INTRODUCTION
Māori are the Indigenous people of New Zealand. Through the principles of the Treaty of Waitangi, Māori have a unique relationship with the Crown that influences policy and legislation. Despite taking a holistic approach to palliative care, Māori have not readily made use of palliative services, and, regardless of education or occupation, they have a poorer health status than non-Māori. Indeed, mortality and other health care parameters indicate a distinct disparity, an inequality, and a widening gap between Māori and non-Māori. We discuss the approaches taken to address Māori health issues and the implications for palliative care provision in New Zealand.

THE NEW ZEALAND CONTEXT
Aotearoa/New Zealand, the largest of the South Pacific Islands in the Oceania group, is located approximately 1,200 miles southeast of Australia. Its population is comprised of Māori (the island’s Indigenous people), settlers from the Pacific Islands, immigrants from a number of Asian countries, and people of European descent (known as Pākehā, they form the largest proportion).

Māori people are tangata whenua: “the people of the land”; or, “the hosts of the land.” They make up 14 to 16 percent of the New Zealand population of four million. The 2006 Census recorded Māori according to ethnicity (or cultural affiliation, 14 percent) and descent (or ancestry, 16 percent) (1). Māori comprise a larger share of the total national population than do other Indigenous groups in the United States, Canada, or Australia; in 2005, Indigenous peoples accounted for about 1 to 2 percent of the populations of these countries (2).

British settlers and Māori signed the Treaty of Waitangi in 1840, establishing a constitutional and political relationship between Māori tribal chiefs and the British Crown. Ratified over time, and on occasion controversial, the treaty is perhaps more relevant to New Zealand society today than ever before. Its principles have been incorporated into legislation, providing a mechanism for taking Māori history and interests into account, recognizing Indigenous rights, and addressing the injustices of the colonial period.

The New Zealand Palliative Care Strategy was introduced in 2001 to institute a “systematic and informed approach to the provision and funding of palliative care services.” It recognized a need for “timely access to quality palliative care services” for the dying and their families. In particular, Māori were highlighted as a group requiring specific policies, community linkages, and care coordinators to ensure “culturally appropriate” and “coordinated” service implementation (3, p. vii).

Māori and non-Māori have different practices related to death and dying. Over half the Māori people who died of cancer in 1996 passed away at home, compared with 30.8 percent of the non-Māori people who died of cancer in the same period (3). Those planning palliative care services for Māori need to give this special consideration. There are no specific Māori palliative care providers, although a number of primary health organizations (PHOs) have been set up by Māori for Māori. (PHOs, which bring together doctors, nurses, and other health professionals in the community — are funded by district health boards to provide primary health care services to their enrollees.) There is therefore a need to ensure that mainstream palliative care providers understand “it is of great importance to the dying to feel that their cultural needs, values, and practices are understood, accommodated and affirmed by those caring for them” (4, p. 22).

Palliative care specifically aims to optimize quality of life for the dying person and his or her family/whānau during life-limiting illness and into death and bereavement. Ngata highlights the
Maori experience of death and dying: "Illness, dying, death and grieving are a central part of Maori life. They are imbued with tapu (sanctity) and whakapapa (genealogy). The formal rituals and practices are elaborate, and the roa (language), hikanga (invocations) and whaiata (charms and songs) are symbolic and poetic, encouraging emotions to be openly expressed" (5).

Unfortunately, there has been no formal review of the New Zealand Palliative Care Strategy and so progress is extrapolated from measures of cancer service provision. The New Zealand Cancer Control Strategy Action Plan (6) was assessed with regard to phase 1 milestones during its first two years. This independent review was performed by the New Zealand Cancer Control Council, and it reported an achievement of only 15 percent of goals in the given period (7); the goals were to improve prevention, screening, diagnosis, treatment, quality of life, service delivery, surveillance, and research.

MAORI MODELS OF HEALTH

The most widely accepted Maori health perspective is a four-sided construct, known as whare tapa wha (four-sided house) (8). The sides are: wairua (spirital aspects), hineangaro (thoughts and feelings), tinana (physical aspects), and whanau (family and community aspects). If all of these aspects are nurtured, then harmony will be ensured, and there will be positive benefits to whanau ora — the overall well-being of the community. Other health perspectives, such as te whare (the octopus) and nga pou mara (supporting structures), value connections with the environment and cultural heritage, with or without the aspects of whare tapa wha (9).

Understanding whare tapa wha is the key to improving Maori participation in health issues. Wairua is generally considered to be the most important requirement of good health. It is essentially the capacity for faith and wider communion and the belief that health is related to unseen and unspoken energies. These energies connect with both the physical and spiritual environments. With discussion, spiritual beliefs surrounding death and dying can be acknowledged in patterns of health care.

