Auckland DHB
Māori Health Plan

2012/2013

Te Runanga o Ngati Whatua

AUCKLAND
DISTRICT HEALTH BOARD
Te Toka Tumai

Mihimihi

E nga mana, e nga reo, e nga karangarangatanga tangata
Ko te Toka Tu Mai o Tamaki Makaurau tenei
E mihi atu nei kia koutou,
Tena koutou, tena koutou, tena koutou katoa.

Ki a tatou tini mate, kua tangihia, kua mihia kua ea
Ratou, kia ratou, haere, haere, haere.
Ko tatou enei nga kanohi ora kia tatou
Ko tenei te kaupapa, Hauora Māori, o Te Toka Tu Mai
Hei huarahi puta, hei hapai tahi mo tatou
Hei oranga mo te katoa.

No reira tena koutou, tena koutou, tena tatou katoa.

Table of Contents

Forward

This plan for Māori health will be the catalyst for driving Māori health gain within our district, and supporting Māori health gain activity across the northern region. It provides Auckland DHB and our local health services with a guide to priority areas for action to achieve demonstrable Māori health gain in twelve months and provides more discipline and accountability for measuring results. One of the key functions of a District Health Board is to reduce the unacceptable disparities in health status by improving the health outcomes of Māori. This means collective action right across the health sector to achieve this, keeping Māori health at the very fore of planning, funding and service delivery activities.

The overall aim of this plan is to improve health outcomes and reduce health inequities for Māori through quality prevention, assessment and treatment services for Māori that take a whānau ora approach. The principles that underpin this plan are:

- Commitment to manawhenua
- Whānau ora
- Health equity
- Self-determination
- Indigeneity
- Ngā kaupapa tuku iho
- Whole-of-DHB responsibility
- Evidence-based approaches

Orienting the health sector to respond effectively to Māori health needs will require the commitment of the wider health workforce, and advanced competencies for health practitioners. Such an approach will also contribute positively to opportunities of potential that a Māori-led health focus brings. It will also inherently require a shift in thinking and practice.

By 2020 we want to see Māori in our region living longer, enjoying a better quality of life with fewer avoidable problems and hospitalisations. We want to see a system that is responsive, integrated, well resourced, and sustainable so that gains we make today can be used and built upon by future generations. These ambitions are certainly achievable and will be one of the key ways in which our success as a District Health Board and as health professionals will be measured in years to come.

Auckland District Health Board Māori Health Plan 2012/13

This Māori Health Plan 2012–13 is signed for and on behalf of:

Auckland District Health Board

Dr Lester Levy Date
Chair

Our Treaty of Waitangi partners
Te Rūnanga o Ngāti Whātua

R Naida Glavish ONZM JP Date
Chair

1.0 Introduction

The Auckland and Waitemata DHBs have developed Māori health plans for 2012-13 in partnership. This built on work that began in 2011 with the development of a *Joint Māori Health Action Plan* (Auckland and Waitemata DHB 2011) which synthesised activities across both DHBs to achieve Māori health gains. Previously, these activities had occurred independently despite both DHBs facing similar issues within their respective Māori populations, and both possessing a Memorandum of Understanding with Te Rūnanga o Ngāti Whātua whose tribal boundary encompasses both regions. The resulting Māori health plans contain further joint priorities that will be the focus for Māori health in both DHBs over the coming financial year. However, for 2012/13 the plans remain separate to maintain an emphasis on addressing the distinctive needs of local populations within each DHB region.

The purpose of the Auckland DHB's Māori Health Plan is to document the DHB's direction for improving health outcomes and reducing inequities for Māori resident, and those who chose to access health services, within its region. The Auckland DHB's direction is conveyed as priorities, and associated actions and indicators. These priorities are received from several sources, for example, national level priorities are identified by the Ministry of Health, regional priorities are developed by the four northern DHBs,[1] and local priorities are informed by local data and health needs assessments. This Plan confirms the Auckland DHB's vision for Māori health. It employs a Tiriti o Waitangi framework by aligning priorities to the principles of Te Tiriti, drawing attention to the importance of partnership between Māori and the Government in achieving Māori health gain.

The DHB's progress will be measured against the indicators and completion of actions that have been developed by the individuals, departments and Healthcare Service Groups responsible for each priority area. In order to achieve the successful implementation of this Plan, the DHB will determine what factors are critical to success and ensure resources are allocated appropriately.

This plan is consistent with, and draws directly from, key Māori health planning documents, including the *Joint Māori Health Action Plan 2011-12* (Auckland and Waitemata DHB 2011), the previous *Māori Health Plan* (Auckland DHB 2011), and the *Auckland DHB Annual Plan 2012-13* (Auckland DHB 2012).

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[1] Northland DHB, Waitemata DHB, Auckland DHB and Counties Manukau DHB

2.0 Vision

To improve health outcomes and reduce health inequities for Māori through quality prevention, assessment and treatment services for Māori that take a whānau ora approach.

2.1 Principles

The following seven principles underpin this Māori Health Annual Plan, and have provided practical direction for the identification of Māori health priority areas and associated activities and indicators.

Commitment to manawhenua

This principle is reflected in a Memorandum of Understanding between Te Rūnanga o Ngāti Whātua and Auckland DHB, which outlines the partnership approach to working together at both governance and operational levels. This relationship will ensure the provision of effective health and disability services for Māori resident within the rohe of Ngāti Whātua.

Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing. The approach is whānau-centred and involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective.

Health equity

As a principle, health equity is concerned with eliminating avoidable, unfair and unjust systematic disparities in health between Māori and non-Māori. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key DHB contribution towards achieving health equity.

Self-determination

This principle is concerned with the right of Māori individuals and collectives to be informed and exert control over their health. This is consistent with full involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence.

Indigeneity

Indigeneity is concerned with the status and rights of Māori as indigenous peoples. The value placed on Indigeneity should be reflected in health policies and programmes that support the retention of Māori identity, the participation of Māori in decision-making, and health development based on the aspirations of Māori.

Ngā kaupapa tuku iho

As a principle, ngā kaupapa tuku iho requires acknowledgment and respect for distinctly Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning, quality programming and service delivery for Māori.

Whole-of-DHB responsibility

Achieving best health outcomes for whānau and health equity for Māori is a whole-of-DHB responsibility. Therefore, contributing to Māori health gain and reducing ethnic inequalities in health between Māori and non-Māori is an expectation of all health activities through Auckland DHB and Waitemata DHB.

Evidence-based approaches

The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgement, drawing on a Māori development perspective and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of Māori health policy, purchasing, service delivery and practice.

3.0 Conceptual frameworks

Reducing inequities in health

Health inequities are differences in health status between groups that are avoidable, unfair and unjust (Kawachi et al 2002). Williams (1997) provides an explanation of the determinants of ethnic inequities in health that differentiates between basic causes and surface causes (Figure 1). Basic causes (e.g. macrosocial factors and racism) are the fundamental drivers of particular health outcomes. Surface causes are risk factors and resources (including health care) which mediate between ethnicity and health status. If the basic causes of social inequity remain intact, addressing surface causes alone will be insufficient to address ethnic inequities in health. Therefore, this framework reminds us that at the very least interventions to address surface causes of health inequities need to take account of the broader structural context that shapes Māori health inequities, and that in order to fully address ethnic inequities in health, action is required on the basic structural causes of inequities.

