The development of Māori primary care services

SUE CRENGLE*

Abstract

This paper provides a broad overview of the development of Māori primary care services over the last decade and an outline of the current scope of Māori primary care services. The paper also recognises the number of challenges and opportunities that face Māori providers and will briefly discuss three that are relevant to all providers: frameworks, information and effectiveness. Developing frameworks for contract specification and performance criteria that reflect Māori models of health and well-being, intersectoral approaches and the use of kaupapa and tikanga Māori in service development and delivery is a major challenge. Current approaches, while acknowledging these areas, for example in contracts, are based within the frameworks of a Western medical model. We have yet to clearly identify how we can meaningfully incorporate these philosophical and practical approaches to providing services into contractual arrangements. Providers have identified a need for information. The providers pass significant amounts of information to the funding agency, however many feel that very little information is returned from the funding agencies to the provider organizations. These providers could well use information feedback from the funding agency when they are reviewing and developing their services. There are also other types of information, for example having access to detailed local epidemiological and demographic information, that would be very useful to providers who are reviewing existing programs and developing new services. The third 'universal' challenge is the need to begin to collect information about how effective current Māori health strategies are, and how effectively services are caring for Māori clients. Developing information on effectiveness could utilize a multi-faceted approach, with information being collected at the provider level as well as at population level. Other questions relate to the effectiveness of our health promoting, disease preventing or disease management interventions. These points are relevant to all providers, but information on the effectiveness of mainstream health services is just as limited. The disparity between Māori and non-Maori health status however, suggests that these services (both public and personal health services) have not been as effective as they could have been.

Introduction

This paper provides a broad overview of the development of Māori primary care services over the last decade, outlining the process, the current scope of Māori primary care services and the current challenges and opportunities. In 1999, the National Health Committee began a work program that examines primary health care services in New Zealand. As part of this program, a discussion paper about Māori primary care services [1] was prepared that forms the basis of this current paper. The views contained in both the paper for the National Health Committee (NHC) and this paper are those of the writer and do not reflect the views of the NHC.

The opportunity afforded was quickly grasped; both by Māori organizations that had provided health services in the past and by organizations who were entering the arena of health service provision for the first time.

This paper will use the definition of primary care services provided by the National Health Committee[2], that primary care is 'local, first contact care for people that is accessed by self-referral. It compromises a range of services, delivered by a range of health practitioners, designed to keep people well and out of hospital, from the promotion of health, screening for disease to diagnosis and treatment of medical conditions'.

*Harkness Fellow in Health Care Policy, Johns Hopkins School of Public Health / Director, Tomaiora Research Group,, Private Bag 92019, Auckland.

The development of Māori primary care services

Prior to the health reforms that were announced in 1991, Māori involvement in the provision of primary care services was limited. One marae based General Practice clinic was in operation. Although Māori were more involved in the provision of health promotion and education programs and services in community based settings, these services were still limited in number and in the scope of their activities[3].

The Government objective for Māori health stated that Māori should have *'...have the opportunity to enjoy at least the same level of health as non-Māori...'*.[4] One strategy that was immediately implemented was the opportunity for Māori organizations to contract with the (then) Regional Health Authority (RHA) to provide primary care services.

Māori groups and organizations had, for many years, expressed the belief that existing services were not adequately meeting the health needs of the Māori community and also voiced the belief that Māori services could achieve better health outcomes given the opportunity and timeframe necessary to see outcomes[5]. The opportunity afforded was quickly grasped; both by Māori organizations that had provided health services in the past and by organizations who were entering the arena of health service provision for the first time. Over the subsequent seven years the focus of the Health Funding Authority (previously RHA) evolved from assisting providers to enter the arena to provider development (assisting the providers to develop capacity) and workforce development. More recently two further changes to the Health Funding Authority's (HFA) approach have been apparent. The first is the identification of 'preferred providers'. Preferred providers are provider organizations that the HFA prefers to contract with. Characteristics of preferred providers include that they have a pre-existing track record with the HFA, and have pre-existing contracts valued over a certain amount of money. Secondly, the HFA has begun to address the responsiveness of non-Māori health service providers and the primary care they provide - the so-called 'mainstream - to Māori health priorities and the needs of Māori patients within these services.

... despite the development of Māori primary care services, most Māori are still seen within 'mainstream' services.

