REPORT OF A MEETING TO REVIEW MAORI HEALTH

CO-ORDINATED BY THE MEDICAL RESEARCH COUNCIL & THE DEPARTMENT OF MAORI AFFAIRS

Held at the Department of Medicine, Wellington Clinical School of Medicine,
Saturday, 12 September 1981

1. PARTICIPANTS, AGENDA AND RESOURCE MATERIAL

... Attached

2. REVIEW AIMS OF MEETING AND AGENDA

The Chairman for the meeting was Dr I.A.M. Prior, Epidemiology Unit, Wellington Clinical School of Medicine. After the customary welcomes the background to and aims for the meeting were outlined by Mr J.A.Borrows, and Drs E.W. Pomare and I.A.M. Prior.

The history of M.R.C. involvement with Maori health topics dates from the review paper prepared by Professor North in 1978, following which Dr Pomare was commissioned to produce the report "Maori Standards of Health" which was published in December 1980. Following a preliminary discussion of the report with representatives of the Department of Maori Affairs, and the Maori Women's Welfare League, and others, an informal meeting was convened by the Rev. Hone Kaa in Auckland in February 1981. The M.R.C., through its Forward Planning Committee, had particularly noted Dr Pomare's comment outlined on page 48 of the Report: "It should be stressed that the Maori is very sensitive to issues which affect his well-being and status within the community, and it will be necessary for him to see the logic behind any proposed studies or intervention programme and to see a clear benefit to himself. I see his co-operation and involvement in planning from the outset as being vital".

One of the main suggestions made following this informal meeting in Auckland was that Maori doctors should discuss the report further and consider the proposal that "Maori Doctor Task Forces" be set up to speak to the important Maori health issues at maraes, trust boards, etc. In order that this proposal be discussed further, the present meeting was convened. This was an historic occasion which for the first time brought together the majority of Maori doctors practising in New Zealand.

3. MAJOR OBJECTIVES FROM THE MEDICAL RESEARCH COUNCIL'S VIEWPOINT

These were outlined as being -

(i) To determine the priority that the Maori people themselves were placing on health and health research.

(ii) To determine which of any health priorities outlined would be amenable to possible solution by -

  (a) application of existing knowledge, eg intervention by appropriate agencies such as the Health Department or Maori Affairs Department.

  (b) Action by the M.R.C. in promoting suitable research.

(iii) To determine a ranking of the topics that were worthy of further research.

(iv) To encourage discussion by Maori doctors of the problems of Maori health and perhaps to increase their awareness of and inclination to undertake research.

4. THE POMARE REPORT AND HEALTH PRIORITIES

Dr Pomare outlined the major Maori health problems and indicated how these related to difficulties in Maori people coming to terms with a so called "Western" type of lifestyle. It was also noted that these problems were not peculiar to Maori people but were problems common to all New Zealanders. Over-nutrition was seen as an important risk factor in several common conditions, including hypertension, diabetes, coronary heart disease and gout. Smoking, likewise, was seen as an important cause of chronic lung disease, lung cancer and coronary heart disease. Alcohol, and particularly its relationship to motor vehicle accidents, was an obvious area for concern. In the young, accidents (motor vehicle accidents, drowning) were the most important cause of death whilst chest infections and asthma were also common. In the elderly, heart disease (I.H.D. and hypertension), lung disease (cancer and bronchitis), and metabolic disorders (diabetes, gout), were the important causes of morbidity and mortality.

It was strongly suggested that the current health problems were related to two major factors. Firstly, socio-economic differences, and secondly low self-esteem. In the subsequent general discussion, these factors were elaborated upon by several of the participants.

A study carried out by Professor Elliott in Auckland in 1975 was cited, indicating that for Socio-economic Class I the health experience of Maoris and non-Maoris in this category was identical. It was also pointed out that from the ages 1 - 5 years health statistics were quite closely related to socio-economic status (poverty) and not so much to the provision of health services per se, and that infant mortality rates were quite closely correlated with levels of unemployment.

