



HEALTH QUALITY & SAFETY
COMMISSION NEW ZEALAND
Kupu Taurangi Hauora o Aotearoa

BULA SAUTU

A window on quality 2021:
Pacific health in the year of COVID-19
He mata kounga 2021:
Hauora Pasifika i te tau COVID-19



'Bula Sautu' is a Fijian saying expressing an aspirational goal for 'good health that is lived to its full potential; a life of abundance'.

Bula Sautu is the product of a partnership and co-development process between Corina Grey, Debbie Ryan and Api Talemaitoga for Pacific Perspectives and the Health Quality & Safety Commission.

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Abbreviations | Ngā whakarāpopoto

ACS	Acute coronary syndrome (heart attacks and unstable angina)
BMI	Body mass index
DHB	District health board
DNA	'Did not attend' an appointment
eGFR	Estimated glomerular filtration rate
GDM	Gestational diabetes mellitus
GP	General practitioner
HbA1c	Glycated haemoglobin (a measure of blood glucose control)
HPV	Human papillomavirus
LMC	Lead maternity carer
MMR	Measles, mumps and rubella (vaccine)
PGPN	Pacific General Practitioners Network
PHO	Primary health organisation
PMMRC	Perinatal and Maternal Mortality Review Committee
PPE	Personal protective equipment
WCTO	Well Child/Tamariki Ora

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Foreword – Associate Professor Collin Tukuitonga | Kupu o mua-Nā Ahonuku Collin Tukuitonga

Good health and wellbeing are fundamental human rights and vital prerequisites for full participation in society.

Pacific peoples who call Aotearoa New Zealand home have been denied their right to health and wellbeing for decades despite clear evidence that inequities exist in almost all health conditions reported.

Inequities in health reflect differences in the broader socioeconomic determinants such as education, employment and housing. Improvement in health and wellbeing is unlikely until there is fairer distribution of wealth and income, and improvements in educational outcomes for Pacific peoples. Access to warm, affordable and less-crowded housing is particularly important for Pacific families given the high incidence among Pacific peoples of infectious diseases such as acute rheumatic fever.

The literature reveals difficulties in access to health care and shortcomings in the quality of care received by Pacific people, across the entire spectrum of services from prevention to rehabilitation and end-of-life care. These shortcomings reflect systematic bias (and racism) in the New Zealand health and disability system and the lack of diversity in the health workforce. There is overwhelming global evidence that concordance between the health care provider and the client (patient) leads to better health outcomes, yet Pacific doctors constitute less than 2% of the total medical workforce in New Zealand. There is, furthermore, only marginal change in the training of a more diverse health workforce in New Zealand.

Despite several national policy statements and strategic plans designed to improve the health and wellbeing of Pacific peoples, there has been little improvement overall except in a small range of areas.

The time has come for a more purposeful and ambitious agenda to eliminate health inequities in New Zealand.

Bula Sautu – A window on quality: Pacific health in the year of COVID-19 is a comprehensive analysis of the health status of Pacific people in New Zealand. The report acknowledges tangata whenua and our shared history and challenges with the New Zealand health system. However, unlike indigenous Māori,

Pacific peoples in New Zealand have no founding document or tribunal to call upon, and we find ourselves subject to the shifting winds of political change, our voices often lost in the scramble for resources. *Bula Sautu* is a challenge to the New Zealand health system and a call for transformation and change.

Addressing improvement in Pacific health is challenging, but there is a way forward. This way forward involves strong and supported Pacific leadership, effective partnerships with Pacific communities, and systematic, coordinated action within all levels of the health and social sectors and beyond. Within the health sector, there are a number of key actions that organisations and individual services can take, many of them within existing resources. These actions, presented as a seven-step framework to improve Pacific health, focus on using data in a meaningful way to inform continuous improvements in service delivery by facilitating access, ensuring continuity of care, promoting high-quality interactions with patients and families, communicating effectively, addressing health and social issues holistically, supporting the Pacific workforce, and engaging authentically with Pacific communities.

The response from the Pacific communities, health care providers, social support agencies and media to the outbreaks of COVID-19 in Auckland have clearly demonstrated the potential of Pacific peoples to make huge impactful contributions. This potential needs to be harnessed and used to co-design a way forward for all health issues.

Improvements in Pacific health outcomes and a reduction in health inequities will not happen without an ambitious change and transformation agenda. A strategy based on 'business as usual' will not enable the change that is required. The collection and analysis of appropriate data for decision-making is a fundamental requirement and a planned approach is needed. Furthermore, investment in improvements in the quality of care is urgently needed, including investment in a diverse health workforce that reflects modern New Zealand society.

Kia monuina.

Associate Professor Collin Tukuitonga
University of Auckland

Preface | Kōrero tīmatanga

While Aotearoa New Zealand has a health system that compares favourably with many overseas jurisdictions, health inequities continue to disproportionately affect Māori and Pacific peoples.

Health inequities are defined as differences in health status or in the distribution of health resources between population groups that arise due to the social and economic conditions in which people are born, live, work and age.¹ This definition of inequity recognises that the differences in health are avoidable, unfair and unjust. Equity approaches recognise that people with different levels of advantage require different approaches and resources to get equitable health outcomes.²

The 2020 Health and Disability System Review recognised and emphasised the role of government in ensuring health equity through the design of systems, structures and processes that support services to recognise and meet the needs of the people they serve.³

For more than 25 years, New Zealand has had high-level policy commitments and identified health system action to address inequalities and improve the health of all New Zealanders.⁴ More recently, the Health Quality & Safety Commission (the Commission) published *He matapihi ki te kounga o ngā manaakitanga ā-hauora o Aotearoa 2019 | A window on the quality of Aotearoa New Zealand's health care 2019*.⁵ This report provided a focus on inequities in Māori health, discussed the reasons for persisting health disparities between Māori and non-Māori, and made recommendations for health system action to advance Māori health.

One of the Commission's findings was that our health care system has organised care in a way that is systematically and structurally racist to the detriment of Māori and Pacific health outcomes. The paucity of nationally reported data available for Pacific peoples, let alone by individual Pacific island ethnicities, is a vivid example of this: the issue cannot even be fully understood because our systems of data collection and analysis are not designed to capture Pacific identities, outcomes or experience appropriately. Prioritising the capture of data that is sufficiently granular to support specific action is paramount for designing a system that meets the needs of Pacific peoples.

We are at a point of change in our system where enactment of Te Tiriti o Waitangi is explicitly part of our health reforms response to the 2020 Health and Disability System Review.³ There is, however, a silence on Pacific issues, and persisting inequities due to system quality and performance issues, in the reforms conversation. This is despite the review's calls for better and more granular capture and analysis of Pacific data, and specific workforce plans for Pacific peoples (p 203, 218 of the review).⁶ During the COVID-19 response we have seen Pacific and Māori providers given and acting successfully on the freedom to pursue contextualised responses that are appropriate to their communities.⁷ Pacific health issues, needs and contexts are intimately connected with those of Māori, but they differ, and they are complex and vary within the umbrella term 'Pacific' itself. 'Every system is perfectly designed to get the results it gets,' wrote Paul Batalden (from a quote by Arthur Jones).⁸ Our mainstream health care system is designed neither for nor with Pacific peoples and is failing to meet Pacific needs. It is in effect designed to get the failures in health care quality and health outcomes and thus the failures of human rights and rights of New Zealand citizenship for Pacific peoples this report will go on to describe.

In response, at a system (macro) level we propose the New Zealand health system creates change in four key areas, and we propose some early steps for this change (see box overleaf).



Four areas for system-level change, and proposed early steps

A structural response is needed from the system

- Address whole-family issues and social determinants of health through comprehensive inter-agency cooperation – health must work with social welfare and with housing, for example, to ‘wrap around’ Pacific consumers and family groups.
- Pacific communities and stakeholders must be consulted over whether Pacific health needs its own specific leadership and commissioning context. We must access and draw on the strengths and creativity of Pacific communities and consumers.

The system must enable Pacific peoples to identify and design Pacific solutions

- Shift resource to give Pacific providers greater freedom to act on their communities’ needs – the COVID-19 response has shown this approach is successful.
- Resource, develop and strengthen mechanisms for the voices of Pacific consumers and families to be heard and acted upon.

