Ccher bro’: a thought that may cross your mind

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Introduction
In 1976, my research career started in the laboratory of the paper-board mill at Whakatane. I worked for the Ministry of Agriculture and Fisheries for four years after I completed my degree in earth sciences. In 1988, I was offered a position at Whakatane Hospital in the Hepatitis Research Unit and my focus became health and the epidemiology of hepatitis B.

A requisite skill in our business is phlebotomy. My introduction was patiently supervised with the wisdom that comes with experience, a high level of skill as well as the steady resolve to account for the novice student. During a morning clinic I was introduced to and observed most of the patients that morning. The process was carefully explained. Before breaking for morning tea my tutor strapped on a tourniquet above her elbow. Pointing unflinchingly to the vein she asked me to draw blood. I was all thumbs as blood was drawn into the syringe. As the syringe filled I became nervous - unsure when to release the tourniquet. The needle was withdrawn and blood dispensed into the evacuated tube once its rubber lid was pierced. No blood was spilt.

In my mind, medical technology is the application of science to the pathology of the human person, their fluids and tissues. An important aspect is the training and credentialing of a highly skilled workforce - pathologists, scientists and technicians. This training and unique skills set are practiced using protocols and a language which to the outsider appears to be a culture unto itself. To many outside the profession, medicine appears this way. For those who work in the profession - pathologists, scientists and technicians - many of us have a high level of skill as well as the steely resolve to account for the novice student. During a morning clinic I was introduced to and observed most of the patients that morning. The process was carefully explained. Before breaking for morning tea my tutor strapped on a tourniquet above her elbow. Pointing unflinchingly to the vein she asked me to draw blood. I was all thumbs as blood was drawn into the syringe. As the syringe filled I became nervous - unsure when to release the tourniquet. The needle was withdrawn and blood dispensed into the evacuated tube once its rubber lid was pierced. No blood was spilt.

In order to provide some evidence as to why you may wish to acknowledge a person who is Māori, back it up if you like, I will outline the health status of Māori as reflected by official statistics, provide a view of health illustrated by a couple of Māori perspectives and then present an analysis of health with respect to the Treaty of Waitangi. Prof Pomare led the research published first by the New Zealand Medical Council (1-3), Pomare’s leadership in Māori health was prematurely ended when he died in 1995. Prior to his death he established a leading Māori health research team at the Wellington School of Medicine in 1992 where he was Dean of Medicine after post graduate study in Bristol. At about the same time a family stricken by liver cancer presented for assistance at the Hepatitis Research Unit at Whakatane Hospital. While neither met, the future for this family along with most Māori living in the Eastern Bay of Plenty was improved with the case Pomare brought to bear with the Ministerial review of the Hepatitis B vaccination program.

While pathology is the focus of this presentation, my view of Māori health may help you better understand the needs of Māori in a broader sense, ranging from hospital to health survey data. And to this end provide you with additional insight that will complement your chosen profession. In New Zealand Māori are well most of the time — most have a high quality of life, are safe, fed and loved. When anyone is not well, society accepts some obligation to meet their needs as is does for all of its citizens. In most cases care is provided and medicine intervenes to mitigate any further harm. Most of this care is provided by the family, however most of the funding is raised by taxes and the Government directs the funding for medicine through Vote:Health.

The broad scope of Māori health and wellbeing is linked to a number of domains that include the environment while measuring the effect of disease and counting numbers who die along side quality of life. The association between environment and health is well rehearsed and articulated within New Zealand (1-9) and by international comparison (10). Other health related data is collected from surveys commissioned by the Ministry of Health. In these surveys on a wide range of health issues, Māori are identified by ethnicity classification (11,12). The standard now accepted is the census ethnicity standard established by Statistics New Zealand (13).

Health indicators and a good life
Life expectancy for example: Life expectancy continues to vary by ethnic group. For non-Māori, life expectancy steady increased in at birth between 1985 and 2002. Boys born during this period are likely...
to live 5.8 years than their older brothers. The same is expected for girls who can expect to live an additional 4.5 years than their older sisters. During the same period Māori, life expectancy increased a great deal for those children born between 2000–2002 after many years of smaller increases in life expectancy from the 1980s and well into the 1990s.

Source: Statistics New Zealand, 2007 (14)

While the gain in life expectancy for Māori over the whole period is 4.1 years for a boy, 2.7 years for girls, this was less than that for non-Māori, Māori gained more than non-Māori in the latter five-year period. Perhaps there has been some catch up as the difference in life expectancy has appeared to reduce. The gap in life expectancy at birth between non-Māori and Māori, which widened by 2.4 years between 1985–1987 and 1995–1997, reduced by 0.6 years in the five years to 2000–2002 (14).

