

The human and health costs of failure to implement pro-Tiriti and pro-equity health policies: let's act as if we know this

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After a twenty-year period of relative stability in the health system, we are entering a period of very considerable change. These changes are driven, in part, by a clearly stated desire on the part of government for fairer health outcomes for Māori. We are seeing a number of important new policies and initiatives taking shape in support of that objective, including the establishment of the Māori Health Authority and the structuring-in of formal iwi-partnership boards. The stakes are high. Unfair Māori health outcomes have been widely documented and discussed for decades and, more recently, have been starkly called out by the Waitangi Tribunal in its Hauora report.¹ My sense is that amongst many of those working in the health system, there is a mood for change and for action on Māori health outcomes, along with a recognition that changes will mean doing the business of health somewhat differently.

The purpose of this editorial is to draw attention to an innovative analysis commissioned by Waitangi Tribunal claimants in response to a recommendation from the Tribunal that the Crown and the claimants “agree upon a methodology for the assessment of the extent of underfunding of Māori primary health organisations and providers. The methodology should include a means of assessing initial establishment and ongoing resource underfunding since the commencement of the New Zealand Primary Health and Disability Act 2000.”¹ Sapere Research Group were commissioned by the claimants to carry out this work with

oversight from an expert advisory group, of which I was a member.

Sapere Research Group's report² makes for sobering reading. An overview of the report was provided in a recent newspaper article.³ I wish here to highlight its importance in the context of the current health reforms. The logic of the report is centred around three sets of questions:

- What did Māori primary health organisations receive by way of funding from the time of the implementation of the Primary Health Care Strategy⁴ in the early 2000s? How much less was this than the actual need for funding? How well was funding distributed according to the patterns of need?
- What would it have taken to implement the Primary Health Care Strategy in a meaningful way for Māori health services? In other words, what was actually required to achieve the promise of the strategy?
- What is the equivalent monetary cost of the health burden experienced by Māori that could have been addressed through proper implementation of the Primary Health Care Strategy?

In brief, some of the answers to these three sets of questions are as follows. First, the cost in dollars for a test population of four Māori primary health organisations indicates that the funding formula, as then used, underfunded those organisations over an 18-year period by between \$346 million and \$412 million. It is no wonder that a

number of Māori primary health providers were closed or were sold during that time.

Second, estimates were made of the cost of delivering a comprehensive primary health care service to a Māori population, consistent with the vision of the Primary Health Care Strategy. The report notes that if the promise of the strategy had fully come to fruition for Māori, then we would expect government to be investing up to \$1 billion per year in Māori primary health organisations.

The answer to the third set of questions is shocking. No one would suggest that dollar values in any way properly reflect the stories of grief and human suffering borne by Māori that lie behind the figures. However, to respond to the recommendation of the Tribunal, the researchers used conventional economic approaches to estimate the dollar-equivalent cost of underfunding and under-provision of primary healthcare for Māori, that is, the cost of poor health and deaths for Māori over an 18-year time period that may be attributable to failed policy implementation. That cost is in excess of \$5 billion per annum.

There are, needless to say, limitations of the methodological approach taken by the researchers, some of which are identified in their report. To my mind the significance of this work far transcends debates over methodological details or interpretation of sensitivity analyses. In attempting to quantify the human and economic costs to Māori of failed policy implementation, the authors have focussed an unforgiving spotlight on the critical imperative to implement the current health reforms so that they actually achieve their pro-equity policy objectives for Māori. Looking back over the past twenty years, it is easy to see that the claimants will feel they have a strong case for compensation because of the direct effects of underfunding. Looking forward it is equally easy to see the implications for

our health system, and those who govern and manage it, as we move into a period of change and reform. For me, the most important of those lessons concern first power, control and decision-making, and second they concern funding of primary care services. The two points are linked.

The first point speaks to the recognition that, to drive pro-Tiriti and pro-equity changes consistently over the long-term within the context of a complex adaptive system that has entrenched Pākehā power within most of its parts, the exercise by Māori of tino rangatiratanga in governance and decision-making is a foundational requirement, hence the importance of the Māori Health Authority and iwi-partnership boards. The theory here is that Māori decision-makers are far more likely to make pro-Tiriti and pro-equity policy and funding decisions, and the cumulative effect of many such decisions will, over time, lead to improved health outcomes for Māori. The second point is that the primary healthcare funding mechanisms must recognise need for healthcare over and above age and sex, and in particular they must recognise the funding requirements of Māori primary health organisations that serve large concentrations of high-needs people where there is little or no opportunity for internal cross-subsidisation of one set of services by another. I am not convinced that any single funding formula can take account of the funding needs of typical general practices and those of Māori, Pacific and other community-owned primary care organisations at the same time. Special funding mechanisms are required for this latter group of organisations.

The Waitangi Tribunal's Hauora report and this subsequent piece of work commissioned by the claimants provide guiding lights for those designing the system. I urge those responsible for decision-making in the design of the new system to heed the lessons that have been so clearly laid out before us.

Competing interests:

Peter Crampton is a researcher and lecturer at the University of Otago. In 2018 he gave evidence to the 2018 Waitangi Tribunal on alleged failures of the Crown to properly implement its 2001 Primary Health Care Strategy. He was a member of the panel that reviewed the health system on behalf of government (the Simpson report), and in 2020–2021 he was a member of the expert advisory group for the claimants who commissioned an analysis of the costs of underfunding Māori primary healthcare organisations. There was no external funding source for preparing this article. The views, opinions, findings and conclusions or recommendations expressed in this paper are strictly those of the author. The paper is presented not as policy, but with a view to inform and stimulate wider debate.

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