Leaders and decision-makers in our training establishments and professions must take decisive action to support and grow the Pacific workforce required at all levels of the system

- Develop a unified, systematic and coordinated approach to increasing Pacific representation in our workforce.
- Increase enrolments of Pacific learners in training institutions and support those Pacific learners in culturally appropriate ways to complete training successfully. We need more Pacific leaders, teachers and academics.
- Drive curriculum change by developing the knowledge of leaders in decision-making positions across all health training institutions. Addressing Pacific health inequities must be a central component within training institutions in Aotearoa New Zealand.

We must address the unacceptable racism of our system, that is a driver of inequitable health care processes and outcomes, and is enabled by the structure of the system

- Health leadership must establish the appropriate measures, benchmarks and local actions for all leaders and decision-makers across the whole system to address Pacific health inequities and to drive measurably improved outcomes for all Pacific peoples in Aotearoa New Zealand (not just those concentrated in the main centres).

Acknowledgement of Te Tiriti o Waitangi and of Māori as the indigenous people of Aotearoa

In te reo Māori there is a whakataukī that states:

*E kore au e ngaro, he kākano i ruia mai i Rangīātea.
(I will never be lost, for I am a seed sown in Rangīātea.)*

Where is Rangīātea? In the words of novelist and social anthropologist Epeli Hau'ofa, it is in 'our sea of islands': the Pacific. It is Rangīātea – Ra'īātea – Hawaiki – Hawai'i – Savai'i, and other locations that our ancient waka sailed from.

Tangata whenua o Aotearoa are the whānau of the Indigenous peoples of the Pacific. What does all of this mean for us today? Māori as the Indigenous people of Aotearoa New Zealand understand that they also belong to tagata o le moana – tangata o te moana nui a Kiwa. Māori and Pacific peoples share rich historical ties and whakapapa (genealogy) that determine their special whanaungatanga (relationship) to and with each other.

Aotearoa New Zealand is a nation that exists on Pacific islands but does not, and perhaps cannot, see itself as a Pacific Island nation or its people as Pacific Islanders.

For most New Zealanders, Pacific Islanders are those who come from a few places to the north – mostly in Polynesia – to clean, to work in factories, to labour, and who had children here. The category that New Zealand has come to use, 'Pacific Islander', has ensured that New Zealand ways of seeing are fundamentally disconnected from the Pacific.⁹

Pākehā New Zealanders live on Pacific islands, but many – perhaps most – identify as 'Europeans', even if the Pacific has been home for generations. In these kinds of understandings and claims, there can be no acknowledgement of Pacific place and Pacific histories, no claiming of a Pacific connection, let alone a Pacific-based identity.

There is consequently little opportunity for New Zealanders to reflect on what the Pacific means. This way of seeing and understanding also does a peculiar kind of violence to those who whakapapa to each other through shared genealogies. Genealogies connect tangata whenua with the other tagata o le moana – the many other peoples of what is now called Polynesia.⁹

As New Zealanders we need firstly to understand that to address the inequities occurring for Pacific peoples we also need to position them in their rightful place, as indigenous peoples of the Pacific, wider whānau of tangata whenua, and current partners in a reciprocal relationship with the government and peoples of Aotearoa New Zealand.

This report acknowledges and pays respect to Māori as the tangata whenua of Aotearoa and proposes a deep commitment to Te Tiriti o Waitangi (Te Tiriti) as a critical tool in advancing Māori health, including equity of outcomes. Article 2 of Te Tiriti – Tino rangatiratanga (self-determination) – recognises the importance of tangata whenua authority and autonomy. A significant element of rangatiratanga (chieftainship) is the obligation to provide manaakitanga (hospitality) to visitors (manuhiri) – in particular, to those connected by whakapapa. In effect, the negative health outcomes described in this report represent a second-order failing of Te Tiriti by showing how our system denies the right of Māori to provide adequate hospitality, livelihood and care to the interconnected peoples of te moana nui a Kiwa living in Aotearoa. Our system fails Māori in their ability to provide according a Māori worldview, social structures and norms. Furthermore, the third article of Te Tiriti – Ōritetanga (equality) – guarantees equitable outcomes for Māori and non-Māori, and establishes that all New Zealanders are equal under the law. Thus, the systems, structures and processes designed to enact Te Tiriti should benefit all other groups living in Aotearoa,¹⁰ including Pacific peoples. The upholding of Te Tiriti does contribute to the elimination of institutional racism, a key determinant of health inequity.¹¹



We are charged as a nation to uphold and enact Te Tiriti o Waitangi. In doing so, we have obligations, responsibilities and accountabilities to tangata whenua to ensure their whānau of the Pacific are supported to access what they need to thrive and be well.

To know that the inequities for Pacific peoples described in this report exist is one thing; to do nothing to address these inequities is another thing entirely. The inequities experienced by Pacific peoples in Aotearoa can be changed. We need to take action across every health and wellbeing context and commit to partnering with Pacific peoples to change these outcomes.

***A'ohe pau ka 'ike i ka halau ho'okahi.
(All knowledge is not taught in the same school.)***

The Ministry of Health's *Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025*¹² aims to provide a new direction for Pacific health and improve Pacific peoples' overall health and wellbeing. The report states that:

Ola Manuia acknowledges health inequities for Māori as tangata whenua of Aotearoa New Zealand. *He Korowai Oranga: The Māori Health Strategy* is the health and disability system's guide to improving Māori health and realising pae ora – healthy futures for Māori. Through its activities, *Ola Manuia* will also advocate, support and contribute to *He Korowai Oranga* objectives to improving Māori health outcomes.¹²

Ola Manuia is the latest iteration of a national health sector plan for Pacific peoples, following on from the first Pacific Health and Disability Action Plan published in 2002.¹³ Other government agencies have also provided guidance through policy and plans relevant to addressing the social and economic determinants of Pacific peoples' health.^{14, 15}

A focus on Pacific health

Eighteen years after the first Pacific Health and Disability Action Plan, *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19* provides a focus on Pacific health for this year's Health Quality & Safety Commission (the Commission) Window on Quality. *Bula Sautu* builds on the Commission's learnings and the perspectives of Pacific experts, clinicians, and community workers and members, and draws on policy frameworks and the evidence base of international and New Zealand research that is available to guide actions to address inequities between population groups.⁴

Bula Sautu considers the health of Pacific peoples and provides a snapshot view of how the health system is responding to work toward equity and the improvement of the health status of Pacific peoples. It considers outcomes, strategies and how these strategies are being implemented, and it emphasises the learnings from initiatives that can be applied in other areas to address the long-standing and persistent disparities in Pacific health.

Bula Sautu also emphasises the importance of the systems we work within, and advises on what can be done at the system level to support health equity and advancement for Pacific peoples. Dominant monocultural worldviews within systems and structures (institutional racism) contribute to inequity for those that have worldviews and approaches that differ.¹⁶ To facilitate health equity and advancement for Pacific peoples, Pacific values, worldviews and expertise are required, not only within service delivery but also at the system level across the agencies and functions of government.

At no time have population health and the impacts of poor health on society been more pertinent than during this unprecedented global COVID-19 pandemic.

Executive summary | Whakarāpopototanga matua

Bula Sautu uses national data to show the complex contributing factors that impact on health for Pacific peoples, from maternity to end of life, using a life-course approach. The report brings together a diverse range of Pacific health and equity experts to share their views of how effectively (or ineffectively) the health system is performing for Pacific peoples.

Bula Sautu shows us some of the worst inequities in our health care system (see box on right) but also profiles providers, communities and individuals responding creatively, brilliantly and vibrantly within the constraints imposed upon them.

The report shows how our mainstream health system is designed neither for nor with Pacific peoples and is failing to meet Pacific needs. It reveals our systems of data and analysis systematically occlude, miss and misunderstand Pacific peoples and their complexity so we at present cannot fully understand the complete nature of these inequities.

These inequities of quality of care and outcome represent a systemic failure of New Zealand citizen and human rights, and a national shame.

The indicators presented here are not a compendium of all epidemiological data available for Pacific peoples. Rather, they represent a compromise between presentation of examples of broader issues, availability and robustness of national data by Pacific ethnicity, and the limitations of space. Data for Pacific peoples is a challenge. Much of the national data is not publicly available for Pacific ethnicities and even less captures individual Pacific ethnic groups.

Pacific peoples are significantly under-represented across the entire health workforce, while representativeness is widely understood as being crucial to effective engagement with the population and to address inequities in health outcomes.