The reduction of life expectancy for Māori children was coincident with the reforms of the 4th Labour Government and the later National Governments of the 1990s. It is unfair to blame governments for differentials in life expectancy and trends that may exacerbate this, however it was a time of relatively greater poverty for Māori as parts of the economy they populated were those most severely affected.

Will a widening of life expectancy be observed for this current recession begun in 2008?

In short the difference remains. Māori death rates are higher than non-Māori death rates at all ages. As a result, life expectancy at birth for females of Māori ethnicity was 75.1 years in 2005–07, compared with 83.0 years for non-Māori females. For males, life expectancy at birth was 70.4 years for Māori and 79.0 years for non-Māori. This is an average difference between Māori and non-Māori of 8.2 years in 2005–07, slightly less than the 8.5 years in 2000–02 and 9.1 years in 1995–97 (Statistics New Zealand, 2009). The impact of shorter life expectancy happens along the life course.

Health data is also collected from hospital discharges, death registration and cancer registration. There is much published in this area. The health status of New Zealand compares unfavorably with many other OECD countries (14). Within the population there are major health inequalities and disparities between Māori and Pacific, and people from low-income families compared to other ethnic groups. The Māori Health Strategy, He Korowai Oranga (15) was set in place in 2000 because New Zealand had relatively high infant death and youth suicide rates, child immunisation coverage statistics were static or decreasing, levels of hospitalisation for asthma and respiratory problems were unacceptable high, and unintentional injury and poisoning rates were high (16). The criteria that set the Māori Health Strategy in place have remained durable and so have the inequalities.

You may have noticed that most of the health data for Māori is contrasted with non-Māori. Comparison with non-Māori is useful when assessing need and has been used to establish a case for changing priorities to shift health resources. However, the evidence for Māori health priorities is often inadequately supported by health data because some issues fall outside the health sector (education and te reo Māori) and the data is not collected. The more serious and systemic Māori health issue for the health sector is the lack of fine grained detail in the statistics because of a “lack of numbers”.

Once we dig below population level data we encounter multiple analytical challenges. Most of these challenges arise from a lack of numbers to populate a comprehensive statistical analysis. Further insight has been difficult to find because of the low numbers of Māori identified. Lack of numbers has precluded sufficient evidence to change priorities for comparatively rare causes of illness or death, or where Māori are disproportionately affected but low rates in the general population rank the issue as a low priority. This has been compounded by incomplete collection of ethnicity data. Recent reforms to data collection and incentives offered to fund health providers using capitation has led to more complete recording of ethnicity. The Government offered the incentive of providing higher fees for more complete patient registration that included ethnicity status.

To improve the quality of data collected in surveys and related health research, the ‘lack of numbers’ the recruitment of Māori for such research has had to under go a major rethink. A policy based on the notion of ‘explanatory power’ (17) was used to ensure sufficient numbers of Māori were enrolled as part of the survey in order to have the statistical power to provide summary data with the same level of confidence as non-Māori.

While challenging the value of medical intervention, the health of Māori, like any New Zealander, is dependent on many factors outside the domain of medicine. Medicine’s value lies in its power to resolve illness after preventative and early intervention strategies have failed. Associated with many strategies for preventing illness are the actions of Government and publically funded services. Most recent strategies for improving Māori have been the Whanau Orā policy initiative driven by the Associate Minister of Health, Tariana Turia (18).

Government assistance

Community and government concern about the well being of Māori has been a feature of policy for some time (16). Widespread concern in social, health and education policy had extended in some cases to questioning the ability of the Government to respond to the needs of Māori (19). In terms of priorities for Māori, the health and well being of Māori children was a concern to both Government and Māori. The nonResponsiveness of the Department of Social Welfare (DSW) was termed “cultural racism” in the findings of Puao Te Ata Tu. The findings were illustrative of the capacity of Government to assess the status of Māori children and intervene in their best interests of Māori (20).

During a series of radio interviews soon after the release of the report of the Ministerial Advisory Committee, John Rangihau predicted the likely life course of his whanau if the response of Government did not change: “I have thirty grandchildren, with ages from twenty, twenty years to twenty days. If we’re, if I am to expect what has been happening over the, over the last few years to my, to Māori children, then I can reasonably expect to have six of those children, somewhere along the line, being absorbed by the institutions of the Social Welfare Department and eventually into the penal institutions of the country. That is the reality for us and that is what we are trying to address when we are talking about Māori people being responsible for looking after their own children which you must admit and people must admit have not been the case up to now and hence, our real need, to have the courts acknowledge the fact that we need to do things in a different way” (21).

