ – still favour Pākehā over Māori. Long-term inequities occur in all indicators including poverty,⁶ housing,⁷ education, justice and the focus of this panui: health.⁸

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The truth relating to inequity in New Zealand is that it has been systematically created from the time of mass European settlement of Aotearoa, initially enforced by soldiers and militia, and now maintained with the financial resources and force of the state.⁹ Discourse on inequities often focuses on the characteristics and behaviours of those suffering inequities. However, the key driver of health inequities for whānau Māori – and the key actor whose behaviour needs to change – is the state.

Māori poverty is a significant legacy of colonisation, exacerbated and maintained by ongoing colonisation.

BARRIERS REQUIRING POLICY ACTIONS

Government policy indifference and inaction

Inequities are unjust, unfair and – in an enlightened society like New Zealand – unacceptable.

Despite this ethical imperative of health equity – and the rights of tamariki Māori as tangata whenua, affirmed by Te Tiriti o Waitangi, Wai 2575,¹⁰ and confirmed by the United Nations Convention on the Rights of the Child,¹¹ and the United Nations Declaration on the Rights of Indigenous Peoples – significant health inequities persist. Māori children continue to experience inequitable, poor health outcomes, due to systems contravening their protected rights under these internationally-recognised human rights frameworks.¹²

The long-term persistent nature of health inequities is due to their systemic causes. Few health inequities have narrowed significantly and in many cases – such as immunisation¹³ – they have become worse in recent years.

This is despite the meticulous recording of the inequities over many decades. **Specifically, the knowledge of the problem has not been enough for the Pākehā-dominated health system to take meaningful action.** This glaring failure has been highlighted in numerous reports. The 2020 Simpson Review of the Health and Disability System was highly critical of the New Zealand health system in regard to its efforts to reduce inequities:

*Improving the equity of the health outcomes achieved in New Zealand requires first that we acknowledge that current inequities are not acceptable, that we understand better what is contributing to that inequity, **and [that] the health and disability system becomes more determined to operate differently so that inequities are addressed.** [emphasis added]¹⁴*

The New Zealand government has long had specific goals regarding reducing inequities and making Te Tiriti o Waitangi a core part of its function. However, these goals have not been supported by meaningful action.

In the Wai 2575 report regarding the New Zealand health system, the Waitangi Tribunal noted: “The permissive nature of the primary health care framework, with its considerable devolution of responsibilities, permits actors in the health sector to downplay their responsibilities to improve inequitable health outcomes for Māori and to abide by Treaty

obligations.”¹⁵ In other words, policy rhetoric is not backed up with meaningful actions and goals.

One of the key recommendations of Wai 2575 was the creation of Te Aka Whai Ora, the Māori Health Authority. Although this occurred, there are a significant number of constraints. One of these is workforce, where there are extremely limited number of Māori in the health system, particularly at senior levels.

The reality is that for the majority of tamariki in Aotearoa their interaction will be with Pākehā and other non-Māori clinicians in a Pākehā system. This is especially true for those with serious illness.

Therefore, system change led by a partnership between Te Aka Whai Ora and Te Whatu Ora (Health New Zealand) must focus on two things:

1. Developing For-Māori By-Māori health services.
2. Addressing the systemic racism that pervades the current health system, through real system change.

The success of a society should be measured by how well it cares for its most vulnerable. In New Zealand, this is tamariki Māori, starting at conception. The significant inequities in the health of tamariki should lead all in Aotearoa to question whether we do care.