To address the inequities highlighted in this report, Pacific peoples need to be positioned in their rightful place, as indigenous peoples of the Pacific, wider whānau of tangata whenua of Aotearoa, and current partners in a reciprocal relationship with

Examples of inequities facing Pacific peoples

- Pacific peoples live, on average, six fewer years than non-Māori non-Pacific.
- Less than half (47%) of pregnant Pacific women were registered with a lead maternity carer (LMC) in 2018, compared with 81% of non-Māori, non-Pacific women.
- Pacific women subsequently experience more complications during pregnancy, more intensive interventions during and after birth, and worse outcomes for both mother and baby than other ethnicities.
- Routinely around 90% of Pacific children aged two and five years old receive all their scheduled immunisations, similar to children of European ancestry. However, only 59% of Pacific families of infants in their first year of life received all their Well Child/Tamariki Ora core contacts, compared with 81% of non-Māori, non-Pacific families.
- Pacific children subsequently experience a higher incidence of a range of conditions, including asthma, dental problems, and ear and skin infections, than children from other ethnic groups. Only 36% of five-year-old Pacific children are free of caries (tooth decay) compared with 69% of non-Māori, non-Pacific children.
- There is a lack of national data on the health of Pacific youth but survey data suggests rising rates of depressive symptoms and attempted suicide in Pacific youth, and barriers to accessing health care.
- For Pacific peoples some aspects of preventative health care, like flu immunisations, seem to perform well, but Pacific peoples bear a disproportionate burden of long-term conditions including gout, cardiovascular disease, kidney disease, cancer and asthma, and, in particular, diabetes. Those with diabetes experience a trifecta of issues:
 - earlier onset leading to earlier and worse complications
 - inadequate management and control of diabetes
 - worse hospitalisation rates relative to other ethnic groups.
- Pacific peoples are significantly under-represented across the entire health workforce.



the government and peoples of Aotearoa New Zealand. In upholding and enacting Te Tiriti o Waitangi, we support tangata whenua to ensure their Pacific whānau are supported to access what they need to thrive and be well here.

Pacific populations are diverse, young, growing, primarily urban and increasingly born in New Zealand. Pacific peoples are more likely than other New Zealanders to experience material deprivation, with a downstream effect on health. However, in the face of ongoing structural disadvantage, survey data reveals Pacific peoples have maintained stronger community connections, bonds of trust and religious identity than New Zealanders as a whole, while holding on to enduring cultural values, highlighting the important strengths and resiliencies in Pacific communities. Survey data also reveals that, despite reporting experience of acutely felt material deprivation, Pacific peoples retain residual high levels of trust in New Zealand institutions, and high self-rated health and life satisfaction. This self-rated health and life satisfaction is, however, in recent steep decline.

While Pacific peoples often face challenging socioeconomic circumstances, the strengths, resiliencies and innovations of the diverse Pacific communities and Pacific health workforce were evident during the response to COVID-19. The COVID-19 response for Pacific communities in 2020 highlighted the positive results of systematic and robust leadership, resourcing and inter-agency collaboration around a specific issue. The Pacific response turned on the strengths of communities and churches, addressed social issues with flexible support and deployed strong communications strategies. Tailored, holistic and integrated models of care flourished in the atmosphere of trust and innovation that funders and commissioners of services offered during the period.

Positive initiatives in Pacific health exist but lack a coordinated and systematic overall approach. In response to the findings in this report, we propose a three-pronged approach:

1. At a system (macro) level we propose the New Zealand health system creates change in four key areas, and we propose some early steps for this change (see grey box on next page).
2. At an organisational and service (meso) level, we propose seven steps for providers to address Pacific health inequities and develop strategies, policies and processes focused on achieving equity and improved outcomes for Pacific peoples (see blue box on next page).
3. At a micro level, the Commission has convened a Pacific consumer group to respond to the findings of *Bula Sautu* with an appropriate diversity of Pacific consumer voices, and will convene a Pacific consumer steering group to plan the Commission's ongoing response.

The inequities demonstrated in this report demand Pacific voices and Pacific issues be a vital part of the health reforms conversation.

Four areas for system-level change, and proposed early steps

A structural response is needed from the system

- Address whole-family issues and social determinants of health through comprehensive inter-agency cooperation – health must work with social welfare and with housing, for example, to ‘wrap around’ Pacific consumers and family groups.
- Pacific communities and stakeholders must be consulted over whether Pacific health needs its own specific leadership and commissioning context. We must access and draw on the strengths and creativity of Pacific communities and consumers.

The system must enable Pacific peoples to identify and design Pacific solutions

- Shift resource to give Pacific providers greater freedom to act on their communities’ needs – the COVID-19 response has shown this approach is successful.
- Resource, develop and strengthen mechanisms for the voices of Pacific consumers and families to be heard and acted upon.

Leaders and decision-makers in our training establishments and professions must take decisive action to support and grow the Pacific workforce required at all levels of the system

- Develop a unified, systematic and coordinated approach to increasing Pacific representation in our workforce.
- Increase enrolments of Pacific learners in training institutions and support those Pacific learners in culturally appropriate ways to complete training successfully. We need more Pacific leaders, teachers and academics.
- Drive curriculum change by developing the knowledge of leaders in decision-making positions across all health training institutions. Addressing Pacific health inequities must be a central component within training institutions in Aotearoa New Zealand.

We must address the unacceptable racism of our system, that is a driver of inequitable health care processes and outcomes, and is enabled by the structure of the system

- Health leadership must establish the appropriate measures, benchmarks and local actions for all leaders and decision-makers across the whole system to address Pacific health inequities and to drive measurably improved outcomes for all Pacific peoples in Aotearoa New Zealand (not just those concentrated in the main centres).

A seven-step framework for health sector organisations and services to improve Pacific health:

1. We know our data
2. We facilitate access, and ensure continuity of care, all along the care pathway
3. We optimise patient experience through high-quality, respectful interactions
4. We communicate clearly and effectively using health literacy principles
5. We ensure our care is holistic, integrated and comprehensive
6. We support our Pacific workforce
7. We engage authentically with Pacific communities and consumers.



Introduction | Kupu arataki

This year's Window on Quality report, *Bula Sautu – A window on quality 2021: Pacific health in the year of COVID-19*, examines health system data on Pacific peoples across the life course – from before birth, through childhood and youth, and into adulthood.

Bula Sautu is intended to provide a current snapshot of Pacific health in Aotearoa New Zealand. Rather than providing a compendium, we have chosen key indicators for health outcomes, examining the strategies and services that contribute to these outcomes and presenting data about how the strategies and services are being implemented. We have included relevant research evidence with the aim of understanding why health inequities for Pacific peoples persist and what is known about how these inequities can be resolved.

We have invited a diverse range of Pacific health and equity experts working in the relevant areas to reflect on the data and share their views of how effectively the health system is performing for Pacific peoples. This approach aligns with understanding that health inequity is complex and that local and contextual expertise is essential to support effective change.¹⁷ The perspectives of these experts are interspersed throughout the following chapters to help provide commentary on the issues, challenges and possible solutions to improving the health status of Pacific peoples. The Commission has convened a Pacific consumer group to respond to the findings of *Bula Sautu* with an appropriate diversity of Pacific consumer voices, and will convene a Pacific consumer steering group to plan the Commission's ongoing response.

Bula Sautu challenges the structures and systems we use to organise health care in New Zealand. In particular, it calls for us to look beyond our current mainstream monocultural approaches that benefit particular groups while disadvantaging others. It offers not only a view of the health inequities that our system is creating for Pacific peoples, but also the multiple ways in which Pacific peoples are adapting and responding in resilient, positive and creative ways to the challenges they face. This report highlights the strength, courage, creativity and enduring collective family and community focus that Pacific peoples bring to Aotearoa, and it challenges us to draw on these to improve our health system for Pacific peoples and for everyone else.