The question of low self-esteem was spoken to with much feeling by Mrs Whiteside during the afternoon. The feeling of low self-esteem was felt in part to result from the imposition on Maoris of a majority Western culture which failed to recognise sufficiently a different set of cultural attitudes and values. It was also felt that lack of pride in oneself was a natural consequence of being socio-economically deprived. Low self esteem was seen as an important factor in the high incidence of smoking and alcoholism (in some communities) among Maoris. It was felt that an improvement in self-esteem was dependent both on an improvement in the economic status of the Maori and a greater involvement of Maoris in the decision making which affected their lives. Social and attitudinal changes were felt to be necessary preludes to the development of effective health care for Maoris.

Although much has been made of the disparity between Maori and non-Maori health performances, Professor Mantell reported that information obtained from Middlemore Hospital indicated that Maori babies did relatively well at birth in spite of the presence of significant adverse risk factors. For instance, a large proportion of these deliveries were "unbooked", their mothers were of low socio-economic status, 80% were smokers, and the majority of the mothers were young. Professor Mantell questioned the notion that Maoris were less healthy than Europeans and suggested that their poorer subsequent health record was related to the availability and effective use of the health services. He suggested there were problems in both the delivery of health care and communication, as potential services were readily available. It was suggested that an investigation into the economic barriers which prevented access to health care might be undertaken.

Dr Mason Durie indicated that most of the problems raised by Dr Pomare were in fact problems of dependence and that consideration should be given to an investigation into the differences in attitudes to "dependence" by different sectors of the Maori population, eg, Mormons. Dr Mason also felt there was a need to find out why it was that Maoris seemed to seek medical help at a relatively late stage. He also suggested that each Marae might consider having a health "counsellor" who was able to demonstrate to Maori people that many of their health problems were long-term, as was their treatment. This was to be contrasted with the one visit/cure consultation with the Tohunga.

One other problem area, which was singled out by Dr Stuart Walker for attention and further study, was that of asthma. Maoris suffered a disproportionate morbidity and mortality with this disease and aspects about the treatment or lack of treatment were discussed.

It became clear from both the morning and afternoon sessions that the concept of "Maori Doctor Task Forces" to address Maori gatherings in a formalised sense, was not an appropriate way to tackle the health problems discussed. However, it was strongly suggested that if we were speaking to Maori groups each one of us had an obligation to take a positive attitude towards health matters, making practical suggestions to improve health. To this end it was suggested that the Maori doctors both in the Auckland and Wellington regions should put their heads together once again and endeavour to develop plans to improve the health status of the Maori in the longer term. It was felt enough had been said about what was wrong with the Maori and the time had come to take positive steps forward.

5. COMMUNITY PROGRAMMES

The major part of the afternoon was occupied in a discussion of community based health services following a paper by Mrs L.R.Whiteside of Auckland. She gave her reaction and views from a "consumer viewpoint" about the delivery of health services to the Maori population, in particular in South Auckland. She spoke with much feeling about the difficulties faced by Maori people in this area and felt strongly that social and attitudinal changes were necessary preludes to the development of effective health care for Maoris. She did not feel that conventional intervention programmes were necessairly appropriate to the Maori and

that much time could be wasted in discussing changes to the delivery of health care when what was required was a fundamental recognition of the total problems facing Maori people today, health being just one. She talked of the negative response and patronising attitudes of many "health workers". In many instances, all that was required was a simple explanation of the problem at hand when more often than not no explanation was given. As a new Maori mother she felt completely downgraded as a result of her contact with the health services.

She then presented a model for a community based health service which was integrated with other cultural and community activities which promoted all aspects of Maoritanga, including language, arts and crafts, etc. These community, cultural activities were seen as the focal point, thus providing a warm and supportive environment. It was into this environment that health matters could be introduced. Support groups emanating from the community would be encouraged and would cover important areas such as adoption, abortion, child birth, etc. Natural and alternative methods of health care would be encouraged and education in health matters undertaken.