Hineangaro encompasses the capacity to communicate, think, and feel. It promotes connectivity between the mind and body. Exploring hineangaro/emotions can uncover misconceptions about conventional (Western) treatment. Clinical management can provoke fear, so there is a need for clinicians to establish a good rapport with the patient and the family/whanau. The understanding that patients and families gain of the diagnosis, need for investigation, and treatment is integral to optimal care. The Maori advocacy and support services commonly available in New Zealand hospitals can also enhance whanau inclusion.

Tinana relates to a physical focus and the capacity for growth and development. Bedside wellbeing is maintained through traditional practices as well as Western public health and health care services. Sensitivity and cultural understanding are essential if mistakes are to be avoided. One area in which understanding tinana is particularly relevant is the disposal or return of body parts and tissues.

Whanau relates to the capacity to belong, care, and share as part of a community. Individuals are socially connected, and support for those in need emanates not only from their immediate families but also from members of their communities. In this society, interdependence is healthier than independence, especially in dealing with serious issues. Such perspectives may not be recognized by health care workers in hospitals and hospices. Subsequently, the importance of working closely with whanau or Maori providers when coordinating care may be undervalued, despite the fact that whanau represents the main support for a dying Maori person.

One study of the cancer journey taken by Maori patients highlights the importance of these aspects of culture, as well as the holistic aspects of health (traditional medicine, massage, metallic healing, reiki, and reflexology) that may be important for Maori. Participants expressed a need for "navigators" to help patients and whanau negotiate the health system, to ensure continuity of care, and to help make patients and whanau aware of all of their entitlements (10).

As in most countries in New Zealand palliative care services function in liaison with primary care services. The general practitioner is the lead provider of medical care for the patient who resides in the community. A good relationship with their GP is therefore beneficial to patients and their whanau. Promoting closer whanaunanga (relationships) between health care professionals and Maori can lead to more effective primary care services, but consultation costs have been shown to influence patient access to primary care (11).

HEALTH DISPARITIES AND HEALTH CARE POLICIES

Regardless of education level or occupation, Maori have poorer health status than non-Maori. Health disparities are well documented and the subject of a range of health interventions (11, 12). From 1980 to 1999, the gap between Maori and
non-Māori survival rates widened. White non-Māori and non-Pacific Islander mortality declined substantially over this interval, but rates of Māori mortality (from all causes) have shown little change (11).

New Zealand cancer service studies highlight health disparities that indicate the need for palliative care services. Indeed, Māori level 18 percent more likely to be diagnosed with cancer than non-Māori, and almost twice as likely to die from their cancer. Māori (excluding those with stomach cancer) are more likely to be diagnosed at a later stage in their illness but less likely to have the cancer stage recorded at diagnosis (12).

Māori experience both a higher cancer incidence and a higher mortality rate. Prostate cancer incidence in non-Māori, non-Pacific Islander men was half that of Māori men between 1996 and 1999. Lung cancer is the most common malignancy in Māori men and the second most common malignancy in Māori women (after breast cancer). The incidence in men from 1996 to 2001 was three times greater for Māori, and deaths were three times more common. Deaths among Māori women were five times more likely than among non-Māori women (12). Breast cancer mortality rates in Māori women were 40 percent higher than in non-Māori women (11).

An Auckland region and Northland lung cancer study showed that Māori patients had a considerable disadvantage in terms of survival compared with non-Māori patients (13). Māori were two-and-a-half times more likely to have advanced disease and four times less likely to have curative treatment than non-Māori. It was also noted that transit times from diagnosis to treatment were longer and that Māori were more likely to decline treatment and miss appointments than non-Māori. Later presentation and lower survival rates for Māori might imply a higher referral rate to palliative care services. However, since there are no published studies on the cultural demographics of patients referred to palliative care services in New Zealand, this has not yet been demonstrated.

“Stark disparities in experiences and outcomes of cancer between Māori and non-Māori” persisted in 2006 (12), despite the development of health strategies and action plans (6, 14, 15). Wāhine: Māori Health Action Plan (15) identified four strategies, underpinned by the Treaty of Waitangi: the development of whakarau, tōi, and Māori communities; Māori participation in the health and disability sector, with active participation by Māori at all levels; effective health and disability services, with high-quality, effective, and culturally appropriate services to increase health and reduce inequalities; a leadership role for the health and disability sector across government sectors and agencies with the aim of achieving whānau ora by addressing broader determinants of health.