The report is divided into five chapters:

- **Chapter 1: Demography** includes reflections on the diversity of the group we include under the catch-all term 'Pacific peoples'. We include data on the growth and youthfulness of the population, the sustaining bonds of community and religion, and the challenges to Pacific peoples' self-rated health and life satisfaction presented by material deprivation, sub-standard housing and lower incomes.
- **Chapter 2: What the data tells us about Pacific health** brings together curated data across the life course to understand the contributors to Pacific peoples' lower life expectancies, including measures of access to and quality of health care.
- **Chapter 3: The Pacific health workforce** reviews data and expert perspectives on the lack of a representative Pacific health workforce and looks at opportunities to improve this.
- **Chapter 4: 2020: The year of COVID-19** discusses the broad and successful Pacific response to COVID-19 in 2020, in the context of evidence suggesting Pacific and Māori populations were likely to be most affected by the pandemic.
- **Chapter 5: A transformative approach** proposes a seven-step framework to address the issues that affect the health of Pacific populations, and to shape positive change.¹⁸ Alongside what providers can do to support Pacific health equity, there is a strong focus on the roles and responsibilities of government agencies and the wider system.

Methods: Kapasa – Pacific policy analysis and the life course

Kapasa, the Pacific policy analysis tool, has provided the overall framework for the approach we have taken in this report.¹⁴ Kapasa recommends three 'overlays' to apply to policy development processes:

1. Information and evidence about Pacific peoples
2. Pacific peoples' values, strengths and diversity
3. Pacific peoples' engagement.

To this we have added relevant approaches from the equity literature. This includes recognising the dual influences of 'place' – where Pacific peoples live and the impact of this on opportunity – and 'life course' – the cumulative impacts of influences experienced at a young age and throughout life.

Part of the foundation of the life course approach is to acknowledge that outcomes in later life are influenced by social advantages and disadvantages over a person's lifetime. From a policy perspective, understanding the mechanisms through which such life course influences operate, and how context shapes them, is central to improving outcomes in later life.¹⁹ By choosing to use a life course approach, we aim to show the complexity of contributing factors that impact health for Pacific peoples, and to highlight that interventions and responses are most usefully directed at the causes of ill health and inequity rather than the consequences. When the causes are systemic, the most useful solutions involve system and structure change.

The indicators presented here are not a comprehensive description of all inequities at play in the life course. Rather, they represent a compromise between presentation of examples of broader issues, availability and robustness of national data by Pacific ethnicity, and the limitations of space. Finding data for Pacific peoples is a challenge. Much national data is not publicly available for Pacific ethnicities, and even less captures individual Pacific ethnic groups. The 2018 Census has had powerful effects on Pacific demographic and other data – the low response rate for Pacific peoples (only 65% compared to 83% of the total population, and a fall of more than 20 percentage points from the 2013 Census) means we used predominantly Census 2013 population numbers to avoid the distortionary effects of this undercount of the Pacific population.²⁰ Chapter 1: Demography and the 'On the life course: youth' section in Chapter 2 further discuss the complex multiple ethnic identities a large and growing number of Pacific peoples negotiate, which are not often well-reflected in the reporting of ethnicity data at a national level. Indeed, a consistent, underlying message of *Bula Sautu* is that better data, better understood, is crucial to the improvement of health for Pacific peoples.

As with all of our Window on Quality reports, indicators used are generally already in the public domain, drawing on data made available by the Commission, the Ministry of Health or peer-reviewed publications. A detailed description of life course epidemiology and a more detailed description of the rationale, methodology and sources for all of the indicators presented are available on request.



In sum, *Bula Sautu* presents a picture that illustrates the following points.

- Pacific populations are configured uniquely with specific strengths, challenges and needs, yet we seem to expect a mainstream system designed neither for nor with Pacific peoples to meet Pacific needs.
- Access to this system for Pacific peoples is often therefore lower because of the way it is designed.
- Even once accessed, care is sometimes worse for many reasons.
- This combination of lower access and worse quality of care can lead to poorer outcomes, which in turn exacerbate the challenges and needs of the community.
- But there are visible glimmers of hope often centred on the strengths of communities, and a transformatory approach for Pacific health can be built on this.
- By embracing and drawing on the expertise, knowledge and worldviews of Pacific peoples, we can strengthen the diversity, inclusiveness and responsiveness of our system, as well as improve health outcomes for Pacific peoples.

Embargoed until 5pm, Monday 5 July 2021

Chapter 1: Demography | Upoko 1: Taupori

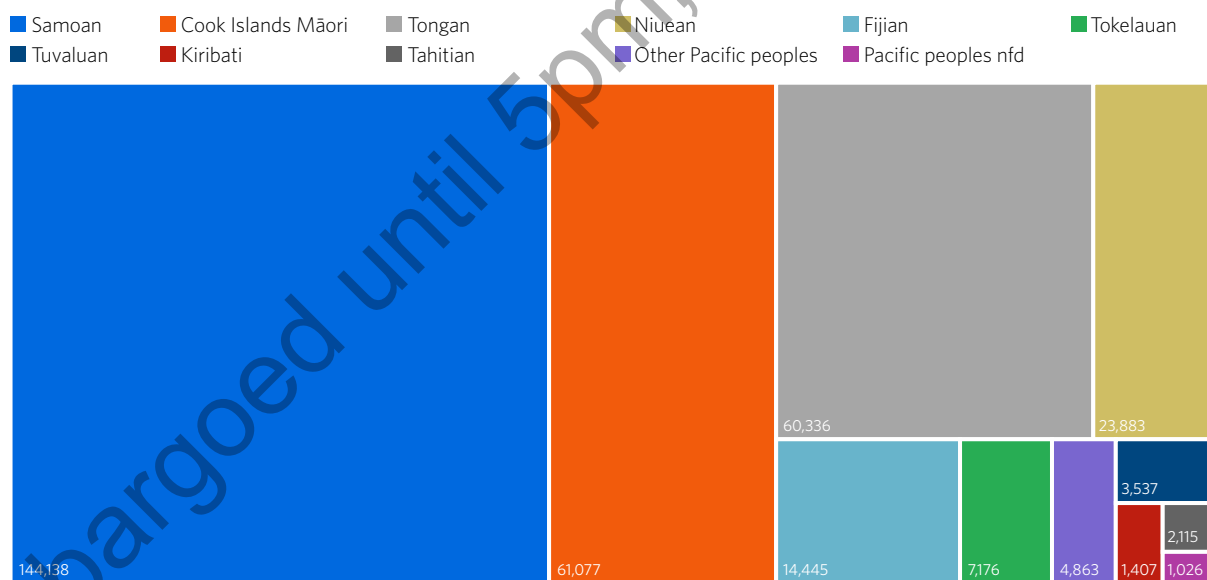
Pacific populations are diverse, young, growing, primarily urban and increasingly born in Aotearoa New Zealand. They are more likely to experience material deprivation than other New Zealanders generally, as reflected by statistics related to employment, income, wealth and housing. All of these structural disparities also have a downstream effect on health. However, in the face of ongoing structural disadvantage, Pacific peoples have maintained stronger community connectedness, bonds of trust, and religious (especially Christian) identity than New Zealanders as a whole, while holding on to enduring cultural values, highlighting the important strengths and resiliencies in Pacific communities.

Diversity

'Pacific peoples' is a collective term for diverse ethnic and cultural groups with heritage links to Pacific island countries. The seven largest Pacific ethnic groups in New Zealand are Samoan, Cook Islands Māori, Tongan, Niuean, Fijian, Tokelauan and Tuvaluan (Figures 1 and 2). Stats NZ lists more than 17 Pacific ethnicities under the level 4 category of the New Zealand Standard Classification of Ethnicity,²¹ demonstrating the significant diversity among Pacific groups.²² There is also diversity within these groups, with 25% of Pacific peoples of all ages and 40% of Pacific children and young people identifying with more than one ethnic group (compared with 7% of non-Pacific) (Stats NZ, 2013 Census).

At the 2018 Census, there were approximately 381,600 people in New Zealand who identified with at least one Pacific ethnic group. This represents around 8% of the total population in New Zealand.²³ As discussed on page 15, Census 2013 is used predominantly due to the low response rate for Pacific peoples in Census 2018.