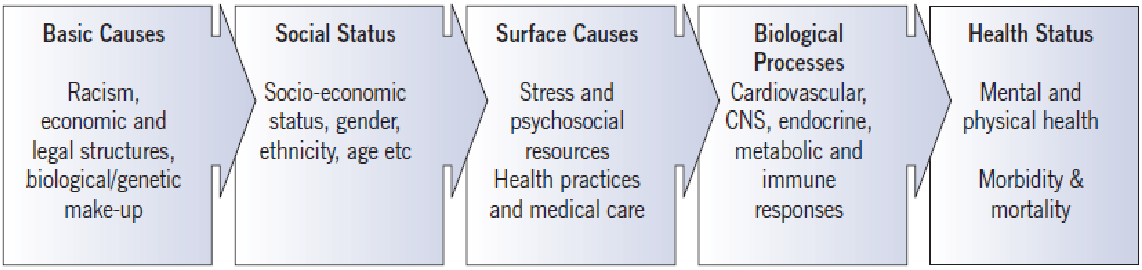


Figure 1: Mills 2010 p54, adapted from Williams 1997

The 'Pathways to Inequities' framework (Reid and Robson 2007, based on Jones 2001) provides further theoretical explanation for ethnic inequities in health which is more explicit in terms of the need for access to quality health care. The framework identifies three main pathways that contribute to ethnic inequities in health.

1. differential access to the determinants of health or exposures leading to differences in disease incidence;
2. differential access to health care; and,
3. differences in the quality of care received.

This plan identifies specific ways in which Auckland DHB will intervene to address each of these pathways.

Te Tiriti o Waitangi

The Public Health and Disability Act 2000 was the first social policy legislation to include reference to Te Tiriti o Waitangi, and places specific requirements on DHBs consistent with Te Tiriti principles. The Auckland DHB has made explicit commitments to Te Tiriti o Waitangi in several high-level strategic documents, including the Auckland DHB Annual Plan 12/13.

Te Tiriti o Waitangi, and specifically the articles of Te Tiriti, are used in this plan as the framework for discussing Māori health priorities for the following reasons.

- First, the importance of a Tiriti-based approach to addressing Māori health has been a common feature of feedback from Māori community consultation; Auckland DHB has made explicit their commitments to Te Tiriti.
- Second, the purpose of Te Tiriti, as outlined in the preamble, includes the protection of Māori wellbeing and the notion of equity is central.

- Third, the Māori right to health is derived from three sources – human rights, indigenous rights and Tiriti rights as tangata whenua. Te Tiriti therefore reinforces the Māori right to good health.
- Fourth, Te Tiriti is a known framework which can be easily understood by the range of Māori health stakeholders.
- Fifth, Te Tiriti is consistent with Māori models of health in that it takes a broad and holistic approach, seeks to protect Māori custom and therefore cultural integrity and whānau structures, and reinforces Māori control over Māori wellbeing.

The articles of Te Tiriti provide four domains under which Māori health priorities are discussed in this plan. Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with iwi at a governance and operational level. Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB activities. Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation. Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, Auckland DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

4.0 Population profile and health needs

4.1 Population profile

Size of the Māori population

Auckland DHB serves an estimated 36,300 Māori. This is only 5.4% of the Māori population in New Zealand, which is the eighth highest number of Māori served by a DHB. Māori make up 8.0% of the total Auckland DHB population.

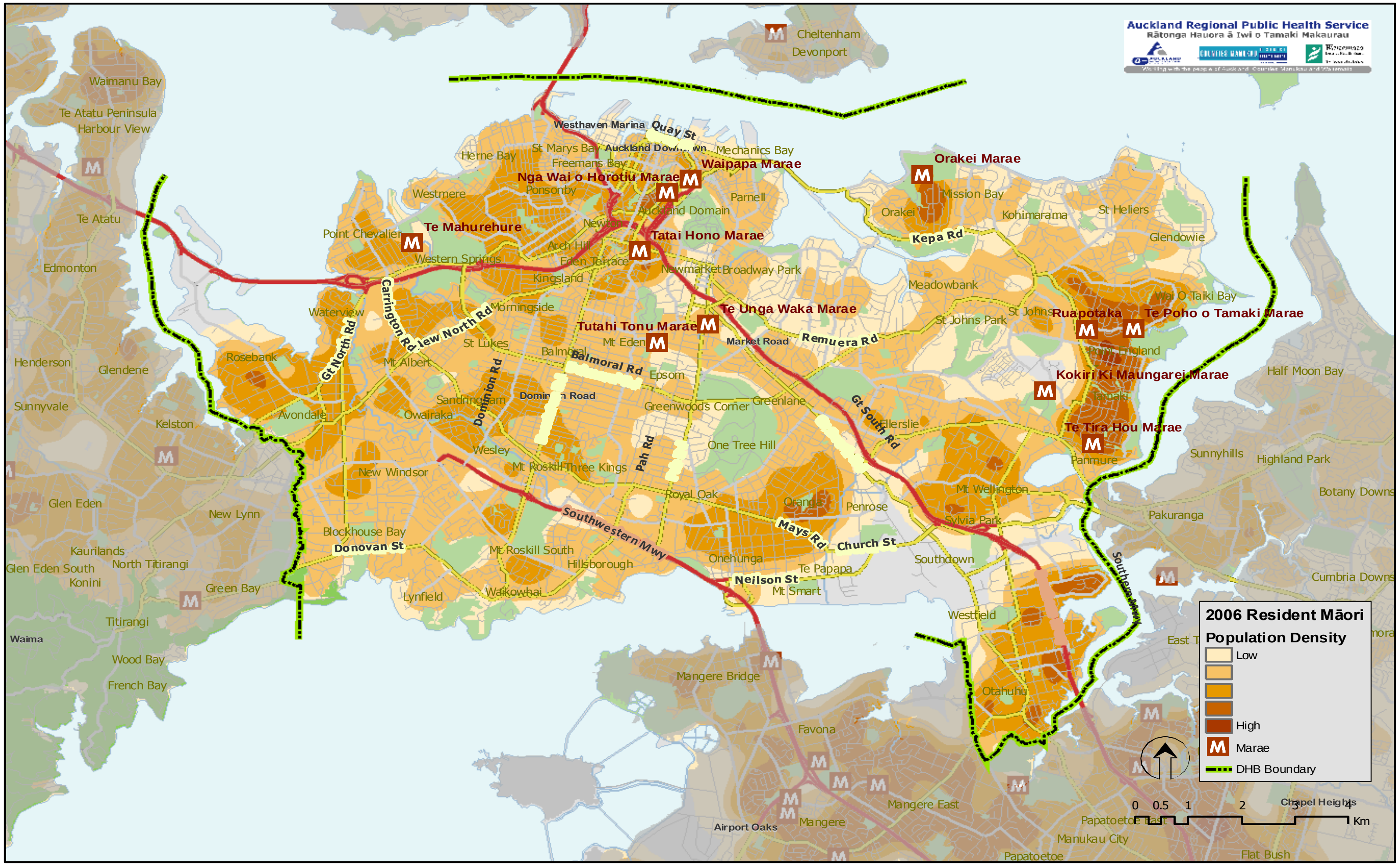
The Māori population in the Auckland district is growing less than the non-Māori population in the district. By 2026, the Auckland DHB Māori population is expected to number 40,500, an increase of 16% from its 2006 census size. The non-Māori population is expected to increase by 30% over the same period. The projected non-Māori population increase has been driven by projected increases in Chinese (80%), Indian (92%), Southeast and Other Asians (79%) and European/Other (14%) between 2006 and 2026. This is despite slightly higher Māori fertility rates, and the relatively youthful Māori population structure. In 2010 Māori comprised 8.3% of all live births in the Auckland DHB region. The Māori birth rate was 47.5 per 1000 females aged 15-49 years old, compared to 37.7 per 1000 females in the same age group for non-Māori.

Composition of the Māori population

The Auckland DHB Māori population is very young compared with the overall population. For Māori 28% of the population are aged less than 15 years, compared with 16% of the Auckland DHB non-Māori population. Like the Waitemata region, the difference is even more marked among older people; with only 4% of the Māori population aged 65 years and over, compared with 10% of the non-Māori population. Also in part reflective of the lower Māori life expectancy relative to non-Māori.