The scope of Māori primary care services

What then do Māori primary care services 'look' like today? It is not possible to describe a 'typical' Māori primary care service, as the typical model does not exist. This lack of a typical model reflects one of the key features of the Māori primary care services. That is, they have developed from within the communities they serve, with an understanding of the health needs of that community. Consequently, while there are similarities between different services, no two are identical. This paper will attempt to describe the range of primary care services, highlighting similarities and differences.

Who delivers Māori primary care services?

Māori primary care services (referred to as Māori services in the remainder of the article) are located within a variety of Māori organizations including iwi (tribal), hapū (sub-tribal) and urban Māori groups, as well as organizations that are located within Māori communities but do not have an affiliation with an iwi, hapū or urban Māori group. All the organizations are governed by Māori. Irrespective of the type of organization they are located within, all Māori primary care services have structures and mechanisms in place that enable the community to have input into the development and function of the service, ensure that the services are accountable to the community, and provide a vehicle for local community health concerns and needs to be brought to the attention of the health services.

The size of health services varies. Some services deliver program(s) that cater to a few hundred people per year. Others have fully fledged General Practice clinics that care for thousands of people as well as providing community health programs to many more members of the community. The HFA had in recent times developed its preferred provider strategy. The preferred providers tended to be the larger providers who had the capacity to deliver many of the programs/services described below.

Māori are situated in a number of different geographical locations ranging from high-density urban locations to very rural regions. Some services cover geographical areas that include a mixture of towns and rural environments. The geographical area covered by the health services can pose specific challenges. This is particularly so for health services located in rural areas that may have greater problems attracting staff (both permanent and to cover staff holidays and time away for continuing education). Clients of rural services may face specific challenges as well, particularly relating to distance from facilities and transport. Solutions adopted to counteract some of these challenges (for example satellite static and mobile clinics) may be more costly to run than similar approaches in urban areas.

Who are they delivered to?

Māori people are the major users of Māori primary care services. The demographic characteristics of Māori clients

using these services match the demography of Māori around the country. There are higher numbers of children and young people, and fewer older people. Many of the clients have low incomes. The health status of Māori involved with Māori health services reflects national statistical information about Māori health status. Information on the health status of Māori is widely available and not repeated here. Non-Māori clients also utilize these services, particularly General Practice services located in urban areas. Many of the non-Māori clients are from lower income families. Some have specific health needs, for example, recent immigrants especially refugees. It is also important to remember that, despite the development of Māori primary care services, most Māori are still seen within 'mainstream' services.

What are the key features?

Prior to and during the early phases of development of Māori primary care services, the need for services that were appropriate for Māori clients and their needs, acceptable to Māori people, accessible, affordable and high quality were often heard. The three key features described below, in my opinion, define Māori primary care services and are important facets of Māori services' strategies to implement these objectives.

... three features of Māori primary care services can be identified: the use of a Māori model of well-being, positive Māori development and kaupapa / tikanga Māori.

The first is that a Māori model of health (rather than the Western illness focused model) is used as a basis for developing and delivering health services. The most widely used model is that of 'Te Whare Tapa Whā' describes four dimension of health: taha wairua (spiritual health), taha tinana (physical health), taha hinengaro (mental health) and taha whānau (family health)[6] This model forms the basis of the philosophical approach to service delivery adopted by many Māori services, which emphasizes well-being in all four spheres of health.

Secondly, as documented at the hui Te Ara Ahu Whakamua, Māori working within the health sector believe that health cannot be separated from economic, cultural, education and employment factors which impact on the health of an individual and their family.[7] Most Māori providers believe that attention must be paid to these determinants in order to maximize the well-being and health of Māori. Thus, health gain is seen as inextricably linked with positive Māori development. Positive Māori development refers to Māori social, economic and cultural advancement within a framework of Māori self-sufficiency and Māori control[8]. The development of Māori health service providers is itself an important step forward in Māori development. In addition to development at an organizational level, providers aim to support positive Māori development at the individual level by addressing clients' needs in educational, employment, social, cultural and related spheres in addition to the immediate health needs. These two characteristics (a holistic approach to well-being and positive Māori development) may pose challenges to funding and policy authorities. In particular contractual specifications and purchasing frameworks may not be able to adequately encompass the approaches of many providers

The third characteristic is that the development of services and their subsequent delivery are undertaken utilizing kaupapa and tikanga Māori. One of the effects of these philosophical and practical approaches to service development and delivery is to increase the appropriateness and acceptability of the programs to those who are served.