Dr Tipene-Leach, Auckland, spoke about aspects of the development of Australian Aboriginal health and the value of community based and "people run" health services. He made a strong case for development of a community centre in an area such as Otara that would provide a base for younger people in particular to visit, help direct, and which would provide resource help in health and other areas. The aim of such centres would be to give such people a greater sense of involvement and personal growth than they might without involvement in such a centre.

There was strong support for the development and trial of such a centre. It was felt that a working paper setting out requirements should be developed since funding would need to come from more than one source.

The proposal to train certain community leaders in areas of health promotion was also felt to be worthy of trial. Such community facilitators would be in a position to help people with health and medical problems and their management there.

The fact that Maori people may have a different perspective and priority on health was stressed by several speakers. Prof. Whata Winiata pointed out that health issues were probably of low priority from a Maori point of view.

One speaker felt that Maoris were a healthy race and that they had a need for a strong positive force working in the Maori communities that outweighed other factors such as shorter life expectancy. Pessimistic talk about poor statistics defeated this. It was also stated that a person could feel healthy even though a heavy smoker and overweight and it was only when an acute attack of gout developed with severe pain and disability that the subject would admit being ill and unhealthy. Once recovery has occurred he could continue with other silent problems without concern.

Dr Tamati Reedy mentioned that the Department of Maori Affairs were particularly interested and concerned about the state of Maori health and indicated their intention to try and raise the consciousness of health in Maori people. He mentioned a health consciousness promotion programme which would include a nationwide health day - "More for your Marae" - in October or November. This would be a fund raising exercise with health as a major theme.

As an adjunct to any educational exercise, it was suggested that audio-visual materials be prepared in a simple but interesting manner which could be shown on an ordinary television set and therefore be available to almost all Maoris. This material could be used by Maori doctors or others as resource material for health promotion during Marae or Kokiri visits.

6. CONCLUDING SESSION/RECOMMENDATIONS

This was an extremely useful meeting and an historic one as already pointed o Socio-economic factors and low self-esteem were felt to be major underlying reasons for the poor Maori health status and that basically socio-political changes were necessary to improve these factors. There also seemed to be serious problems in the delivery of health care, especially in urban areas. Community based programmes which were integrated with other community activities were suggested. As a target area for further action infant health (0-5 years) was recommended - this of necessity would include not only the infant but also Maori women. The time had arrived for positive attitude to be taken towards Maori health rather than a promulgation of negative statistics.

It was recommended

(i) That groups in Auckland (Professor Mantell) and Wellington (Dr Pomare) discuss further the concept of community based health strategies that could both improve the delivery of health care and promote the well-being of Maoris in the longer term. The use of support materials (video tapes etc.) needed developing.

(ii) That for the present time the concept of "Maori Doctor Task Forces" be abandoned but that Maori doctors as individuals would be prepared to speak to Maori gatherings on health issues.

(iii) That any research into Maori health at the present time be low-key and if possible undertaken by Maoris.

(iv) That research into the following areas be given priority:-

(a) Socio-economic factors and Maori health.
It was considdred that a New Zealand programme examining socio-economic factors, education and income, and causes of mortality would be an important step.

The first phase could take all Maori deaths in certain age groups, match with non-Maori deaths, and match for key socio-economic variables such as occupation, education, smoking and accidents.

Such a study would be best based in Wellington where there was access to data needed from the different sources.

(b) The attitudes of different sectors of the Maori population to "dependence" problems eg smoking, alcohol.

(c) Maori asthma morbidity and mortality.

(d) Studies in children 1 month - 1 year (sudden death in childhood syndrome).

Studies of morbidity and mortality under 5 years.

Ear disease study in under 5 year olds. This would involve both Maori and non-Maori children.