Map 1 on the following page outlines Māori population density within the Auckland DHB region. The highest population density areas for Māori are in the high deprivation and low socio-economic suburbs of Glen Innes, Tamaki, Panmure and Otahuhu. More than 60% of the resident Māori population in the Auckland DHB region live in the most deprived areas compared with less than 39 percent for non-Māori. Other concentrations of Māori population are in Mt Wellington, Penrose, Panmure, Orakei, Mt Roskill and the west Auckland suburb of Avondale.

The Auckland DHB Māori population is diverse in terms of iwi affiliations. According to iwi affiliation data collected in the 2006 Census, the most commonly identified iwi affiliations for Māori living in the Auckland DHB region were Ngāti Whātua and Ngāpuhi.



Map 1: Auckland DHB Māori population density, Census 2006

4.2 Māori health needs

Even though Māori in the Auckland DHB region experience better health status than the average for Māori in New Zealand, there are still substantial unmet health and healthcare needs for local Māori which have high potential to benefit from intervention. Findings from the Auckland DHB's health needs assessment (Auckland District Health Board, 2006) are summarised below in terms of the Treaty framework.

Article 1 – Kawanatanga - Health system performance

A high performing health system involving quality data collection and monitoring and quality health care is fundamental to the elimination of health disparities for Māori.

There is evidence that health system performance for Māori in Auckland DHB requires further improvement. For example, consistent with national trends under-recording of Māori ethnicity in primary care is still a major concern (Cormack and McLeod 2010, Bramley and Latimer 2007, Ghafel 2011).

In addition to data collection issues, a recent review of Auckland DHB patients accessing inpatient kidney dialysis services found that Māori patients were concerned with accessing the service, preferring to have the service located closer to home (Auckland DHB, March 2012).

Article 2 – Tino Rangatiratanga - Māori participation and leadership

There are a number of mechanisms for Māori to participate in the governance and delivery of health services in Auckland DHB's region.

In terms of Māori controlled health services, there are a range of Māori providers who deliver a variety of health care services within a kaupapa Māori framework. Māori are involved in the governance of Auckland DHB through: An MoU with Te Rūnanga o Ngāti Whātua; a joint Māori Health Gain Advisory Committee between Auckland and Waitemata DHBs that provides advice to the Boards of both DHBs on Māori health issues; and, Māori membership on the shared (between ADHB and WDHB) Community and Public Health Advisory Committee and the Hospital Advisory Committee.

Within Auckland DHB, Māori comprise 2% of medical staff, 2% of nursing staff and 2% of technical support staff. Work is required in order to increase the capacity and capability of the Māori health workforce at all levels and in a variety of roles in order to best contribute to Māori health gain. Māori health workforce development has been identified through consultation as a priority for Auckland DHB.

Article 3 – Oritetanga - Achieving health equity

Within the Auckland DHB region, the state of Māori health is poor relative to that of non-Māori, as measured by life expectancy, potentially avoidable hospitalisations, potentially avoidable mortality, and a range of other indicators.

Life expectancy provides a summary measure of the health of a population, and comparison of life expectancy between population groups provides an indication of the extent of health disparities. Māori within Auckland DHB's region experience a longer life expectancy than Māori in New Zealand overall, although marked inequalities between Māori and non-Māori persist.

Between 2001 and 2010 (Figure 1) Auckland DHB Māori life expectancy at birth has remained largely unchanged (75.5 years in 2001 and 74.8 years in 2010). Māori males and females had the lowest life expectancies of all ethnic groups. Māori die earlier than any other ethnic groups, at around 8.2 years earlier for males and 7.8 years earlier for females.

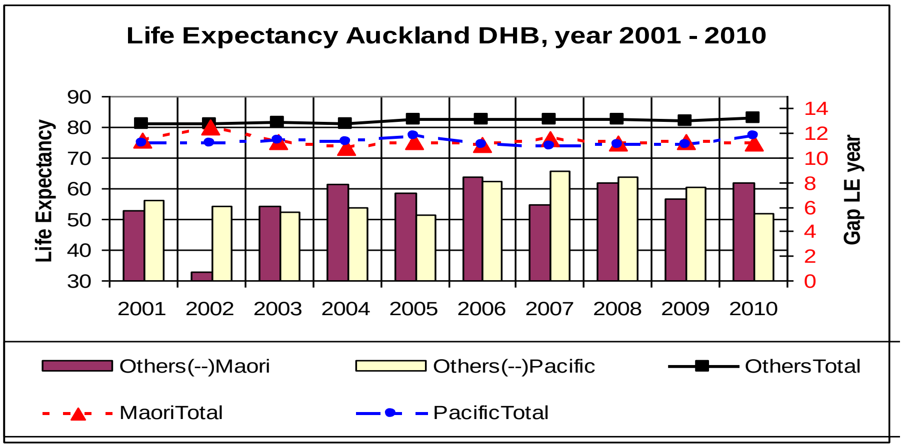


Figure 1: Life expectancy at birth in Auckland DHB by ethnicity

Māori report higher levels of unmet need for GP care compared to non-Māori (12.3% vs. 5.8%) and experience ethnic inequalities in access to angiography and angioplasty relative to non-Māori. In 2011, the Did Not Attend (DNA) rate for Auckland DHB outpatient appointments for Māori was 12%, compared to 7% for all ethnic groups. In the same year the DNA rate for specialist appointments for Māori was twice that as for all ethnic groups (18% compared to 9%).

Table 1 below compares age-standardised hospitalisation rates between Māori, Pacific and non-Māori non-Pacific in 2009, as an indicator for unmet need in primary care.

Table 1: Total hospitalisations, year 2009 (age-standardised rates per 1,000)

	Māori	Pacific	Non-Māori Non-Pacific	Total
Auckland DHB	160	189	100	114
NZ Total	148	171	107	116

There were 5,715 discharges occurring before the age of 75 years for Māori in 2009/10. Of these hospitalisations, 1,267 or 18.8% were considered avoidable. The rate of avoidable hospitalisations for Māori was 19% higher than for the non-Māori Auckland DHB population. The highest rates of potentially avoidable hospitalisations for Māori were for respiratory infections and asthma, followed by cellulitis and dental conditions.

In 2008, Māori had higher overall mortality rates than non-Māori, but lower rates than Māori nationally. Table 2 shows all cause mortality rates by ethnicity compared with New Zealand as a whole.

Table 2: All-cause mortality (Age-standardised rates per 1,000)

	Māori	Pacific	Non-Māori	Total
Auckland DHB	6.7	7.2	3.9	4.1
NZ Total	7.5	6.6	4.0	4.2

For Māori, 540 deaths occurred before the age of 75 years in the Auckland DHB region between 2003 and 2007. Of these, 392 or 73% were considered avoidable deaths. The rate of potentially avoidable mortality for Māori (306 per 100,000) in the Auckland DHB region was over two and a half times higher than for the non-Māori non-Pacific Auckland population (110 per 100,000).

Table 3 below shows the potentially avoidable mortality (PAM) for Māori, Pacific, non-Māori non-Pacific and the total population in Auckland DHB compared with New Zealand as a whole. The rate of potentially avoidable mortality for Māori in the Auckland DHB region (306 per 100,000) was less than the rate for New Zealand as a whole.

Table 3: Potentially avoidable mortality 2003-2007 (Age-standardised rates per 100,000)

	Māori	Pacific	Non-Māori Non-Pacific	Total
Auckland DHB	306	279	110	139
NZ Total	362	262	131	159

Table 4 below shows the top five causes of PAM for Māori and the total population in Auckland DHB between 2003 and 2007. For Māori, ischemic heart disease was the leading cause of avoidable mortality followed by lung cancer, suicide, COPD and diabetes.