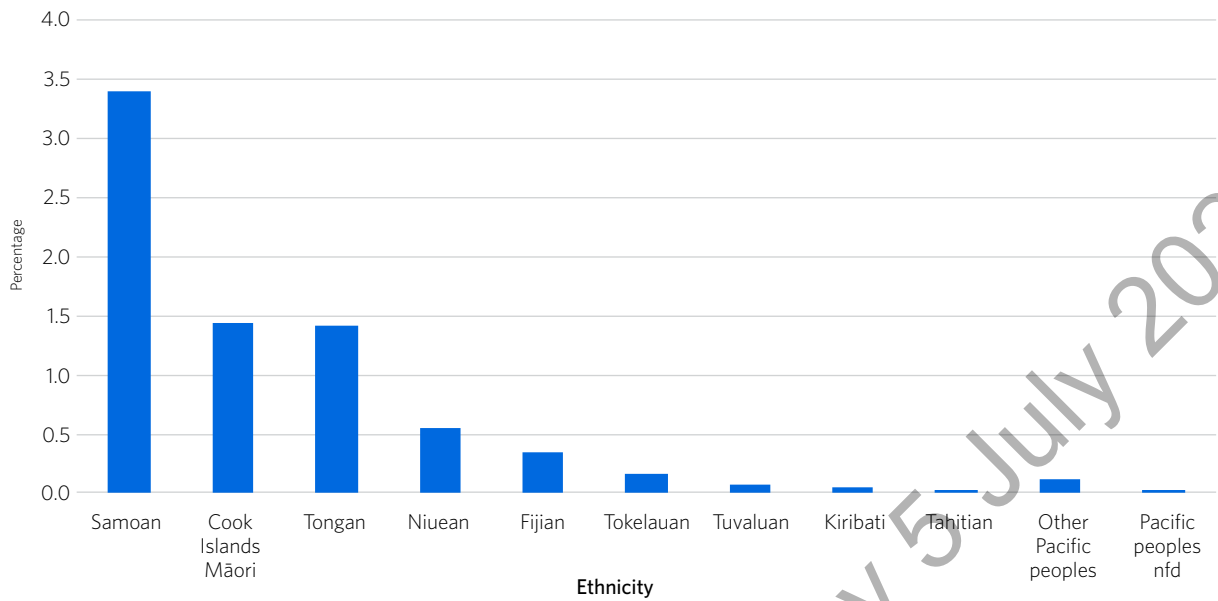
Figure 1: Pacific peoples in New Zealand, 2013 Census



nfd = no further details.
Source: Census 2013.



Figure 2: Pacific peoples in New Zealand as percentage of New Zealand population, 2013 Census



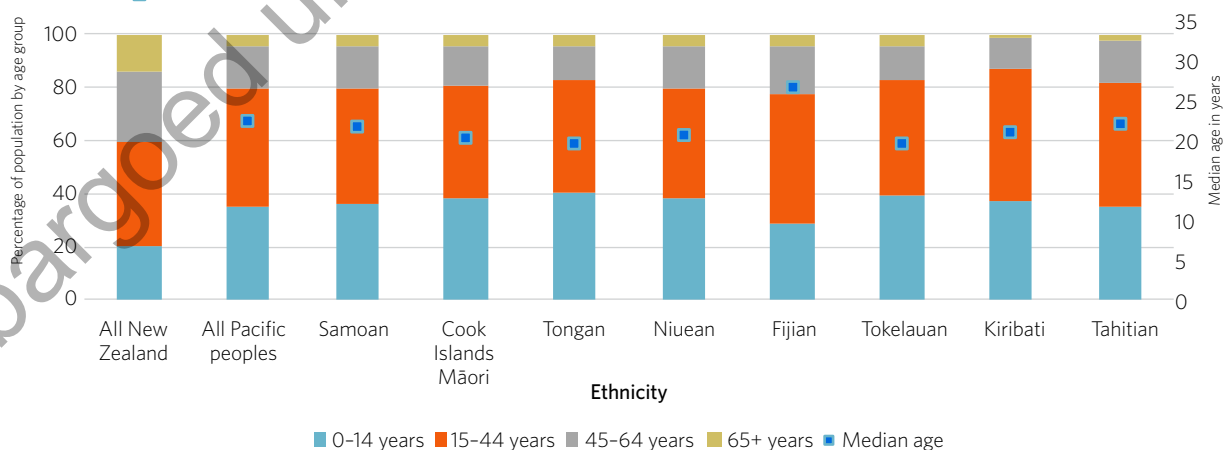
Note: nfd = no further details.
Source: Census 2013.

Youthful population

Pacific peoples have a much younger age profile than the general population (30% to 40% are younger than 15 years, compared with 20% for the whole population). The median age of the total New Zealand population was 38, whereas for all Pacific peoples other than Fijian the median age was around 20 years (Figure 3).

Forecasts estimate that by 2026 Pacific peoples will make up a significant proportion of the New Zealand labour force and potentially 30% of the Auckland working population.¹²

Figure 3: Percentage of population by age group (left-hand scale) and median age in years (right-hand scale), by ethnicity, 2013 Census



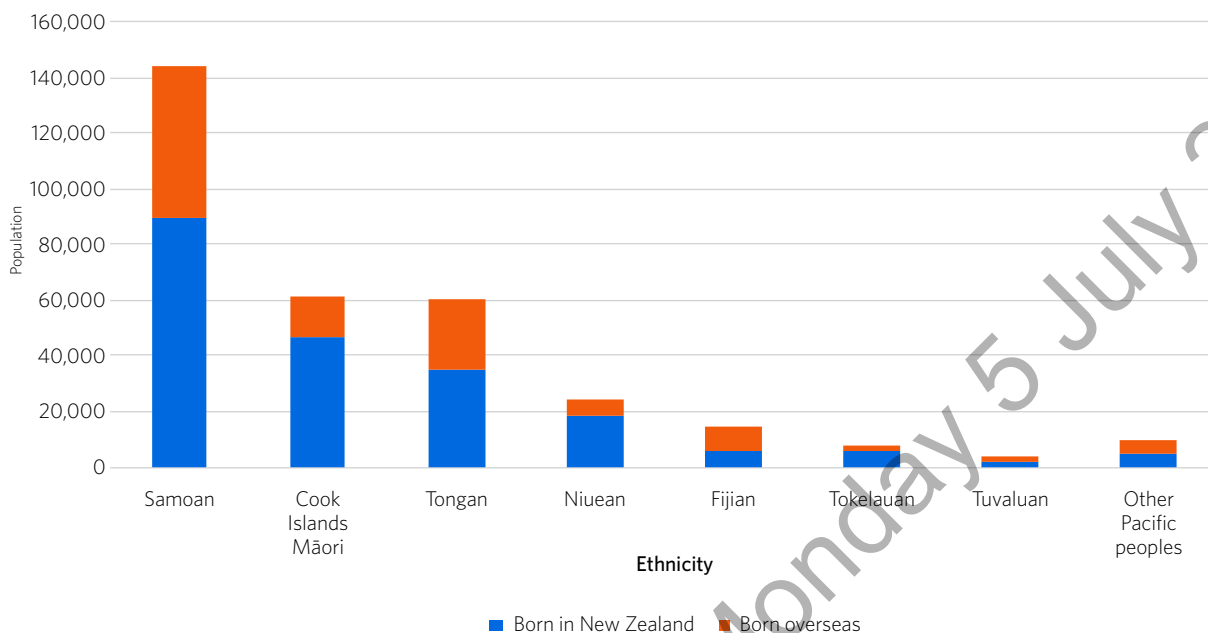
Source: Census 2013.

The evolving identities of young Pacific peoples, who are increasingly born in New Zealand, is discussed further in the 'On the life course: youth' section in Chapter 2.

Place of birth

The majority of Pacific peoples living in New Zealand were born in New Zealand, except for the Fijian and Tuvaluan populations (Figure 4).

Figure 4: Pacific peoples population by place of birth, 2013 Census



Source: Census 2013.

Trans-national communities

Pacific peoples have been described as trans-national communities, reflecting the patterns of mobility and strong kinship, social and economic ties between Pacific peoples who have settled in New Zealand, the Pacific nations and large Pacific communities in Australia and the United States of America.¹² The Pacific diaspora transcends nation boundaries, continuing models of movement and engagement that Pacific scholars argue have persisted for centuries. Renowned Tongan scholar Epeli Hau'ofa's conception of the Pacific as 'Our Sea of Islands' provides a metaphor for a holistic understanding of Pacific identity that is dynamic and encompasses diversity but also deep connections:

So much of the welfare of ordinary people of Oceania depends on an informal movement along ancient routes drawn in bloodlines invisible to the enforcers of the laws of confinement and regulated mobility.²⁴

In 2020, the global pandemic presented major challenges for these trans-national communities due to laws of regulated mobility as part of the official responses to COVID-19.