(v) That a larger and more widely representative seminar on Maori Health be convened in the first half of next year, that the meeting be of at least two day's duration, and held in a Maori setting.

On behalf of all those who attended this meeting I would like to thank the Medical Research Council for their initiative and support in making this meeting possible.

E.W. Pomare, M.D., F.R.A.C.P.
Senior Lecturer in Medicine

October 1981

MAORI HEALTH REVIEW MEETING

CO-ORDINATED BY, MEDICAL RESEARCH COUNCIL & DEPT. OF MAORI AFFAIRS

Wellington Clinical School - Department of Medicine, Level G. (G23)

Saturday, 12 September 1981

A G E N D A

10.00 am	MORNING TEA AND REGISTRATION.
10.30 am	REVIEW AIMS OF MEETING AND AGENDA: J.Borrows, MRC Eru Pomare - Development of priorities for Health Promotion and Health Education. - Priority areas requiring further research: summary of conclusions of meeting held in Auckland, 5.3.81 - I.PRIOR.
11.00 am	THE POMARE REPORT AND PRIORITIES FOR ACTION: Eru Pomare - Exchange of views from participants, to include: Maori High Risk Status - Socio-economic . - Cultural - Genetic familial Can frontal attack on Maori Health be justified?
12.30 pm	LUNCH - Cafeteria.
1.30 pm	STRATEGIES TO BE CONSIDERED: - Maori Dr Task Force Marae Meetings. - Community Programmes - L.WHITESIDE. - Role of other groups and Government Departments: "Health Education, Health Promotion" What areas could be tackled? What resource material required? - baseline data, bibliography, audiovisual material. Other areas - publications, schools, radio, TV: - Improved screening, individual compliance to treatment. - Resource material available - short papers.
3.15 pm	AFTERNOON TEA.
3.45 pm	A PLAN OF ACTION FOR NEXT SIX MONTHS: - Evaluation and how? - Research needs. - Major meeting - when?
5.00 pm	END OF MEETING.

MAORI HEALTH SEMINAR

Saturday, 12 September 1981

PARTICIPANTS

Dr R.Beaglehole, AUCKLAND.

Dr H.Bennett, TE AWAMUTU.

Rt Rev. M.Bennett, TE PUKE.

Mr J.Borrows, AUCKLAND. (Sec. MRC)

Dr H.Broughton, TE AWAMUTU.

Dr R.Campbell-Begg, WELLINGTON.

Miss A.Delamere, WELLINGTON.

Miss T.Donnelly, WELLINGTON.

Dr G.S.Douglas, AUCKLAND.

Dr M.H.Durie, PALMERSTON NORTH.

Miss C.Fleming, WELLINGTON.

Dr J.Joseph, WELLINGTON.

Professor C.D.Mantell, AUCKLAND.

Professor K.W.Newell, WELLINGTON.

Dr P.Ngata, WELLINGTON.

Dr N.M.Paewai, AUCKLAND.

Dr K.Pickens, WELLINGTON.

Dr E.W.Pomare, WELLINGTON.

Dr I.A.M.Prior, WELLINGTON.

Mr K.Puketapu, WELLINGTON.

Dr Tamati Reedy, WELLINGTON.

Miss M.Reid, AUCKLAND.

Dr A.A.Ruakere, OPUNAKE.

Dr A.Smith, WELLINGTON.

Dr N.Thomson, TE KUITI.

Dr D.Tipene-Leach, AUCKLAND.

Dr S.Walker, AUCKLAND.

Mrs L.R.Whiteside, AUCKLAND.

Professor W.Winiata, WELLINGTON.

APOLOGIES

Dr L.Broughton, HASTINGS.

Dr J.Hall, AUCKLAND.

Dr E.T.T.Raumati, RANGIORA.

Dr P.W.Tapsell, ROTORUA.

Dr M.M.Wong, AUCKLAND.

Dr D.E.T.Yates, HASTINGS.