What is delivered?

Māori primary care service providers deliver a wide range of programs. It is convenient to arbitrarily categorize services in the manner undertaken below. However, in reality there may be overlap between different programs. For example, a youth focused community health program may provide clinical services from a nurse and/or doctor as well as health education from community health workers and/or nurses.

The range of programs that may be delivered in a Māori primary care service includes:

- Community health programs focusing on health promotion, health education and screening. Programs may focus on specific population groups or on specific topics, conditions or diseases. Examples of programs include well child programs, womens' health (cervical and mammography screening), youth health, elder health, asthma, diabetes and nutrition.
- Intervention and/or clinical services, for example midwifery services, general practitioner services, dentistry and counseling for specific issues such as sexual abuse, alcohol and substance abuse.
- Disability support services. Examples include home help for the elderly, sheltered workshops and residential care for people with physical and intellectual disability.
- Mental health services such as community support services, respite and residential care.
- Traditional healing services may be provided within the Māori primary care service or through referral to a traditional healer.
- Training and workforce development. Several providers also deliver training programs. Examples include training for iwi or community support workers in the disability and mental health areas and community training programs in nutrition and child health

Table 1. Barriers to care and solutions used in Māori primary care services

Barrier	Solution
Financial barriers: ¤ Unable to afford user co-payment for GP ¤ Unable to afford prescription co-payment	¤ Markedly cheaper co-payments. E g. all children under 16 years free, reduced co-payments for adults with and without Community Services Card (CSC) ¤ Agreement with local pharmacist that co-payment will be discounted by effectively making drugs free for those with CSC and reduced for those without CSC.
Geographic and transport barriers to reaching service (whether GP or health promotion/education)	¤ Use of mobile clinics and satellite clinics to improve access and reduce cost of accessing services for client. ¤ Transport of patients to site of clinic / service.
Lack of knowledge of health issues, screening programs, how to access health information	¤ Providing these services in a wide variety of locations, venues and community activities e.g. on marae, at hui, sports grounds, cultural festivals, educational and childcare institutions etc. ¤ Providing information in ways that are easily understood and appreciated by Māori
Barriers within the healthcare system: ¤ Inability to receive care at the time it is needed ¤ Failure to effectively identify and reach those at risk ¤ Limited follow-up ¤ Lack of confidence/inability to negotiate aspects of health system e g. out-patient clinic appointments etc.	¤ Flexibility with appointment systems ¤ Ability to walk-in and be seen. ¤ Provision of services in satellite clinics or in mobile clinics · Proactive outreach using a variety of locations and methods · Proactive follow-up utilizing health service staff and community networks ¤ Integration of community health and general practice services with a focus on health promotion and education ¤ Assistance with these types of appointments, including staff attending clinic with the person
¤ Cultural barriers such as failure to provide health information in ways that are appropriate for use in Māori communities ¤ failure to provide services that are appropriate and acceptable to the clients	¤ Delivery of services using Māori cultural practices and beliefs ¤ Employment of Māori staff ¤ Presentation of information in ways that are appropriate and acceptable for use with the Māori community ¤ Use of resources which are appropriate and acceptable for use with the Māori community

Decision making about which programs to deliver, particularly in the early years post-health reforms, was driven by an awareness of the health needs of the local community informed by local knowledge rather than formal health needs assessments or epidemiological information. More recently providers have expressed a need for information that can be utilized to inform decision-making about service development at the local level.

How are services delivered?

As discussed earlier three features of Māori primary care services can be identified: the use of a Māori model of well-being, positive Māori development and kaupapa / tikanga Māori. These features are instrumental in ensuring that services are culturally acceptable to Māori clients. However, cultural barriers are not the only barriers that may face Māori clients. A variety of barriers that challenge minority and / or low income people have been identified[9,10,11,12,13,14]. Table 1 identifies these barriers and also provides an example of the way in which Māori primary care services attempt to overcome these barriers.

Providers who deliver a limited range of the programs are able to refer to other groups or organizations to ensure that clients who have needs in health, social, training, employment or other similar services have their needs met. In the case of large, multifaceted organizations these services may be provided from within. In other instances these services may be available from external organizations or agencies.