Table 4: Top five PAM for Māori Population and total population Auckland DHB between 2003-2007

Māori	**Rank**	**Total**	**Rank**
Ischaemic heart disease	1	Ischaemic heart disease	1
Lung cancer	2	Lung cancer	2
Suicide	3	Suicide	3
COPD	4	Breast cancer	4
Diabetes	5	Colo-rectal cancer	5

The most common causes of death for Māori in Auckland DHB are circulatory diseases, cancer, respiratory disease, and endocrine conditions including diabetes. Broken down into age groups, the major causes of death among young Māori aged 15-24 years, compared to non-Māori non-Pacific are death from motor vehicle accidents and cancer. The leading causes of death among Māori aged 25-64 years are cancer, ischemic heart disease and circulatory system disorders. Older Māori adults (65yrs+) have higher rates of disease than other ethnic groups and die at younger ages than non-Māori from conditions such as ischemic heart disease, cancer and COPD.

In general, Māori are more likely to die earlier than any other population groups and are more likely to have suffered from conditions that are preventable through health sector interventions, particularly at the primary care level, than other populations.

Article 4 – Te Ritenga - right to beliefs and values

This priority can be measured by monitoring and evaluating how well staff and services incorporate Māori tikanga into practice.

A health workforce with knowledge of Māori cultural values and rights can dramatically improve the experiences of Māori accessing health services, and engagement with patients, whānau, providers and communities. Auckland DHB and Ngāti Whātua have developed the Tikanga Recommended Best Practice Policy (the Policy), a policy document that provides practical ways in which Auckland DHB staff can incorporate Ngāti Whātua tikanga into their own practice. In order to facilitate this, training is offered to staff on both how to utilise the Policy and the Treaty of Waitangi in their practice with Māori patients and their whānau. Despite the provision of face to face training, the numbers of staff who take up the training remain relatively low. One solution has been the development of an online training tool.

In addition to Auckland DHB staff, there is also a need for the providers who the DHB contracts to provide health and disability services to improve their responsiveness to Māori accessing their services. Although many have Māori health plans assessed by the DHB, very few have any formal relationship with Ngāti Whātua and therefore lack an understanding of how they too could also incorporate Ngāti Whātua tikanga into practice.

In summary, more work is required within Auckland DHB’s region to improve the responsiveness of both DHB provided and contracted services. One way to do so is through a closer relationship with Ngāti Whātua and furthering their involvement in monitoring the health workforce and providers.

5.0 Strategic priorities and activities

The following three sections of the Plan present Auckland DHB's priorities in Māori health for 2012-13. The key priority areas are broken down into national, regional and local priorities. The national priorities, as defined by the Ministry of Health, address three of the six national health targets for 2012-13, which are increased immunisation, better help for smokers to quit, and more heart and diabetes checks. In addition to these priorities, others include primary care enrolments, supporting whānau ora across the region, reducing ambulatory sensitive hospitalisations, and workforce development that are key priorities for our DHB, MoU partners - Te Runanga o Ngāti Whātua, and providers within our region.

The suite of national measures of DHB performance are excluded as priorities in this Plan but are covered fully in the *Auckland DHB Annual Plan 2012-13*. As well, the activity within this Plan represents a portion of the activity that will be carried out across the entire organisation to achieve Māori health gain, some of which is also provided in the *Annual Plan*.

Also in accordance with the *Annual Plan*, no ethnic specific targets have been set by Auckland DHB. Instead, a single general target has been set to be achieved across all ethnicities (equality), and we understand that this will require differing levels of resource allocation to help raise the general rate for priorities we measure (equity). These general targets represent targets that we will achieve over time for Māori.

Auckland DHB will, in all relevant forums, promote the Plan and its priorities. This will include discussions with our iwi partners, primary care and other NGO provider partners, and any national forums we participate in. To ensure senior management are kept informed of progress against the Plan, data will be regularly disseminated to senior management members and governance committees.

Each priority can be aligned to the following Te Tiriti o Waitangi framework which was used above in the analysis of health needs within our district:

Te Tiriti o Waitangi principle	ADHB priority
Article 1 – Kawanatanga: health systems performance	NP 6.1 – Accuracy of ethnicity reporting in PHO registers RP 7.1 – Data collection across the Māori mental health and addictions sector to inform workforce planning RP 7.7 – Whānau ora service development
Article 2 – Tino Rangatiratanga: Māori leadership and participation	RP 7.2 – Build the leadership capability of the Māori health workforce RP 7.5 – Develop a joint work programme in Māori health RP 7.6 – Increase iwi involvement in Auckland DHB activities

Te Tiriti o Waitangi principle	ADHB priority
Article 3 – Oritetanga: achieving health equity	NP 6.2 – Increase the percentage of Māori enrolled in PHOs NP 6.3 – Reduce ASH rates for Māori NP 6.4 – Seasonal influenza immunisation Māori rates in the eligible population (65 years and over) NP 6.5 – Exclusive breastfeeding at 6 months for Māori children NP 6.6 – Percentage of the eligible Māori population who have had their CVD risk assessed within the past five years (q) (ht) NP 6.7 – Rate of tertiary cardiac intervention (no rate info only) NP 6.8 – Breast screening rates for Māori women NP 6.9 – Cervical screening rates for Māori women NP 6.10 – Percentage of hospitalised smokers provided with advice and help to quit NP 6.11 – Identified current Māori smokers enrolled in a PHO and provided with advice and help to quit NP 6.12 – Percentage of Māori two year olds fully immunised RP 7.3 – Reduce Did Not Attends (DNAs) RP 7.4 – Reduce the rates of rheumatic fever among Māori children and whānau LP 8.1 – Develop school-based programmes that reach children and adolescents early LP 8.2 – Increase percentage of Māori pre-school aged children accessing oral health services
Article 4 – Te Ritenga - right to beliefs and values	LP 8.3 – Implement year one Tikanga Strategic Plan priorities

6.0 National Priorities

NP 6.1 - What are we trying to do? Accuracy of ethnicity reporting in PHO registers	**To achieve this we will focus on:** Increase the percentage of PHO enrolments with ethnicity stated at enrolment	**Who will be responsibly?** Māori Health Gain Manager, Primary Care Manager, Chief Planning and Funding Officer	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Implement strategies to ensure that ethnicity is stated at enrolment and recorded accurately • Work with PHOs to ensure that ethnicity is consistently and regularly checked as part of PHO enrolment practice • Ensure PHOs demonstrate their commitment to this priority in their PHO Māori health plans Monitor activity through regular meetings with PHOs	Reducing health inequalities is a key government priority including those that affect Māori. If Māori are to live longer, have healthier lives, and fulfil their potential to participate in New Zealand, then the factors that cause inequalities in health need to be addressed. The factors that lead to poor health are complex. The challenge is for PHOs to identify and address those factors. Addressing this will mean a gradual re-orientation of the way PHOs plan and deliver their services. An ethnicity data project focusing on Auckland DHB's PHO clinics in 2010/11 found that Māori enrolment data sits well below census projections (13%) due to data capture processes. This has prompted a focus on ensuring that ethnicity is aligned to the census question and is routinely checked by practice/PHO staff.	In 2011/12, an ethnicity audit framework was completed in partnership with ProCare A review of PHO enrollments by ethnicity matched against census data has found that Māori enrolment rates were 13% below census population predictions, whilst pacific was 46% over estimated	**Business as usual:** 95% correct ethnicity data for PHOs **New:** Review of ProCare ethnicity reporting completed by 1 December 2012, and other PHOs engaged in January 2013 PHOs have their 2012-13 Māori Health, SIA and HP Plans reviewed by September 2012 and agreed to by He Kamaka Oranga and MoU partners
Key issues: Incomplete ethnicity data collection at enrolment and ethnicity misclassification are a problem for PHOs (Ghafel 2011). Accurate ethnicity data allows the Auckland DHB, and our primary care partners, to monitor inequities at the primary care level in order to effectively allocate resources, and support the use and implementation of specific tools and interventions to achieve Māori health gain.			

