



Whangai Hauora – to adopt and nurture

Progressing healthcare
outcomes for Māori



By past Auckland District Health Board member,
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In 1995, I was hospitalised after experiencing heart palpitations. It turned out that 75% of a heart artery was blocked, and I ended up having a double bypass. I was only 49-years-old, so doctors wanted to know 'Why so young? Did you have rheumatic fever as a child?'

I didn't know. A large number of my family were dead from diseases like tuberculosis, so there was nobody to share that information with me. Then in 2005, I had a relapse and another triple bypass. Admittedly, I had some weight issues.

This time, however, when I presented myself to the doctor, I introduced myself formally, in Te Reo. I saw his expression change, it was as if he was looking at me with new eyes. Suddenly, it seemed as if he understood me, the person I am – a living human being with a past and a future; a man with tamariki and mokopuna.

From that moment, there existed a relationship between me and my doctor that was founded on mutual respect. In a way he adopted me, accepting responsibility for my health and, importantly, he began to believe in me and my ability to get healthy. His support and belief was key in my recovery. We would hongi when we met, and we were able to openly talk about things like cost when we met because there was a new understanding between us.

I have not had a relapse.

You may think that this is a no-brainer.

Doesn't this kind of relationship exist between all patients and their doctors? In some instances,

it does – where a patient and a doctor manage to connect at a personal level – but by and large it does not. With the sheer volume of patients and workload that health services undertake, one could suggest that a relationship between patients and healthcare providers is almost impossible, especially when it comes to crossing the cultural divide (where it exists), between a doctor or a nurse and the patient.

Productive way forward

In many ways, the New Zealand health system is based on the European health system. Influenced by the industrial revolution of mass production and mass processing, there can be a tendency for people to be seen as units in a production line; it can be organised, time bound, no-nonsense, authoritative – all that is required to be efficient and effective.

The system may say, for efficacy and efficiency and for ethical reasons, there must be boundaries.

Except it isn't working very well for some, particularly for those cultures, such as Māori, whose culture was not heavily influenced by the industrial revolution. We can see this from the results as they stand today.

Disparities in primary health outcomes for Māori are well

documented. Māori live shorter lives, are twice as likely to die from cancer and heart disease, twice as likely to have diabetes and 1.4 times more likely to have high blood pressure – despite the best efforts of Government and health care providers over the last couple of decades.

Identified barriers

Increases to funding, healthcare subsidies, greater localisation of services, Māori representation at DHB and PHO level, health education for Māori – even cultural education for doctors and nurses – and a drive to recruit more Māori healthcare practitioners have resulted in some gains but, for the most part, they have failed to achieve parity in primary healthcare outcomes for Māori.

Some of the barriers that have been identified include social, cultural, economic and geographical. The reality remains, however that, short of free healthcare, economic affordability is always going to be a challenge for Māori when



you consider that more than half of children who live below the poverty line are Māori. With lower average salaries than non-Māori and higher unemployment, even paying \$5 for medicine is a stretch for many Māori (never mind GP's and other fees).

While access in terms of cost, education and geographical location are important, even where primary healthcare has been offered virtually free, the uptake by Māori has not shown as significant an improvement as we have desired.

There has been some discussion about addressing social and cultural barriers to primary healthcare, but the concept is intangible. One solution was greater Māori community representation in healthcare, but this alone is clearly insufficient.

Fixing some of these issues is important but, to an extent, they are red herrings which take us away from the real issue.

The real issue is that we need change at a social and service level in primary healthcare.

Adopting the cultural divide

The culture and traditions of Māori, along with many other indigenous peoples around the world, are vastly different from the European, industrial revolution-based ways of acknowledging and engaging with people.

For Māori there are no boundaries. Nothing is impersonal. Everything is related and

interconnected. It is how we understand our relationship to all things, as well as our place in the world. Whakapapa is an expression of our need for kinship with the world.

Rituals, such as various forms of greeting, have existed and flourished amongst Māori and other indigenous people – including Europeans pre-industrial revolution – to break down boundaries; a way to welcome each other and acknowledge our shared humanity.

Why do Māori hongi? Why do we exchange breath? The hongi is a ritual greeting; an expression of unity and belonging, and importantly, adoption. Hold on to this word 'adoption' – it is important.

The hospital, a clinic, or GP's rooms can be intimidating places for Māori. Places associated with illness, not wellness. Healthcare structures in New Zealand are based on Western practices and ideas – where greater value is placed on individualism, privacy and confidentiality. In some ways this is the exact opposite

of Māori identity, which is intrinsically entwined with family, community and tribe.

For Māori, the individual's health concerns are not their own. They are the concern of the whole Whanau.