ISSUES

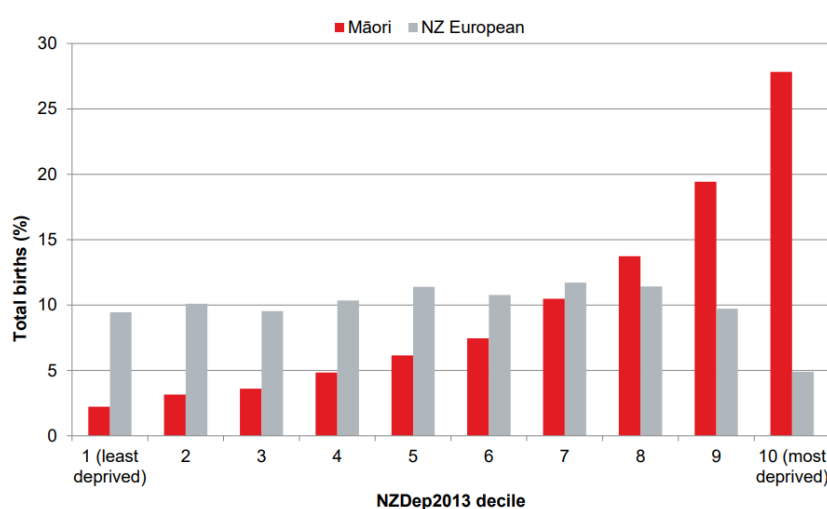
authored by Dr Mataroria Lyndon

Health inequities for tamariki Māori

Māori disproportionately are locked into economic hardship: approximately one-fifth (19%) of Māori children live in households experiencing material hardship (compared with 8% of Pākehā children), and one-third (33%) of Māori children live in families with incomes below the AHC60 poverty line (compared with one quarter of Pākehā children).¹⁶

Figure 1 below shows that around 60% of Māori pēpi are born into the 30% most deprived areas; and they are over five times more likely than Pākehā babies to be born in the most deprived decile.

Figure 1: All births by NZDep decile, Māori and Pākehā 2009–2018¹⁷



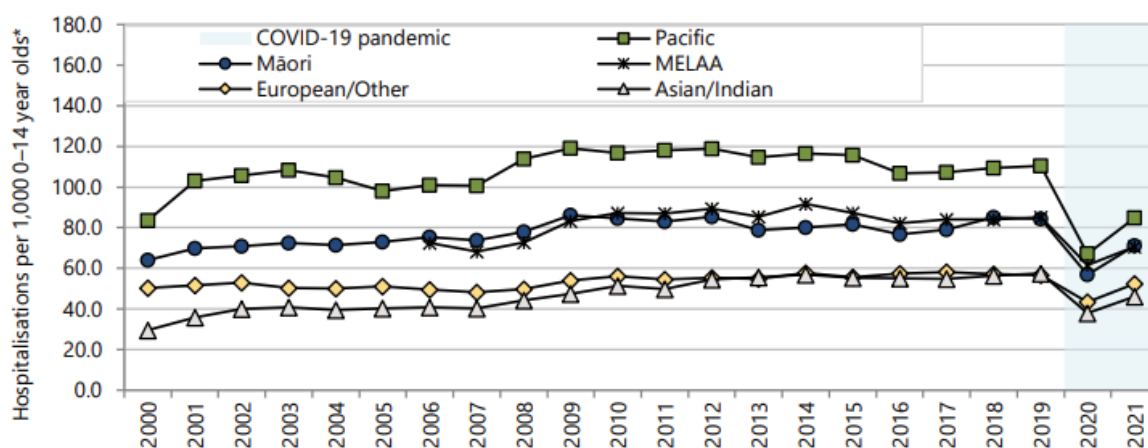
Reproduced from [PMMRC 2021](#)¹⁷

As well as poor housing, nutrition and education, the toxic stress of poverty can also lead to other wellbeing challenges. For example, being systemically locked into poverty increases the likelihood of smoking and/or living with someone who smokes.¹⁸ This contributes to inequitable rates of smoking at the beginning of pregnancy for Māori.¹⁹

Pregnancy and birth: Inequitable rates of adverse health outcomes extend from pregnancy onwards for tamariki Māori. Pēpi with Māori birthing parents face increased risk during the antenatal period and are more likely to be stillborn, experience pre-term births, or die as newborns.²⁰