NP 6.2 - What are we trying to do? Improve access to primary care	**To achieve this we will focus on:** Increase the percentage of Māori enrolled in PHOs	**Who will be responsibly?** Māori Health Gain Manager, Primary Care Manager	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Work in partnership, through the Toi Oranga initiative, with schools (pre-, primary and secondary) and other community based organisations to promote primary healthcare and oral healthcare enrolment to Māori children, adolescents and their whānau Work with maternity services to enrol all newborn Māori children and their whānau with a GP and a Well Child provider in their area as a pre-discharge action and follow this up post-discharge Ensure PHOs demonstrate their commitment to this priority in their PHO Māori health plans and regularly meeting with PHOs to review progress against their Māori health plans	Māori enrolment rates are lower than non-Māori/Pacific rates within Auckland DHB. Enrolment within a primary care practice increasing a families/whānau's relationship with a provider, increases access to and awareness of relevant health initiatives. For the PHOs and the DHB, this allows for the better allocation of resources.	76.2% of people are enrolled with a PHO	**Business as usual:** PHOs improve enrolment rates to 100% **New:** Toi Oranga programme, subject to business case approval, fully operational by 1 February 2013 Maternity programme fully operational by 1 February 2013
Key issues: Improved access to primary health care services will result in earlier detection of preventable illnesses, better management of chronic conditions outside of an acute setting, and increased access to preventative services for all members of the whānau/family. Access can, in part, be improved through enrolment which not only reduces the cost to attend a primary healthcare provider, but also improves the relationship between the provider and the whānau/family. Specific projects, further detailed in this plan, will specifically target enrolment among school-aged children and their whānau/families.			

NP 6.3 - What are we trying to do? Improve access to primary care	**To achieve this we will focus on:** Reduce Ambulatory Sensitive Hospitalisation (ASH) rates	**Who will be responsibly?** Māori Health Gain Manager, Primary Care Manager, Chief Planning and Funding Officer	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Implement an inpatient whānau ora assessment tool within Auckland City Hospital to assess whānau needs in the community after they are discharged from inpatient services Work in partnership with PHOs (namely Greater Auckland Integrated Health Network (GAIHN)) to increase the number of Māori being referred to the Primary Options for Acute Care (POAC) programme and ensure this is a priority within PHO Māori Health Plans - Monitor this activity through regular meetings with GAIHN and the PHO CEO forum Undertake clinical pathway reviews for the POAC programme ensuring that they account for Māori needs (i.e. after hours, inter-sectoral)	In order to reduce ASH rates for Māori several key compounding factors need to be addressed – access to primary care, the quality of programmes provided to support management of acutely unwell Māori patients and their whānau in the community, and integration of services across and within sectors. Therefore, a new approach is required to capture relevant information to support the identification of whānau needs and refer them on to relevant support services within community that can address that need. Actions associated with this priority rely on a range of organisations, programmes and leadership from the DHB to coordinate activities to address these factors.	Age group 00-74 ASH rate per 100,000 are 2850 Age group 00-04 ASH rate per 100,000 are 4072 Age group 45-64 ASH rate per 100,000 are 4069	**Business as usual:** Age group 00-74 ASH rate per 100,000 to 1665 Age group 00-04 ASH rate per 100,000 to 3164 Age group 45-64 ASH rate per 100,000 to 2129 **New:** Regular meetings with GAIHN Evaluation of assessment tool completed by January 2013 Implemented tool across Auckland City Hospital wards on 1 February 2013
Key issues: There are wide ethnic disparities in ASH rates for Māori. Ambulatory sensitive admissions can be reduced through better access for Māori to primary healthcare providers, improved quality of care in the primary healthcare setting and better coordination between secondary and primary healthcare services.			

NP 6.4 - What are we trying to do? Improve the health of older people	**To achieve this we will focus on:** Seasonal influenza immunisation Māori rates in the eligible population (65 years and over)	**Who will be responsibly?** Primary Care Manager	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Identify practices with high Māori enrolment to promote free flu vaccine to those on their register who are aged 65 years and over Promote free flu vaccines at Marae, community gatherings and cultural events where older Māori may be in attendance – utilise existing provider capacity to lead this initiative Develop PHO specific solutions to create flu vaccine promotion systems for Māori over 65 years PHOs demonstrate their commitment to this priority in their PHO Māori health plans	The complications of influenza in older people can be serious or life threatening. A large proportion of Māori are enrolled with general practices which provide the main access point to medical services for whānau, and therefore PHOs are the critical access point to provide influenza vaccinations for older Māori. The information sheet will promote positive stories from kaumatua promoting Māori uptake of influenza immunisation.	Seasonal influenza immunisation rates for eligible people aged 65 years and over are 63.9%	**Business as usual:** Seasonal influenza immunisation rates for eligible people aged 65 years and over at 75% **New:** A call back system introduced by PHOs for people aged over 65 years by 1 March 2013
Key issues: Influenza in older people can be serious and life threatening, yet many barriers exist for Māori accessing these free services in Auckland DHB. Generic barriers include cost and access to a general practice. Other barriers include a negative ill-informed perception of the vaccine and the effects it could potentially cause.			

NP 6.5 - What are we trying to do? Improve child and maternal health	**To achieve this we will focus on:** Exclusive breastfeeding at 6 months	**Who will be responsibly?** Primary Care Manager, Child Health HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Better coordinate breastfeeding activity and initiatives within the region • Review current breastfeeding services and strategies for Māori, including the Community Breastfeeding Service and Baby Friendly accreditation, and make recommendations to providers	Māori have low rates of exclusive breastfeeding relative to non-Māori, and face barriers that can be overcome through increased access to support services.	19% at 6 months	**Business as usual:** 27% at 6 months by 30 June 2013 **New:** Complete reviews by 1 December 2012 and provide recommendations to the Ministry of Health
Key issues: Breastfeeding meets a term infants nutritional needs for the first six months of life and provides protection against a range of conditions. Māori rates of exclusive breastfeeding are lower in Māori than non-Māori. Barriers to continued breastfeeding include poor initiation of breastfeeding (Ministry of Health 2002). Issues that will be addressed through improved access to support services.			

NP 6.6 - What are we trying to do? Reduce morbidity and mortality through improved cardiovascular access and care	**To achieve this we will focus on:** Percentage of the eligible Māori population who have had their CVD risk assessed within the past	**Who will be responsibly?** Primary Care Manager, Chief Planning and Funding Officer, Cardiac HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Support General Practice in the use of a population audit tool and electronic clinical decision support tool to identify eligible Māori patients and, using the Long Term Conditions Coordinators, proactively contact and invite Māori due for risk assessments and risk reviews Ensure PHOs demonstrate their commitment to this priority in their PHO Māori health plans and monitor progress through regular meetings	Given the significance of cardiovascular disease for Māori, access to, and completing, a risk assessment is critical as a start point for discussions with health professionals. General practices provide the main access point to CVD risk assessments. We will focus on outreach to indentify and notify Māori who are eligible for, yet have not completed, a CVD risk assessment.	55.6% of people have had their CVD risk assessment	**Business as usual:** 75% of eligible population have had their CVD risk assessment by 30 June 2013 **New:** Tool and process in place by 30 June 2013
Key issues: There are wide ethnic inequalities in cardiovascular health outcomes for Māori. There is substantial scope to effectively achieve cardiovascular health gain for Māori, and risk assessment at the primary health care level as a central strategy. Māori in Auckland have lower rates of absolute CVD risk assessment by general practices than the total population.			