During the final years of the Health Funding Authority, some Māori providers groups were involved in the development of Māori Integrated Care Organizations (MICO). These organizations provided a variety of management and administrative functions to the providers who joined the organizations. It is not clear how these organizations will evolve in the moderate to long term as there is further development of Māori health services at both the funding agency level and within the provider organizations.

Where are they delivered?

Māori providers deliver community health programs in a variety of sites including marae, in the services offices/ buildings, mobile clinics, peoples' homes, kohanga reo and educational institutions, at sites of hui, sports or cultural events, and at other local community events and venues. While the diversity of sites applies particularly to community health programs (health promotion, education, screening and well child programs), general practice (GP) services are also provided from a variety of venues. Many services offer GP services in static clinics away from the base clinic, or in mobile vans fitted out to function as mobile surgeries.

The use of a diverse range of sites has a number of implications for service providers. Firstly, resources (community networks, staff, time, and money) are required in order to identify opportunities for community health program activities, and the subsequent organization and undertaking of these activities. Similar resource requirements are necessary for delivering GP clinics at outreach sites or in mobile clinics. These clinics are also more costly in terms of staff resources as time is spent traveling to and from outreach sites. However, the use of such clinics and a variety of sites for delivering community health programs also has a number of advantages. Community awareness of the health issues relevant to the community health programs is heightened and it is likely that these messages reach a wider audience than they would if a more limited approach was adopted The profile of the provider is also raised, and more people become aware that Māori service providers are available should they wish to access them. Increased access to general practice care is also a major benefit to outreach general practice clinics. During outreach general practice clinics computerized notes are usually necessary in order to ensure that preexisting information is available, and to ensure that information is kept up to date

The disparity between Māori and non-Maori health status however, suggests that these services (both public and personal health services) have not been as effective as they could have been.

How are they doing?

Information about the impact, outcomes and effectiveness of Māori primary care services is currently limited although there is some information to suggest that these services are having a positive impact on some health indicators[15]

Challenges and opportunities

A challenge also represents an opportunity. A number of challenges and opportunities face Māori providers. Some are universal and faced by all. Others are more specific to providers and may arise because of geography and/or the size of providers. In this paper I will briefly discuss three that are relevant to all providers: frameworks, information and effectiveness. The reader is referred to Maori Primary Care Services: A Paper Prepared for the National Health Committee[1] for more detailed information about challenges and opportunities that are not discussed here.

Developing frameworks for contract specification and performance criteria that reflect Māori models of health and well-being, intersectoral approaches and the use of kaupapa and tikanga Māori in service development and delivery is a major challenge. People at all levels of the Māori health sector including policy makers, those who work in funding agencies, service providers and members of the community will need to be involved in these processes. Current approaches, while acknowledging these areas, for example in contracts, are based within the frameworks used in the past (Western medical model). That is, we have yet to clearly identify how we can meaningfully incorporate these philosophical and practical approaches to providing services in to contractual arrangements.

Providers have identified a need for information. Several areas of information are discussed. Firstly, the providers pass significant amounts of information to the funding agency. However, many providers feel that very little information is returned from the funding agencies to the provider organizations. These providers feel that they could use information feedback from the funding agency when they are reviewing and developing their services. Concern has also been raised about how the information obtained from the providers is used, what safe guards are in place to ensure that it is not used for purposes other than what is was collected for, and whether it is ethical to collect and store information that is not used for any purpose.

There are also other types of information that, if available to providers, could facilitate the development and delivery of their programs. For example having access to detailed local epidemiological and demographic information would be very useful to providers who are reviewing existing programs and developing new services. Such information, if it were available, would complement the provider's local knowledge and understanding of the health needs of the community. Māori providers have been more community oriented than other (non-Māori) primary care providers. Māori providers today are well positioned to develop and incorporate elements of 'community-oriented primary care'[16 17 18]. To do so would require the more detailed information, as described above, about the communities that they serve.

The third 'universal' challenge is the need to begin to collect information about how effective current Māori health strategies are, and how effectively services are caring for Māori clients. As stated earlier, information on the effectiveness of Māori health services is quite limited. Developing information on effectiveness could utilize a multi-faceted approach, with information being collected at the provider level as well as at population level. As we begin to consider collecting information on effectiveness we also need to answer several other questions. Firstly, what are measures of effectiveness in Māori health? Should the beliefs, values and methods in the discussion on frameworks for contracts be incorporated into measures of effectiveness? If so, how will they be incorporated?