Culture, wellbeing and religion

The Ministry for Pacific Peoples points to a strong foundation for thriving and resilient Pacific communities in New Zealand, based on a set of enduring shared cultural values. These values include the importance of family, collectivism and communitarianism, spirituality, reciprocity and respect.¹²

Social bonds and community values are a notable strength of Pacific peoples in New Zealand. Pacific peoples are least likely of all ethnicities to report feeling lonely (Figure 5) and are the most likely to have face-to-face contact with family and friends at least once a week (Figure 6).



Figure 5: Percentage of New Zealanders who reported feeling lonely in the last four weeks (Wellbeing Measures), April 2018–March 2019

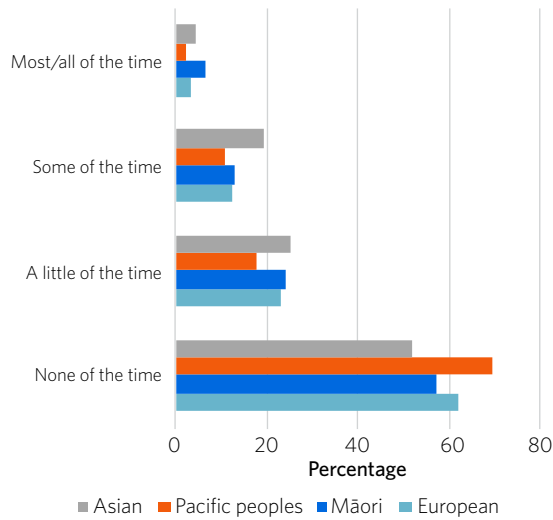
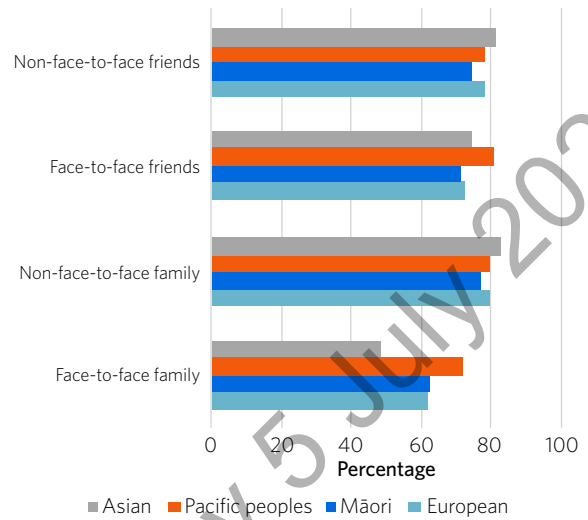


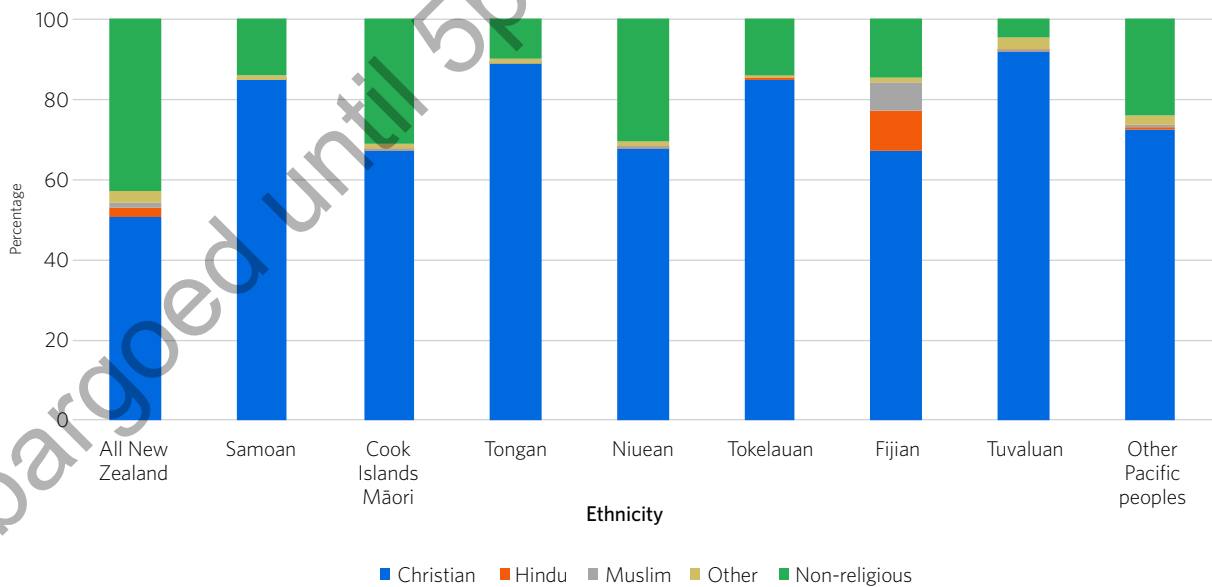
Figure 6: Percentage of New Zealanders who reported having contact with family and friends at least once a week (Wellbeing Measures), April 2018–March 2019



Source: Wellbeing Measures.

Relative to other ethnicities, the 2013 Census shows Pacific peoples have much higher rates of religious affiliation and are more likely to have a religious affiliation than not (Figure 7). Churches play an important part in many Pacific peoples' lives and working with churches is one way to engage with Pacific communities. This was one of the strategies during the COVID-19 response, which is discussed in further detail in Chapter 4.

Figure 7: Religious affiliation of Pacific peoples in New Zealand, by ethnicity, 2013 Census



Source: Census 2013.

Place of residence

Approximately two-thirds of the Pacific population reside in the greater Auckland area, with the largest number in Counties Manukau District Health Board (DHB), outnumbering those domiciled in Auckland and Waitematā DHBs combined (Figure 8).

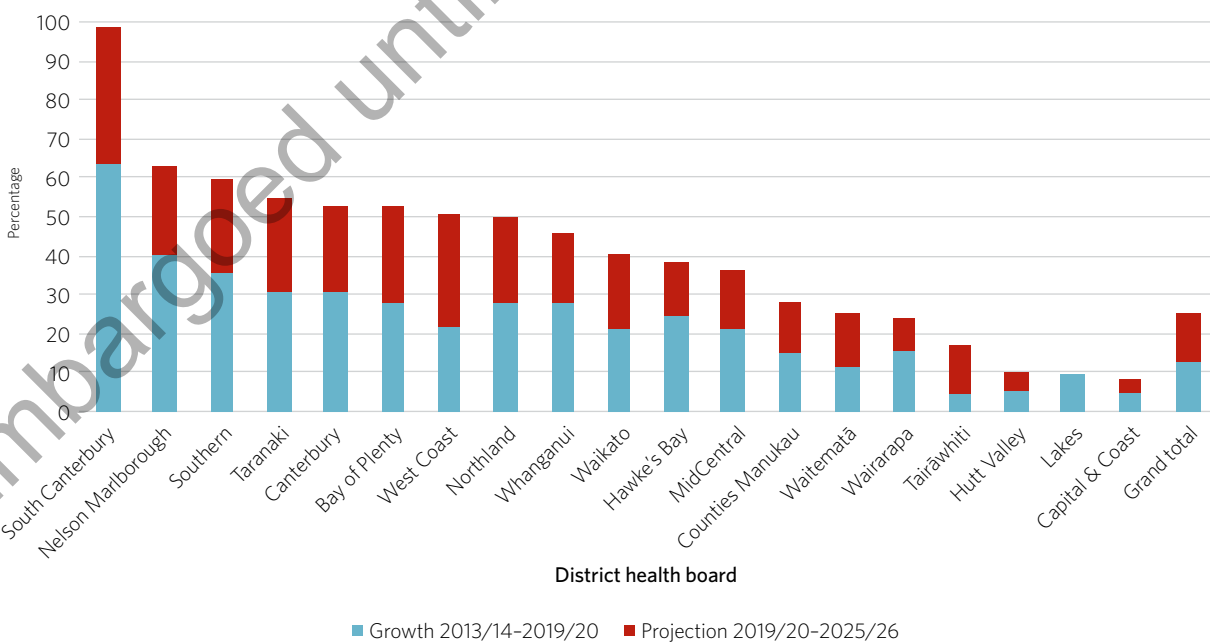
Figure 8: Pacific peoples population by district health board, Stats NZ 2019 projection



Source: Stats NZ.

However, smaller DHBs with smaller Pacific populations have experienced the largest percentage growth in their Pacific populations and are projected to see more.