NP 6.7 - What are we trying to do? Reduce morbidity and mortality through improved cardiovascular access and care	**To achieve this we will focus on:** Rate of tertiary cardiac intervention (information only)	**Who will be responsibly?** Māori Health Gains Manager, Cardiac HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Continue to monitor tertiary cardiac intervention rates Implement recommendations from the cardiac rehabilitation review completed in 2012 • Develop an HSG work stream to oversee implementation of the recommendations	Analysis of Auckland acute cardiac revascularisation data (2000-2008) by ethnicity demonstrates ethnic inequities in access to interventions (angiography and angioplasty) for Māori. Regular monitoring is required to understand trends, to ascertain the likely causes of disparities, determine whether there are differential referral/treatment patterns, and if identified how they are best addressed to improve consistency of access and care.	A review of cardiac rehabilitation services concluded in June 2012	**New:** The baseline for equity of access for cardiac surgery established by December 2012 A strategy for addressing inequities will be developed by 30 June 2013
Key issues: There are wide ethnic inequalities in cardiovascular health outcomes for Māori. There is substantial scope to effectively achieve cardiovascular health gain for Māori, and risk assessment at the primary health care level is a central strategy.			

<table>
<tr><td>NP 6.8 - What are we trying to do?
Reduce cancer morbidity and mortality</td><td>To achieve this we will focus on: Breast screening rates for Māori women</td><td colspan="2">Who will be responsibly? Māori Health Gain Manager, Primary Care Manager, Women's Health and Cancer and Blood HSG leadership</td></tr>
<tr><td>What are we going to do?</td><td>Why carry out these activities?</td><td>Where are we at now?</td><td>Where do we want to get to in a year?</td></tr>
<tr><td>Monitor access to breast screening services for Māori in partnership with BreastScreen Auckland Ltd. Where inequity of access to and through services exist, make recommendations for service improvements to the Ministry of Health

Utilise links to the Northern Regional Cancer Network to pool and utilise resources from a broad range of organisations that specifically target Māori women from promotion, to outreach, delivery closer to home, and the dissemination of easy to read and understand material for women and their whānau</td><td>Māori women have lower rates of breast screening coverage than non-Māori women. We will review breast screening services for equity of access during 2012 and provide recommendations to the Ministry of Health for implementation among their providers.</td><td>65% breast screening rate for women</td><td>Business as usual:
70% Breast Screening Aotearoa coverage rate by 30 June 2013

New:
Regular meetings with Northern Regional Cancer Network organised by 1 October 2012

Recommendations provided to the Ministry of Health by 1 February 2013</td></tr>
<tr><td colspan="4">Key issues: Reducing cancer morbidity and mortality is a priority for Auckland DHB. National data indicates that Māori women are more likely to be diagnosed at a later stage of disease spread for breast cancer. Further, for many cancers, at each stage Māori cancer-specific mortality post diagnosis is greater (Cormack et al 2005). Breast screening coverage rates are lower for Māori women in Auckland than for non-Māori women.</td></tr>
</table>

<table>
<tr><td>NP 6.9 - What are we trying to do? Reduce cancer morbidity and mortality</td><td>To achieve this we will focus on: Cervical screening rates for Māori women</td><td colspan="2">Who will be responsibly? Primary Care Manager, Women's Health HSG leadership</td></tr>
<tr><td>What are we going to do?</td><td>Why carry out these activities?</td><td>Where are we at now?</td><td>Where do we want to get to in a year?</td></tr>
<tr><td>Implement an Auckland Metro Cervical Cancer Coordination Service to improve the coordination of, and women's access to, cervical screening services in primary care with a focus on Māori</td><td>Cervical cancer is one of the most preventable cancers with regular cervical smear tests (recommended to be triennial). The primary care setting offers that best opportunity to implement programmes that promote and coordinate activities specifically targeted at reaching Māori women.</td><td>53.1% cervical screening rate for women</td><td>Business as usual:
75% Cervical Screening Programme coverage rate by 30 June 2013
New:
Service fully operational by 30 June 2013</td></tr>
<tr><td colspan="4">Key issues: The cervical screening rate for Māori women in the Auckland DHB region is much lower than for non-Māori women. This is concerning given that having regular three yearly cervical smear tests can prevent cervical cancer. Access to primary healthcare services is seen to be a barrier for many women, as well as other patient-level factors like effective recall services, cost and awareness, that can be addressed with a coordinated approach requiring several agencies and organisations from across the health and support service spectrum.</td></tr>
</table>

NP 6.10 - What are we trying to do? Reduce cancer mortality and morbidity and improve respiratory health through reducing smoking rates	**To achieve this we will focus on:** Percentage of hospitalised smokers provided with advice and help to quit	**Who will be responsibly?** Executive Director of Nursing, Cancer and Blood HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Improve data collection and monitoring system in secondary care to help services better target resources to Māori, and manage their progress towards meeting and maintaining the health target Augment the initiatives to support smokers with advice and help to quit through the inpatient whānau ora assessment project to ascertain whether or not a patient smokes and provide advice to quit. And identify and refer patients to smoking cessation services within the community	Māori who smoke and spend time within Auckland DHB secondary care services provide an ideal opportunity for staff to, firstly, ascertain whether they smoke or not, and if so to provide relevant information with advice to quit. This builds on work undertaken in the previous year which also saw several Māori health staff members trained as Māori smoking cessation practitioners. These staff members will lead the provision of smoking cessation material to patients and whānau, and referrals to quit services.	90% of hospitalised smokers given brief advice to quit smoking	**Business as usual:** 95% of hospitalised patients who smoke are offered brief advice and support to quit smoking **New:** Data collection improvements made by 1 December 2012 Inpatient whānau ora assessment rolled out by 1 February 2013
Key issues: Smoking is a major health risk for Māori in the Auckland DHB's region, and is an area of substantial inequity. It is a risk factor for key conditions for which Māori experience a high disease burden (e.g. cancer and respiratory disease).There are wide disparities in smoking prevalence between Māori and non-Māori. Smoking also makes a major contribution to ethnic disparities in life expectancy for Māori.			

NP 6.11 - What are we trying to do? Reduce cancer mortality and morbidity and improve respiratory health through reducing smoking rates	**To achieve this we will focus on:** Identified current Māori smokers enrolled in a PHO and provided with advice and help to quit	**Who will be responsibly?** Primary Care Manager, Cancer and Blood HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Work with PHOs to develop initiatives that target enrolled Māori who identify as smokers with support and advice to quit Ensure PHOs demonstrate their commitment to this priority in their PHO Māori Health and Health Promotion plans Develop and implement a programme to increase referrals of pregnant women by GPs and private Lead Maternity Carers to promote smoking cessation services for pregnant women with a particular focus on Māori	Māori use of general practice services, even for an unrelated health care need, is an opportunity to ask them about their smoking status, provide brief advice, and make referrals to quit services. A new programme targeting pregnant women will also use primary healthcare professionals to refer to Lead Maternity Carers to promote smoking cessation.	ABC/smoking cessation training has been provided to primary care clinicians 37% of smokers enrolled in a PHO are provided with advice to quit	**Business as usual:** 90% or primary care enrolled patients who smoke will be provided with help and advice to quit **New:** Meetings with PHOs to confirm plans undertaken by 1 December 2012 90% of pregnant women who come through National Women's health are offered advice and support to quit
Key issues: There are wide disparities in smoking prevalence between Māori and non-Māori. Smoking makes a major contribution to ethnic disparities in life expectancy for Māori, and it is a major risk factor for key conditions for which Māori experience a high disease burden including cancer and respiratory disease.			