Other questions relate to the effectiveness of our health promoting, disease preventing or disease management interventions. For which health promoting, disease preventing or disease management interventions will we measure effectiveness? How will we measure the effectiveness of these interventions? What is the evidence that currently recommended practices have measurable effects on long term health status? These points are relevant to all providers, but information on the effectiveness of mainstream health services is just as limited The disparity between Māori and non-Maori health status however, suggests that these services (both public and personal health services) have not been as effective as they could have been. It is imperative that all providers are subject to the same level of scrutiny for effectiveness that Māori providers are.

The health reforms have offered Māori the opportunity to participate in the health sector as health service providers. Many groups and organizations took up that challenge and spent the next seven years developing and implementing their services. For those involved in these services it has been an exciting and challenging time as they have 'learnt on their feet' and forged new roads in the development of primary health care. The environment still has new challenges, and the opportunity to improve Māori health and further Māori health development as these challenges are met

Acknowledgements

I remain extremely grateful to everyone who shared their opinions and experiences for the original paper written for the National Health Committee.

References

1 Crengle S (1999) *Māori Primary Care Services. A Paper Prepared for the National Health Committee.* http://www nhc.govt nz/pub/phc/index html

2. National Health Committee (1999) *NHC Primary Health Care Work Programme*

3 Durie M (1994) *Whaiora: Māori Health Development.* Oxford University Press

4. Department of Health (1992) *Whaia Te Ora Mo Te Iwi: Strive for the Good Health of the People.* Department of Health, Wellington

5. Department of Health (1984) *Hui Whakaoranga: Māori Health Planning Workshop.* Department of Health, Wellington

6. Durie M. (1985) *A Māori Perspective of Health* Journal of Social Science and Medicine Vol 20; No 5 pp 483 - 6

7. Te Puni Kokiri (1994) *Te Ara Ahu Whakamua. Proceedings of the Māori Health Decade Hui, March 1994.* Te Puni Kokiri, Wellington

8 Durie M , (1992) *Māori development, Māori health and the health reforms.* Paper presented at Hui Hauora a Iwi, Takapuwahia Marae, Porirua 11/4/92

9 Benzeval, M , Judge, K , and Whitehead M. (Eds) (1995) *Tackling Inequalities in Health. An agenda for action.* Kings Fund, London

10 Riportella-Muller, R , Selby-Harrington, M., Richardson, et al (1996) *Barriers to the Use of Preventive Health Care Services for Children.* Public Health Reports January/February 1996, Vol 111, pp 71-77

11. Margolis, P., Carey, T , Lannon, C., et al. (1995) *The Rest of the Access-to-Care Puzzle: Addressing Structural and Personal Barriers to Health Care for Socially Disadvantaged Children.* Archives of Pediatric and Adolescent Medicine, May 1995, Vol 149: pp 541-545

12 Schorr, L (1989) *Within Our Reach: Breaking the Cycle of Disadvantage.* Anchor Press/Doubleday

13 Ginzberg, E. (1994) *Improving Health Care for the Poor: Lessons From the 1980s.* Journal of the American Medical Association February 9, 1994 Vol 271: No 6. pp 464-467

14. Adler, N., Boyce, W., Chesney, M , et al (1993) *Socioeconomic Inequalities in Health: No Easy Solution.* Journal of the American Medical Association Vol 269, No 24. Pp. 3140-45 June 23/30 1993

15. Crengle S. (1997) *Mā Papatuanuku, ka Tipu ngā Rākau. A Case Study of the Well Child Health Programme Provided by Te Whānau o Waipareira Trust.* Master in Public Health Thesis, University of Auckland, 1997

16. Abramson J (1988) *Community-oriented primary care - Strategy, approaches, and practice: A Review* Public Health Reviews 1988; 16: 35-98

17. Nevin J and Gohel M (1996) *Community-oriented Primary Care* Primary Care Vol. 23, No 1 pp. 1-15 March 1996

18. Garr D., Rhyne R, And Kukulka G. (1993) *Incorporating a Community-oriented Approach to Primary Care.* American Family Physician 47 (8) 1699-1702 June 1993.

HE KUPU HOU

he maremare	*a cough*
he kea	*phlegm*
he hemanawa	*dyspnoea*