Figure 9: Growth and projected percentage growth in Pacific peoples population by district health board, Stats NZ 2019 projection, 2013–26



Source: Stats NZ.

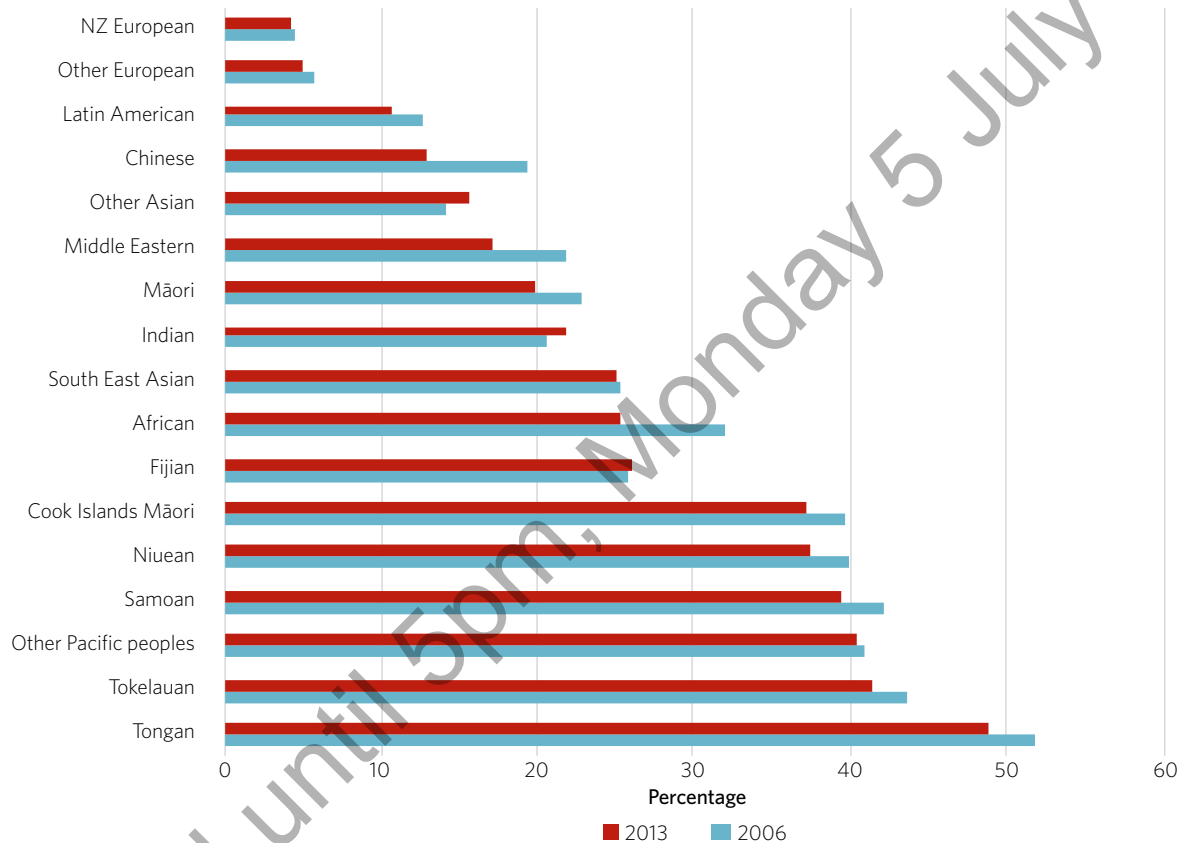


Housing

Those living in crowded housing are more likely to report housing problems such as damp and mould.²⁵ Crowded housing is consistently associated with close-contact infectious diseases, such as rheumatic fever, pneumonia and tuberculosis, and a range of other negative health outcomes such as skin infections.²⁶

Using Stats NZ's measure of crowding,²⁵ Census 2013 found Pacific ethnic groups occupied the seven highest slots for percentages of people living in 'crowded households' (Figure 10). Pacific peoples generally, at 39.8%, were eight times more likely than Europeans to live in a 'crowded' house, compared with 20% of Māori. Nearly half of all Tongan people lived in 'crowded' homes.

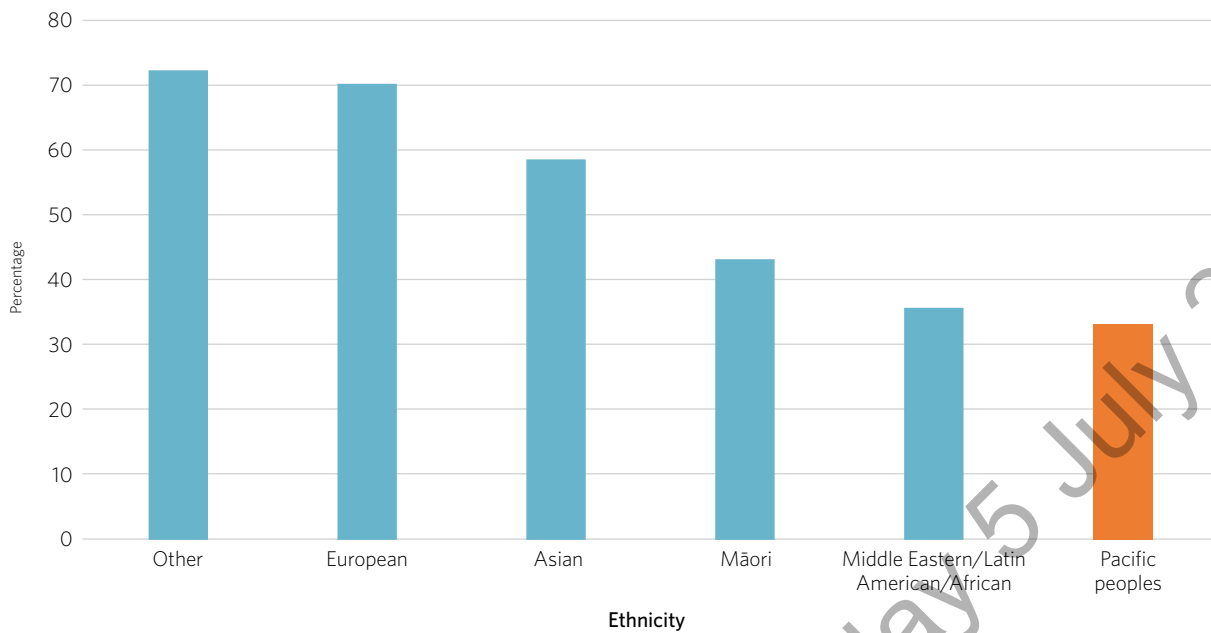
Figure 10: Crowded households in New Zealand by ethnicity, 2006 Census and 2013 Census



Source: Stats NZ.

Added to the picture of some of the negative health effects of crowded housing differentially affecting Pacific peoples is data on the quality of that housing and home ownership. At just 33% (compared with 70% of Europeans), Pacific peoples were least likely of all ethnicities to own their own home (Figure 11). Home ownership is a significant part of family wealth in New Zealand and provides a means to pass on resources between generations.²⁷ However, declining home ownership rates, particularly for Pacific peoples, reduce the ability to pass on wealth to younger generations, a stated aspiration for many Pacific families.²⁸

Figure 11: Home ownership in New Zealand by ethnicity, 2013 Census



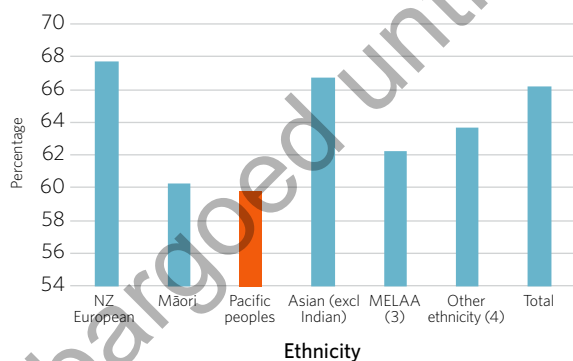
MELAA = Middle Eastern, Latin American and African.
Source: Stats NZ 2019.

Employment and income

Pacific peoples in New Zealand are less likely to be employed than all other ethnic groups...