<table>
<tr><td>NP 6.12 - What are we trying to do? Improve child health</td><td>To achieve this we will focus on: Percentage of Māori 8 months olds fully immunised</td><td colspan="2">Who will be responsibly? Primary Care Manager and Child Health HSG leadership</td></tr>
<tr><td>What are we going to do?</td><td>Why carry out these activities?</td><td>Where are we at now?</td><td>Where do we want to get to in a year?</td></tr>
<tr><td>In collaboration with primary care achieve improved immunisation by:
1. Implementing a programme that ensures 90% of all newborns are enrolled with a GP and Well Child provider at birth
2. Improving access to, and coordination of, immunisation services across Auckland and Waitemata DHB, and primary care

Auckland DHB immunisation governance group to meet regularly to monitor immunisation progress, and expand membership to include PHO leadership

Ensure PHOs demonstrate their commitment to this priority in their PHO Māori health plans</td><td>We will work with general practices with high Māori enrolment and low immunisation coverage to improve their coverage. Although outreach remains an important aspect of our programme of work to reach and exceed proposed targets, a new programme to register newborns with a PHO will be a core focus for 2012/13.</td><td>77.1% of 8 month olds fully immunised</td><td>Business as usual:
85% of 8 month olds are fully immunised by 30 June 2013

New:
Newborn enrolment programme in operation by 1 February 2013

New Auckland and Waitemata DHB immunisation governance and monitoring structure operational by 1 December 2012</td></tr>
<tr><td colspan="4">Key issues: Immunisation coverage for Māori children is lower than for non-Māori children in our region. Immunisation can prevent a number of diseases and is a very cost-effective health intervention to improve child health. It provides not only individual protection, but for some diseases also population-wide protection by reducing the incidence of diseases and preventing them from spreading to vulnerable people.</td></tr>
</table>

7.0 Regional Priorities

RP 7.1 - What are we trying to do? Improve the responsiveness of mainstream mental health services	**To achieve this we will focus on:** Data collection across the Māori mental health and addictions sector to inform workforce planning and forecasting	**Who will be responsibly?** Māori Health Gain Manager, Mental Health HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Undertake a stocktake of the Māori mental health workforce in partnership with the Northern District Support Agency	This will provide us with data on how best to target resources to increase the capacity and capability of the Māori mental health workforce and align this activity to NGO Māori health plans.	This is a priority within the Northern Region Māori Mental Health and Addictions Plan 2010 – 2015.	**New:** Review completed by December 2012 Recommendations presented to Mental Health HSG leadership in June 2013
Key issues: It is important that we work with quality information and research to inform decisions about resource allocation, and where to focus on building the capability and capacity of the Māori mental health workforce.			

RP 7.2 - What are we trying to do? Develop the Māori workforce	**To achieve this we will focus on:** Build the leadership capability of the Māori health workforce	**Who will be responsibly?** Executive Director of Nursing, Chief Medical Officer, GM Human Resources	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Develop and implement a leadership programme for Māori clinical leaders, senior managers and emerging leaders	In order to achieve Māori health gain, it is important that we develop a workforce that is able to effect, lead, and implement change. The identification of clinical and managerial Māori leaders at Levels 2 and 3, and emerging Māori leaders across the DHB, will allow us to concentrate training and development programmes on their specific needs and career aspirations.	A leadership programme is yet to be developed along with other northern region DHBs.	**New:** 60% of level 2 and 3 leaders complete components of leadership development training
Key issues: It is important for Auckland DHB to focus on developing future leaders through the establishment of a leadership programme that is relevant at a professional, regional and national level. The benefits of well trained staff at the higher levels of the organisation will see benefits trickle down across patient experience, leadership of individuals, teams and organisational goals, retaining staff, communication with a wide variety of stakeholders and quality of services provided.			

<table>
<tr><td>RP 7.3 - What are we trying to do? Increase Māori access to outpatient services</td><td>To achieve this we will focus on: Reducing Did Not Attends (DNAs)</td><td colspan="2">Who will be responsibly? Māori Health Gain Manager in partnership with the Northern Region Māori General Managers, all HSG leadership groups</td></tr>
<tr><td>What are we going to do?</td><td>Why carry out these activities?</td><td>Where are we at now?</td><td>Where do we want to get to in a year?</td></tr>
<tr><td>Work with Waitemata DHB to secure regional support for jointly developed recommendations for regionally consistent Māori DNA processes, including Māori DNA support services

Implement recommendations from the DNA project completed in 2011</td><td>Māori have substantially higher rates of DNAs for outpatient appointments than other ethnic groups in our region.

We will build on work completed as part of a Māori DNA project carried out in 2009/10, and continued through to 2010/11 which established recommendations for system changes in the booking and scheduling of outpatient appointments, and will focus on Inter District Flow DNAs.</td><td>The DNA rate for Māori for the year ending 30 June 2012 was 19%*.

Staff dedicated to providing transport to ‘at risk’ patients (patients who have DNA in the past) for a limited number of services.</td><td>New:
Recommendations for regionally consistent DNA processes have regional support and processes implemented

1% reduction of all DNAs by DHB of residence</td></tr>
<tr><td colspan="4">Key issues: Although it is known that DNA rates for Māori are generally higher than for other ethnic groups there are still significant barriers in trying to reduce these rates, issues such as a lack of correct information, multiple bookings for appointments at outpatient clinics, feeling disempowered, cost or lack of transport, dependent family members, cost of medication and a transient population have all been identified as barriers to access for Māori.

* Note that this data is taken from outpatient appointments across Auckland DHB’s adult health services, cancer and blood services, cardiac services, children’s health services, women’s health services, and operations and clinical support services.</td></tr>
</table>

RP 7.4 - What are we trying to do? Improve child health	**To achieve this we will focus on:** Reduce the rates of rheumatic fever among Māori children and whānau	**Who will be responsibly?** Primary Care Manager, Child Health HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Work with the Northern Regional Rheumatic Fever Alliance Group, which includes primary care, to implement sore throat clinics in at least 4 identified high need schools Raise awareness of detecting and avoiding rheumatic fever through the whānau ora school-based Toi Oranga programme and other schools within high-needs areas in metro-Auckland	Children are the most at risk of developing rheumatic fever. Schools provide an opportunity to screen children for infections that may lead to rheumatic fever, and additionally provide information on ways to prevent and detect infections. In order to address rheumatic fever within our district, buy-in from a range of providers across primary health care and social support services that can reach out to whānau/families is required.		**New:** Rheumatic fever sore throat clinics successfully implemented and operational by 30 June 2012 Progress is made toward the following long term targets: • Rate of Rheumatic Fever is below 0.4/100,000 (by 2020) for all populations • Rheumatic Fever rates for Māori children have decreased to the same level as other children (by 2020)
Key issues: Inequalities are evident in rates of rheumatic fever between Māori and non-Māori/Pacific and also affect children from poorer families more frequently and more severely. Substandard housing is a common issue and on this and other issues we will collaborate effectively with other sectors such as Housing, Education, Ministry of Social Development and Auckland Council.			

RP 7.5 - What are we trying to do? Regionalisation	**To achieve this we will focus on:** Develop a joint work programme in Māori health	**Who will be responsibly?** Chief Advisor Tikanga, in partnership with Te Runanga o Ngāti Whātua	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Continue collaboration across Waitemata and Auckland DHB in Māori health Develop a joint work programme for Māori health with Waitemata DHB and Te Runanga o Ngāti Whātua (TRONW)	Working at a regional level is critical for achieving greater Māori health gains through increased communication, better coordination and resource allocation. As well, it supports joint work programmes to address regional priorities of our MOU partners TRONW.	Appointment of a lead CEO – Māori health Appointment of regional Chief Advisor Tikanga Regionalisation of the Māori health governance committees to Māori Health Gains Advisory Committee Manawa Ora	**New:** A regional Māori health work plan completed and agreed to by Waitemata DHB and TRONW by September 2012
Key issues: Effective system delivery and responsiveness to Māori health need is the ultimate aim for Auckland DHB, Waitemata DHB and our iwi partners TRONW. To do this requires the health sector to have culturally responsive services, systems, workforce, training, education, relationships and infrastructure. To this end, this approach relies heavily on a shared vision and collaboration from the DHBs and TRONW for a dedicated whānau ora approach that seeks to best utilise the Māori health workforce in the most effective way and to develop integrated strategies that can demonstrate Māori health gain.			