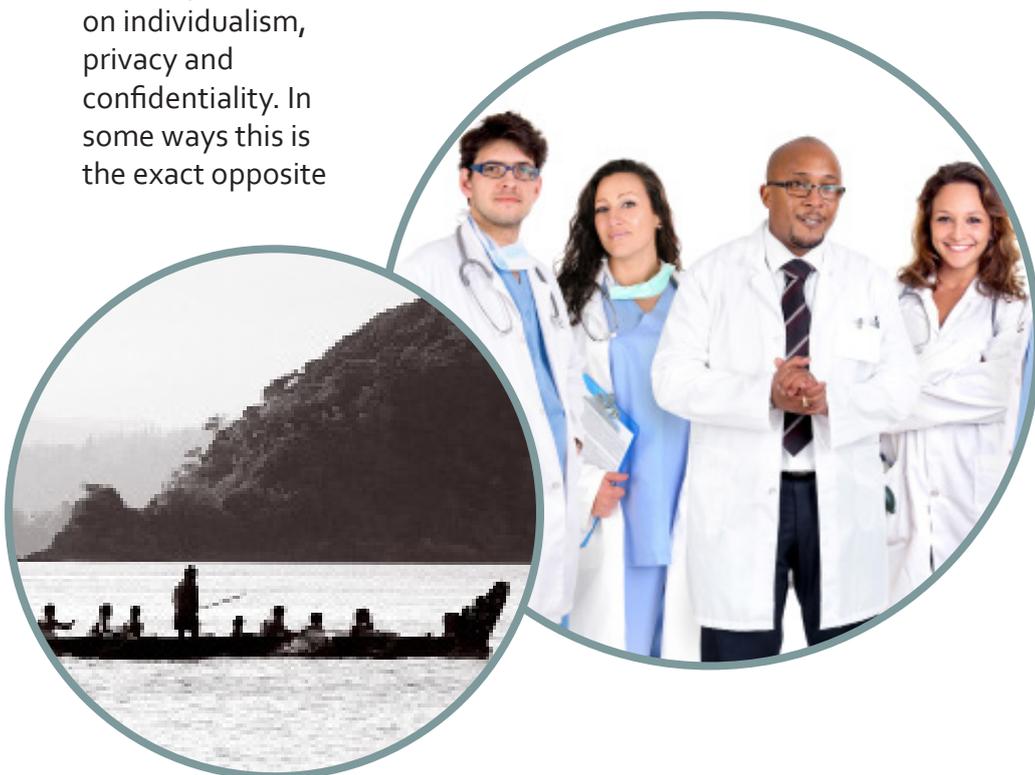
Clearly, it is time to evolve the Western model of healthcare. It is time to acknowledge, and come to grips with greater adoption of Māori culture, affiliations and community identity – the Māori worldview – in how we deliver services as primary healthcare level.

It is time for Whangai Hauora.

Whangai Hauora

Whangai means to 'adopt and nurture'.

By bringing the concept of Whangai into the primary healthcare 'system', we will shift the social dynamic, between those delivering healthcare and those receiving it, to one that is more socially dynamic.



Forecasting the future

It is interesting to observe the dynamic between a child and a doctor, or a child and a nurse. In some cases, the healthcare worker will go to extraordinary lengths to secure the co-operation of a child in their own treatment.

Take for example the case of a little girl who had a suspected broken arm. She held the arm against her body and would not, for any reason, allow any of the nurses or doctors to examine the arm to determine whether it was broken.

Then one of the nurses offered her a popsicle in her favourite flavour. The little girl immediately reached out with the suspected broken arm to take the popsicle – an important step in her treatment.

This example is not to suggest that doctors and nurses offer their adult patients popsicles, but simply to suggest that the healthcare providers went to extraordinary lengths to break down barriers to engage the child and advance her treatment.

Why do we not put in similar efforts to engage adult patients and break down barriers, to help them achieve healthcare outcomes?

The evidence is pretty solid when it comes to proving that greater patient engagement in their healthcare improves outcomes. Whangai can help us achieve this deeper level of clinician/patient collaboration.

The benefits of Whangai are better patient experience, better population health – particularly among Māori – and most likely lower overall healthcare costs.



The way forward

We need a system with Whangai that is more personal and which acknowledges and engages patient and clinician differently. For example:

1. The patient needs to be better equipped to express their Wairuatanga and the confidence to act
2. Doctors and nurses need to be equipped with the appropriate tikanga that acknowledges patients and allows them to feel equal, engaged, adopted, and nurtured
3. Whangai adopt and nurture at service level needs to be accepted as the cornerstone of future development

The aims are:

- Better patient experiences
- Better clinician experiences
- Improved health outcomes
- A change in thinking within the healthcare system

This paper does not pretend to know all the answers about how Whangai may be implemented. What it does do is propose that we need greater 'social' engagement with Māori in a way that acknowledges their wairua and whakapapa – a healthcare system built on relationships, not units in production – and that there is a Maori concept that can underpin that change.

Next steps

1. Communicate with potential relevant groups of interest
2. Encourage the political will for Whangai to emerge
3. National consultation to how Whangai could work
4. Secure the buy-in of the healthcare industry
5. Implementation at primary healthcare level



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