If government services continued to plot the same course, Rangihau’s forecast and the prospects for Māori youth were poor and lent support for better consultation with Māori. Prior to the radio interview, a strong recommendation was made to undertake consultation with Māori. The Royal Commission on Social Policy suggested that consultation be
undertaken with Māori to further social policy objectives: “Debate need not dwell on whether Māori values or delivery systems are appropriate to a particular policy area; more [sic] fruitfully, objectives should examine the methods by which Māori participation can be maximised and effect given to the Treaty of Waitangi” (22).

In the 1980s, the relative newness of the consultative role for Māori in informing social policy was illustrated by the consultation process that resulted in the recommendations of the report, Pua0-Te-Ata-Tu –The Report of the Ministerial Advisory Committee on a Māori Perspective For The Department of Social Welfare (Pua0-Te-Ata-Tu) and the April Report (20, 22-24).

Pua0 Te Ata Tu was the report of an inquiry to inform the then Minister of Social Welfare, Hon Ann Hercus on her department’s responsiveness to Māori. The report was presented in July 1986, published in 1988. Within two years Dr Mason Durie was appointed as one of the three commissioners on the Royal Commission into Social Policy and in turn as part of the commission inquiry heard much about the social circumstances of Māori (22). The responsiveness of government to Māori has been poor at times, and the report by retired Family Court Judge Michael Brown (25) provided evidence of the inaction and policy-led neglect by Government through its Ministries.This inquiry was informed by interviews undertaken by Judge Brown.

There has been, and still is, a lack of detailed information to describe the health and wellbeing (including mental health) of Māori in terms that would inform the comprehensive delivery of health and related social services (26,27). The scarcity of such information limits the effective planning, development, funding, delivery and evaluation of prevention and treatment services for Māori, but also the assessment of the determinants of health. The fragmented approach governments have taken to addressing the needs of Māori remained a theme consistent for some time. The aim of Whanau Ora will be to reduce some of this fragmentation and have more Māori providers funded to address unmet need (18).

Māori health in government and non-government

The Government’s influence on the needs of Māori is influenced by the structure of government, external pressures and changes made by government in the health sector. Many organisations take responsibility for maintaining the health of New Zealand and for promoting Māori health priorities. The health sector is complex with the Ministry of Health (MOH) primarily responsible for health policy and health funding for Māori health. In addition the office of the Health and Disability Commissioner and a number of other ministries now have an explicit interest in the health and wellbeing of Māori, including the Ministry of Social Development (MSD), the Ministry of Youth Affairs (MYA) and The Ministry of Māori Development Te Puni Kākiri (TPK). Outside government a number of non-government organisations (NGO) have specific interests’ in Māori health, many are Māori organizations including Māori health providers, Waananga and tribal executives.

Influencing health are social, cultural and economic factors (28) or health determinants as described by the National Health Committee (NHC) in the first section of their 1998 report (29). The NHC observed there was “now good evidence that social, cultural and economic factors are the most important determinants of good health” (29) — a relationship exists between these determinants and health. A point of view shared by the health determinants and their association with health have their genesis in the disciplines of economics and social sciences (30). The use of social epidemiology and economic theory provided new perspectives and tools with which researchers and policy makers explored economic and social data and where appropriate, undertake an analysis of indicators relevant to the health of the population. While economic theory may provide a choice of models on which to understand the behaviour of populations and inform policy development, how Māori health is understood crosses disciplinary boundaries that may ascribe health domains in a manner not sensible to Māori. An understanding of how health can be described from several Māori perspectives will provide new insight into how cultural, social and economic factors may influence Māori health.

Health concepts and being well

The introduction of models to describe health and wellbeing for Māori enabled the provision of more appropriate delivery mechanisms for health services in a health sector where Māori views were quite different to the paradigm of western medicine. The development of health services for Māori is not only prefaced on equity of health status for Māori, and the availability of choice as to provider but also in cultural relevance and cultural congruity.

Three models will be analysed and discussed in relation to the notion of health determinants for Māori. The models are Te Whare Tapa Whā (reference 31, pp. 69-73, 76) and Te Whake (reference 31, pp.74,76; reference 32). They are presented in their order of appeared in the literature, however, this does not reflect on their origins, nor their importance, as they are views of health which accord with contemporary Māori thinking.

Te Whare Tapa Whā

Dr Mason Durie (reference 31, pp. 68-73) concluded a health hui for Māori Women’s Welfare League workers undertaking training for the Rapuora research project (33). Durie drew together themes identified by speakers to create an image of a house, a representation of relationship between four principles of health. The house (te whare) is a metaphor for health where the house’s four sides (tapa whā) represent spiritual (taha wairua), mental (taha hinengaro), physical (taha tinana) and family (taha whānau) health. Together all four are necessary to ensure strength and symmetry, and in balance, represent good health.