Disease: Tamariki Māori consistently experience inequitably high rates of potentially preventable hospital admissions for respiratory conditions and infectious diseases compared with non-Māori/non-Pacific children.²¹ Many potentially avoidable hospital admissions for poverty-related infectious diseases such as serious skin infections, respiratory infections such as bronchiectasis (chronic lung damage), influenza, pneumonia and gastroenteritis are higher for Māori children than for Pākehā children. The gaps for all medical conditions, and for injuries, have continued over the past two decades, as Figure 2 demonstrates.²² Māori children are 40 times more likely to be hospitalised with rheumatic fever than Pākehā children.²³

Figure 2. Potentially avoidable hospitalisation rates, 0–14 year olds, by ethnicity 2000–2021.²⁴



Reproduced from [Child Poverty Monitor 2022](#)²⁴

Disability: Tamariki Māori experience high rates of disability. In the 2013 Disability Survey, it was reported tamariki Māori experienced a disability rate that was 36% higher than the overall child disability rate²⁵ – and even this inequitably high rate faced by Māori is likely to be under-reported due to identification barriers and access barriers (see CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs).

Mental health inequities: Using diagnoses as proxies for mental health need is likely to under-report inequities, as there are inequities in identification of mental health need for Māori.²⁶ Using self-reported distress, Māori children aged 14 years and under are more likely than any other reported ethnic group (Pacific, Pākehā/Other, Asian) to consult whānau or friends “for mental health” in the past year (13.1% vs 8.7% overall).²⁷

The Youth2000 study found that mental health needs increased inequitably between 2012 and 2019, including for rangatahi Māori.²⁸ The “What about me?” survey found rangatahi Māori experienced discrimination because of their ethnicity; were more likely than other ethnic groups to also experience discrimination because of their gender or sexual identity; and rated most aspects of their school life experiences lower than other young people. They also worried about their whānau’s household bills (kai, housing, transport) more than Pākehā young people.²⁹

Child Poverty Action Group acknowledges the mamae and pain that any suicide represents, for the victim and for whānau, friends and community. Rates of hospitalisation for intentional self-harm events have increased 3-fold for Māori aged 0 to 19 since 2001³⁰ and, while those hospitalisation rates are similar to those of Pākehā, Māori face inequitable rates of self-reported self-harm and thoughts of suicide for high school students³¹ as well as completed suicides for rangatahi aged 15 to 24 (2.25 times the rate for Pākehā).³² This has been identified as a significant concern within the community.³³

When asked “What is one thing that would make things better for young people you know who have a hard time or who feel bad?”, one Māori rangatahi tane, aged 14 years, responded: “Make the kids not live the life they may have been in [...] (e.g. struggled and had nothing when they were young).”³⁴

Contributing factors to these inequities include social determinants of health, such as poverty, discrimination, and limited access to health services including culturally appropriate mental health services. (See CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs.)

BARRIERS REQUIRING POLICY ACTIONS

Tamariki Māori face more barriers than non-Māori to primary healthcare, outpatient care, medicines and laboratory investigation.³⁵

- **Primary health care:** Hospital admissions, largely preventable with timely assessment and treatment, highlight ongoing barriers to effective primary healthcare.³⁶
- **Antenatal care:** The system provides Lead Maternity Carers at a lower rate to Māori birthing parents, in part due to factors associated with poverty.³⁷
- **Disability support:** Māori access to Ministry of Health Disability Support Services and to social support such as the Child Disability Allowance has been increasing but is still low.³⁸
- **Mental health:** It is likely that rangatahi Māori are under-served by the mental health system because of significant under-reporting, assessment, and treatment of emotional conditions relative to non-Māori, non-Pacific youth. Mental distress of rangatahi Māori is less likely to be identified until distress symptoms become more severe and explicit (such as self-harm injuries). There is also likely to be a shortage of culturally appropriate mental health services for rangatahi.³⁹

RECOMMENDED POLICY ACTIONS

Across all of the pathways recommended below are these principles as tuāpapa (foundations):

1. Address the Crown's obligations under Te Tiriti for health and equity.
2. Empower whānau, hapū, and iwi Māori to exercise leadership in setting directions and making decisions about their health.
3. Integrate Te Ao Māori solutions within care models for whānau.