As a result of these strategies, a number of targeted and tailored health policies and approaches have been established to address specific Māori health needs and disparities (2). The Māori Health Action Plan’s approach to improving health reflects the proposal by Cormack, Robson, and Purdie that health outcome disparities arise from three sets of interlocking factors related to health systems, health care processes, and patient-level issues (16). From the health system viewpoint, failure to respond to the Māori need for cancer services has led to health disparities related to service organization, funding, resources, and waiting times. This is compounded by differential access to health care and variance in the quality of care received.

Several issues define health care process factors. These include: the way service providers communicate and interact with each other; composition (age, gender, and ethnicity) of the health care workforce that delivers services to Māori; and clinicians’ perceptions of Māori — for example, stereotypical beliefs about Māori service preferences. These factors can affect the type and range of options provided to Māori patients and whānau, influencing not only the initial consultation but also permeating ongoing health care relationships and perceptions regarding Māori.

At the level of the patient, the combined effect of socio-economic position, location, access to transportation, knowledge, beliefs, and access to health resources can disadvantage Māori. By providing health care to Māori within the framework of Western culture and traditions, we often fail to acknowledge, and we sometimes stifle, the Indigenous population’s customs and rituals related to health practices and beliefs. For Māori, tradition, family, and community are central to health and well-being at all stages of life.

CHALLENGES AND OPPORTUNITIES
While much has been achieved in New Zealand in addressing more general Māori health needs, there remain a number of obstacles to providing targeted and tailored palliative care for Māori, along with other ethnic groups. Consequently, in order to meet challenges to providing palliative care at a national level, we must improve integration with, and the understanding of, other service providers in palliative care; access to palliative care services (that is, we must increase awareness of services, overcome cultural barriers, support

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initiatives in rural settings, and liaise with other specialties, such as pediatrics, to optimize care; standards and quality assurance; workforce planning; and sustainable funding for services (3).

These challenges were confirmed through an Auckland-based (regional) review of palliative care service provision (17). The review also noted specific issues related to: liaison and support between primary care and palliative care; people with non-malignant conditions; people who are socially isolated; people in institutionalized care, especially the elderly; pediatric palliative care; marginalized ethnic groups and research. Such service issues impinge on the care for all, but they are accentuated for the Māori population, given its cancer statistics and the health disparities it suffers.

A range of Māori health education initiatives for all health professionals in New Zealand have been introduced. The aim is to improve practice by raising awareness of Māori language, culture, and traditions (18). For example, nurses are trained to respect all cultures they encounter during clinical practice through Te Kawa Whakaruruhau, a cultural safety program designed by Māori (19). Other initiatives include developing and implementing palliative care education strategies through district health boards; establishing palliative medicine as an academic discipline in medical and nursing programs (although it is still only supported by a few academic appointments and a curriculum that has yet to be fully adopted (20-22)); and increasing Māori representation in the health care workforce through Māori-led positive action programs and through access and support programs that encourage young Māori to pursue higher education.

The New Zealand Ministry of Research, Science and Technology defines Māori research as that initiated by issues deemed important by Māori, and it assumes that the benefits of such research will flow to Māori. Recent policies — such as the Māori Potential Framework, Te Puni Kokiri (23) — mark a shift toward recognizing and developing existing Māori skills. Issues relevant to health care service provision, and hence palliative care, are thus being addressed rather than simply the socioeconomic disadvantage of the Māori.

CONCLUSION

Health care activities need to be set within the wider societal and cultural context. Through the Treaty of Waitangi, it has been suggested that New Zealand take a more focused policy approach toward its Indigenous peoples and minorities than other countries do (2). However, despite national strategic frameworks and policies to address wide-ranging social and cultural inequalities, "New Zealand Māori live on average over seven fewer years than Pakehā ... with this being a greater difference than that between native North Americans and their Canadian or US counterparts" (24). Structural and systemic changes to community, hospice, hospital, and specialty services have been put in place to support the implementation of the New Zealand Palliative Care Strategy. The active consultation and involvement of Māori people and health providers is required to identify needs and plan appropriate services. Utilization of the Māori Potential Framework may enhance the positive contribution that Māori make. As MacLeod notes, the New Zealand Palliative Care Strategy provides an opportunity to meet social obligations and "provide care for people, wherever they are, in an effective and compassionate way" (25).

Through the Treaty of Waitangi, principles of partnership, participation, and protection can be provided to help address health disparities and inequalities. Initiatives that address the underlying causal factors of inequality in exposure to health determinants, access to health care, and quality of care received may also help promote systemic change. With many health care workers practising in multicultural societies, there is an increasing awareness of the need to acknowledge and understand the different cultural traditions and practices surrounding death, dying, and end-of-life care. The health workforces in countries that have Indigenous populations, however, must also consider, respect, and actively engage with the unique cultural heritage and expectations of such peoples. This will enable the most appropriate provision of palliative care to meet the needs of patients, their families, and communities.

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