RP 7.6 - What are we trying to do? Effective implementation of the MOU with Te Runanga o Ngāti Whātua (TRONW)	**To achieve this we will focus on:** Increase iwi involvement in Auckland DHB activities	**Who will be responsibly?** Chief Advisor Tikanga, Māori Health Gains Manager in partnership with Te Runanga o Ngāti Whātua	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Complete review of the MOU between Auckland DHB and TRONW Implement the iwi-based Whānau Ora Outcomes framework across Auckland DHB activity Implement priorities within the sustainability plan for Te Kahupokere	It is expected that we will need to develop these relationships further and gain a greater level of participation, knowledge sharing and shared decision making by iwi in achieving Māori health gain. We need to make available resources to support their ongoing involvement in Auckland DHB developments, ensure they are engaged regularly, and provide leadership in areas of Māori health and whānau ora.	Operational arrangements exist with TRONW Sustainability plan and iwi-based Whānau Ora Outcomes framework developed	**New:** MOU review completed by December 2012 Sustainability objectives agreed and implemented At least one Auckland DHB Board and TRONW Board meeting held
Key issues: Currently Auckland DHB has an MOU with TRONW; this MOU outlines the intent to work together within a health context and encourages shared information and shared decision making. Within the context of the MOU, Auckland DHB recognises the sole manawhenua status of TRONW in our area.			

RP 7.7 - What are we trying to do? Better, sooner and more convenient services for whānau	**To achieve this we will focus on:** Whānau ora service development	**Who will be responsibly?** Māori Health Gain Manager, Primary Care Manager, Chief Planning and Funding Officer	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Establish a Whānau Ora Integration Leadership Group (WOILG) Develop a whānau ora regional strategy in partnership with Te Runanga o Ngāti Whātua Support TPK by participating whānau ora activity • Regional leadership group • Assessing of Plans of Actions Work with the whānau ora collectives in our region, and any other emerging Collective, in the district, to support implementation of their Whānau Ora Plans of Action Support the Ministry of Social Development's integrated contracting programme	Within the Auckland DHB region there are three BSMC business cases and two Whānau Ora Collectives, each with their own strategic objectives. The roles of the DHB and Te Runanga o Ngāti Whātua are to support these organisations and groups of providers by providing leadership, and a strategic context with which this activity can be aligned to.	A scoping exercise with a Māori health provider in the Maungakiekie-Tamaki Ward was completed in 2011/12	**New:** WOILG operational by 1 December 2012 Support the development of a Ngāti Whātua-led Whānau Ora Centre through the commitment of identified and agreed health services for location in, and provision from, the Centre This activity will be measured against the achievement of Plans of Action objectives set by each Collective and agreed to by the Auckland DHB All health contracts held by Māori health providers integrated into a single outcome-based contract per provider by 1 July 2013
Key issues: Whānau ora provides the catalyst for improving the capability of health providers and hospital-based services to deliver high quality, integrated, and responsive services to whānau and families. None of which cannot be achieved without commitment from all relevant organisations, collaboration and integration across and between sectors, and strong leadership from the DHB. This is difficult to achieve within a heavily siloed environment where funding is based on models that do not support collaboration, and where resources are scarce.			

8.0 Local Priorities

<table>
<tr><td>LP 8.1 - What are we trying to do? Improve the health of Māori children and adolescents</td><td>To achieve this we will focus on: Develop whānau ora school-based programmes that reach children and adolescents early</td><td colspan="2">Who will be responsibly? Māori Health Gain Manager, Child Health HSG leadership</td></tr>
<tr><td>What are we going to do?</td><td>Why carry out these activities?</td><td>Where are we at now?</td><td>Where do we want to get to in a year?</td></tr>
<tr><td>Develop and implement a whānau ora school-based Toi Oranga programme, subject to business case approval, in at least two Māori medium education settings</td><td>Implementing this initiative will foster relationships between primary healthcare providers, schools and whānau, promote and increase the uptake/awareness of health initiatives targeted at children, youth and whānau utilising the schools' existing relationships with whānau.

It is also an important age to introduce concepts of health to children and their whānau, enrol children in a primary care provider, and ensure good health behaviour (oral health and hand hygiene) is instilled.</td><td>A governance group to oversee the implementation of the project was established in 2011/12 and operational throughout that year developing relationships between the various players who will be involved in the project.</td><td>New:
100% of youth participating are offered a HEADSS assessment

95% of participants are enrolled with a general practice

95% of children participating receiving oral health care

100% of children and 95% whānau participating report increased knowledge of Rheumatic Fever and hand hygiene in preventing skin infections</td></tr>
<tr><td colspan="4">Key issues: There are significant inequities between Māori and non-Māori/Pacific children. For example rates of rheumatic fever, respiratory disease, avoidable injury and skin sepsis are much high among Māori children then non-Māori children. Children are a relatively difficult group of the population to promote health initiatives to due largely to the fact that their behaviour usually depends on their whānau/family around them. Therefore, an approach to address these inequities should include the entire whānau not just the individual child or children of the whānau/family.</td></tr>
</table>

LP 8.2 - What are we trying to do? Improve the oral health of Māori children	**To achieve this we will focus on:** Percent of Māori pre-school aged Māori children accessing oral health services	**Who will be responsibly?** Child Health HSG leadership	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Develop plans and strategies in conjunction with Auckland Regional Dental Service and pre-school coordinators to increase Māori pre-school aged children enrolment with oral health providers Promote enrolment within kohanga reo and pre-school centres in high-needs areas utilising pre-school coordinators	This programme will focus on pre-school aged children. It is an important age to introduce concepts of health to children and their whānau, enrol children in a primary care provider, and ensure good health behaviour is instilled.	60% of Māori children at the age of 5 years are free of dental caries 11.8% of children under 5 years enrolled with an oral health provider are Māori	**New:** 69% (by end of 2012) and 74% (by end of 2013) of children at the age of 5 years are free of dental caries Increase the number of Māori children enrolled with an oral health provider Pre-school co-ordinators are in place to access pre-school centres, kohanga reo and language nests
Key issues: Access to oral healthcare and good oral health information is a significant issue for Māori pre-school aged children and their whānau. Enrolment within a provider at an early age increases the child's and whānau's exposure to good oral health information that can be utilised within the home and decreases the chances of social and severe health issues later in life.			

LP 8.3 - What are we trying to do? Improve staff competency and commitment to implementing the TRBP Policy	**To achieve this we will focus on:** Implement year one Tikanga Strategic Plan priorities	**Who will be responsibly?** Chief Advisor Tikanga, all HSG leadership groups	
What are we going to do?	**Why carry out these activities?**	**Where are we at now?**	**Where do we want to get to in a year?**
Establish Tikanga Best Practice champions for each of the Healthcare Service Groups Audit the performance of three Healthcare Service Groups in implementing the Tikanga Best Practice Policy	Priority areas for our DHB are to increase the cultural competence of staff and strengthen the capacity of staff to integrate culture into the clinical context through Tikanga Recommended Best Practice, and thereby maximise health gains for Māori. Tikanga Recommended Best Practice Guidelines have been established for Auckland DHB, and those Guidelines have been integrated into the Auckland DHB Health Excellence Framework. To support implementation of the Guidelines, service specific tikanga education and an associated assessment process (to assess staff competency in implementing the Guidelines) will be put in place.	A Tikanga Strategic Plan has been developed	**New:** Tikanga Best Practice champions appointed across all Healthcare Service Groups Tikanga Best Practice Audits completed for 3 Healthcare Services Groups
Key issues: Health services provided by DHBs are accessed by people of all ethnicities. Each of whom have different expectations of the quality of service they receive. Māori, like other ethnic groups, see culture and health as a single concept and therefore expect cultural customs to be observed by staff treating and interacting with them, so long as it does not directly conflict with recommended best practice clinical guidelines. A Tikanga Strategy and associated policy documents, guidelines and training programmes are all aimed at supporting staff to better integrate traditional Māori concepts into practice.			

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