Te Whare Tapa Whā is an influential model for describing concepts of health and wellbeing from a Māori perspective. The durability of this model and it’s wide application in health policy indicate a successful “bridge” between two worldviews as non-Māori begin to deliver services, referencing this model to meet Māori need and also featured in the ‘April Report’ (22). While physical and mental health are informed by interviews undertaken by Judge Brown.

Te Whake

Dr. Rangimarie (Rose) Turuki Pere, a well-respected indigenous educator, described Te Whake (the octopus), a model of health, at the Hui Whakaoranga (reference 31, pp. 75) in 1984. Dr. Pere described eight principles that intertwined like the tentacles of the octopus. The inter-relationship between these principles and wellbeing (32). The intertwining of the tentacles is an influential model for describing concepts of health and wellbeing. The durability of this model and it’s wide application in health policy indicate a successful “bridge” between two worldviews as non-Māori begin to deliver services, referencing this model to meet Māori need and also featured in the ‘April Report’ (22).

The additional aspects of health as described by Pere suggests that there are aspects of Māori health that may provide finer detail to understanding health determinants that may fit outside the narrow scope of health indicators we use in medicine.
Phlebotomy is also an example of multi-tasking, an artful application familiar is a good start. quickly a comfortable relationship is established. Knowing the vein and extracting the blood while putting the patient at ease. The tasks of the phlebotomist include the location of a suitable vein, may guide you these situations is what understanding more about the relationship Māori had with their whanau. A recurring theme in these three models was the recognition and maintenance of inter-personal relationships and the balancing of well being with that of the whanau, environment. Being Māori is healthy for Māori.

Health, safety and culture
The science on which medicine was established is added to by the second. An important scientist was Professor Eru Pomare. He established a sound footing for Māori health research at the Wellington School of Medicine and championed the establishment of Māori health within the new Health Research Council in 1991. For Professor Pomare, Māori health was an essential part of the health and well being of New Zealand. Many people were influenced by Professor Pomare and I am one of them. He not only added to the value of my work at the Hepatitis Research Unit easier as patron, he enabled the application of the skilled researchers working at Wellington Hospital to bring a new understanding to the epidemiology of hepatitis B in a family who was stricken by liver cancer. This new knowledge improved the health and well being of the family by bringing into their lives the option of diagnosing liver cancer at an earlier stage by regular review of those family members identified as hepatitis B carriers and preventing chronic infection with hepatitis B vaccine for those who had not been exposed to the virus. While liver cancer had brought this family in contact with the Hepatitis Research Unit and the skills of the Wellington School of Medicine, their willing participation in research gave new understanding to their health needs and Māori health. Being Māori and sharing similar cultural values made the building of a relationship much easier and sharing similar cultural values was important.

Culture is often how the behaviour and values of ethnic minorities are described to others. In the context of culture, the issue of health is shared between the patient and health professional but viewed from their perspective which may not share important factors. Understanding how safety is threatened by known scientifically proven hazards is something we are trained for as scientist. Differences in cultural norms play an important role in the relationship between the patient and the health professional. Mitigating the risk of the unknown may in part be a matter of understanding what health issues are important to your patient and strategies that can be used to avoid risk or mitigate negative outcomes while maintaining high scientific standards. Understanding not only the situation in which your patient may present but also the balancing their expectations with what can be expected is where professional skill meets art. Considering what may guide you these situations is what understanding more about Māori health may contribute to the better application of science to meet the health needs of your patients.

The skill of the phlebotomist is reflected in the willingness of the patient to be a partner to the successful extraction of blood. The tasks of the phlebotomist include the location of a suitable vein and extracting the blood while putting the patient at ease. Ensuring that the patient is relaxed as possible is in part how quickly a comfortable relationship is established. Knowing the person’s name and pronouncing it in a manner in which they are familiar is a good start.

Phlebotomy is also an example of multi-tasking, an artful application of science and social skills. However, for the learner the art of putting the patient at ease comes some time after the anatomy of the vein is intuitive and the insertion of the needle a reflex. For many Māori tena koe is a greeting said by a host who wishes to acknowledge their visitor as a Māori. To the patient who is Māori, tena koe is the recognition of a human person by another who appreciates the value of being Māori. Cher bro is used by younger Māori as a greeting signifying warmth and familiarity, having the same positive recognition as tena koe and bringing minds closer together.

Māori health is different to that of non-Māori. Health statistics tells us a story of a greater burden of ill health and disease borne by Māori and that Māori die earlier than their non-Māori peers. The factors of life and environment that influence Māori health and wellbeing are known and can be treated as health determinants. Where people interact with medicine is an opportunity to get off to a good start and build a good relationship. When next you meet a new patient and think to yourself should I address this person with tena koe or cher bro, you will have undertaken a new way of thinking about your patients. Should you begin to think of new and old patients in this way, the next time you are face to face with a patient, you reward your self with a “cher bro”.

References