Hāpori/Communities, whānau, and individuals:

- Implement comprehensive initiatives that tackle social determinants of health, including supporting whānau to access safe and secure housing, reducing child poverty, and expanding access to quality early childhood education. (See CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs.)
- Increase investments in health-promoting interventions that create healthier environments, prioritising nutrition, physical activity, and preventive measures including equitable childhood vaccination rates, and oral health promotion. (See CPAG 2023 Policy Briefs at www.cpag.org.nz/policybriefs.)
- Foster permanent partnerships and fund them on a long-term basis, between healthcare services and community organisations to improve outreach and access to care for Māori populations.

- To address mental health inequities, develop and fund targeted interventions, such as mental health services grounded in Te Ao Māori, early intervention programs, and community-based support networks, which are specifically designed to meet the unique needs of tamariki Māori and their whānau.⁴⁰ This is crucial.

Youth2000 identified six wellbeing requirements for rangatahi Māori: pride in whakapapa; aroha for whānau and tupuna; connection to whenua; time with loved ones; holistic care for body, mind, heart and spirit; and growth through shared experiences and trying new things.⁴¹ The 2022 Taitamariki Declaration calls for “spaces in which cultural and spiritual wellbeing is prioritised for youth”.⁴²

Healthcare providers and services:

- Develop and promote health outreach approaches within Te Ao Māori settings, such as Kōhanga Reo, Māori early childhood care and education, kura kaupapa and marae, to enhance healthcare access and health promotion activities for tamariki Māori and their whānau. These initiatives should be supported by adequate and sustained government funding. These approaches can build on existing relationships with whānau within these settings, to increase engagement and trust in healthcare services and health promotion activities.
- Mandate nationally consistent cultural safety training for healthcare professionals,⁴³ and increase the proportion of Māori in the healthcare workforce to better mirror the communities they serve.
- Enhance funding for Hauora Māori providers to ensure tamariki Māori have equitable access to kaupapa Māori healthcare services, including equitable access to midwifery services and antenatal care.
- Invest in wrap-around support for whānau with support that is tailored to their individual needs and aspirations.

Health system and cross-sectoral actions:

- Develop a Child Health Strategy within the system reforms that includes a focus on addressing the social determinants of health contributing to health inequities.
- Embed actions for Māori child health equity within the future NZ Health Strategy, Child Health Strategy, Te Pae Tata NZ Health Plan, and the Hauora Māori Strategy.
- Strengthen system monitoring and accountability for Māori child health equity by health authorities including Te Aka Whai Ora and Manatū Hauora (Ministry of Health).
- Increase health funding for tamariki Māori to a level that promotes equitable child health outcomes.
- Increase funding for research into health inequities specifically focusing on tamariki Māori.
- Ensure that the Health and Disability System meets the needs of tangata whaikaha (disabled Māori), including disabled tamariki Māori and their whānau.

IMPACTS AND INDICATORS

If implemented, these actions would be steps towards moving Aotearoa to be a nation where all children and families flourish free from poverty.

They would assist us to make significant strides towards achieving health equity for tamariki Māori across all health measures:

- **Sustaining hauora:** Addressing the social determinants of health, such as poverty and inadequate housing, is a key enabler to improving equitable health outcomes of tamariki Māori, and preventing many health challenges before they become more serious.
- **Guaranteeing access to trusted, appropriate care:** Increasing funding for Hauora Māori providers can contribute to greater access to Te Ao Māori solutions and services, including access to midwifery, antenatal care, and mental health services.

Eliminating health inequities for tamariki Māori will assist the Crown in addressing:

- Te Tiriti o Waitangi obligations, including health equity⁴⁴
- Targets for UN Sustainable Development Goal 3: “Ensure healthy lives and promote well-being for all at all ages”⁴⁵
- Obligations under the UN Declaration on the Rights of Indigenous Peoples, including (but not limited to), Article 24, ii: “Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.”
- Obligations under the UN Convention on the Rights of the Child, Article 24: “recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.”⁴⁶

And they will help us all realise the national vision “that New Zealand be the best place in the world for children and young people”.⁴⁷

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