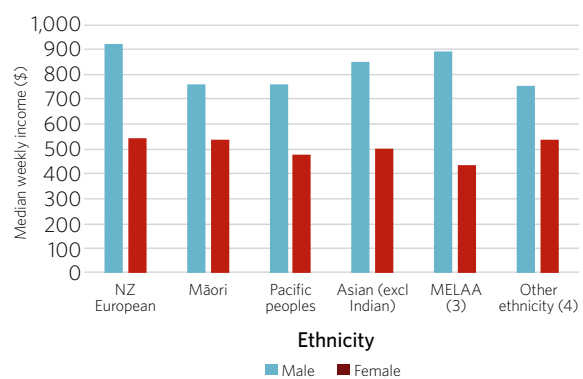
... and when employed, Pacific peoples' median weekly incomes are lower than those of other populations, with the disparity greatest for males. Pacific women's median weekly income is second lowest of all groups.

Figure 12: Employment by ethnicity, Aotearoa New Zealand, 2016



MELAA = Middle Eastern, Latin American and African.
Source: Stats NZ.

Figure 13: Median weekly income by ethnicity and sex, Aotearoa New Zealand, 2019



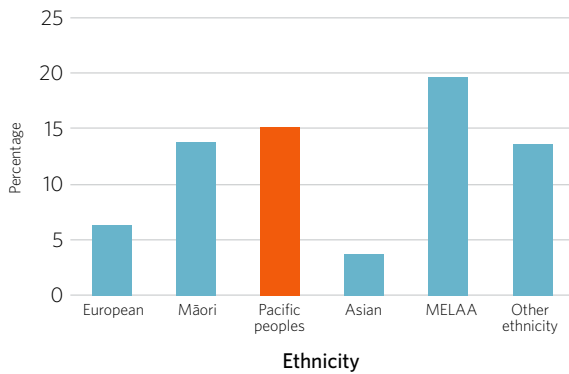
Median individual Pacific net worth was \$12,000 in 2016, well below the \$87,000 median for all New Zealanders, mostly due to low levels of assets rather than high liabilities. More than 26% of Pacific peoples hold \$20,000 or more of non-mortgage debt (compared with 13% of the total New Zealand population).²⁹

The impact of these disparities in housing, employment and income disproportionately affect Pacific children.



A higher percentage of Pacific children live in poverty relative to Māori, European and Asian children...

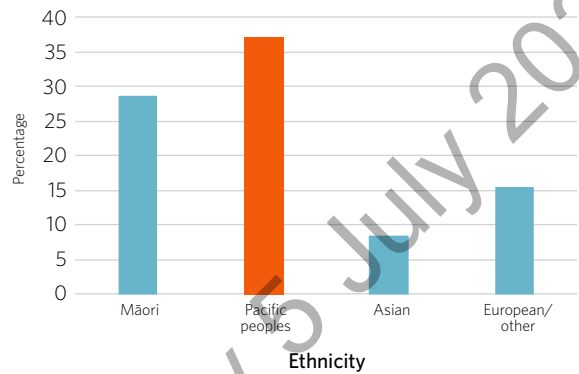
Figure 14: Child poverty by ethnicity, Aotearoa New Zealand, 2019



MELAA = Middle Eastern, Latin American and African.
Source: Stats NZ 2019.

... and 37.1% of Pacific children live in food-insecure households. A quarter of all children in food-insecure households are Pacific, while Pacific children make up only 13.5% of the total child population.

Figure 15: Children in households with food insecurity, by ethnicity, Aotearoa New Zealand, 2015/16



Source: New Zealand Health Survey.

Self-rated health and life satisfaction

The Stats NZ Wellbeing statistics 2014-18, derived from the General Social Survey, are based on a combination of objective information and people's assessments of their own lives.³⁰ This data echoes the above findings in terms of high levels of material deprivation and poor housing yet, paradoxically, it shows high levels of institutional trust coupled with relatively high self-rated health and life satisfaction – though both self-rated health and life satisfaction are in sharp decline.

Between 2014 and 2018, Pacific peoples' self-rating of their general health status as excellent declined from 26% to 15% of respondents, paralleling (though larger than) the decline among Māori.

The decline continues on other indicators of wellbeing. The percentages of Pacific peoples rating their overall life satisfaction and how worthwhile they felt their lives were as 10 out of 10 were both largest among all ethnicities in 2014 – but by 2018 both were lowest (falling from 26% to 16%, and 31% to 20%, respectively).

Material deprivation

Further evidence of the felt impacts of financial and material deprivation emerges from these self-ratings in the 2014-18 Wellbeing statistics.

A quarter of Pacific peoples reported not having enough money to meet everyday needs, the highest of all ethnicities in New Zealand, and 45% responded they had 'only just enough money' – again the highest in this category.

In 2018 Pacific peoples rated highest of all ethnicities for every category of deprivation in material standard of living. Pacific peoples reported keeping costs down in the prior 12 months by:

- spending less on hobbies or special interests than they would like (80%)
- delaying replacing, or repairing, broken or damaged appliances (71%)
- cutting back on or going without trips to shops or local places (70%)
- putting up with feeling cold (59%)
- going without fruit or vegetables (56%)

- postponing or putting off visits to the doctor (38%)
- not paying bills on time due to shortage of money (38%).

Pacific peoples, at 37%, rated highest of all ethnicities by 11 percentage points in being very limited by money when buying or thinking about buying clothing or shoes.

More than half of Pacific peoples reported not being able to buy a \$300 item in the next month - the highest of all ethnicities by 17 percentage points.

Trust and safety

By contrast, evidence of bonds of trust in society and community appear to persist in the data.

Pacific peoples showed comparatively high levels of trust in New Zealand institutions, including educational institutions (on a par with European populations), health institutions (at 27%, second only to Asian populations in the highest trust rating) and parliamentary institutions (again on a par with European populations).

Pacific peoples reported high feelings of safety and security at similar rates to other ethnic groups.

In sum, the data reveals that despite reporting experience of acutely felt material deprivation, Pacific peoples retain residual high levels of trust in New Zealand institutions, and they report high self-rated health and life satisfaction, though this is in recent steep decline.

Embargoed until 5pm, Monday 5 July 2021

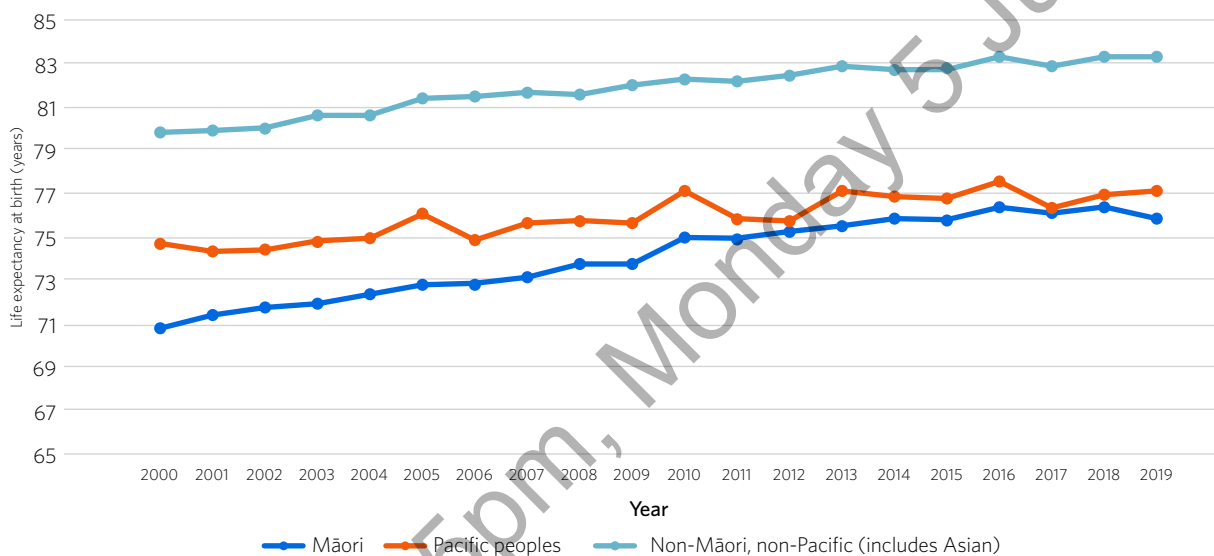


Chapter 2: What the data tells us about Pacific health | Upoko 2: Hei tā te raraunga hauora Pasifika

Life expectancy

Life expectancy at birth is the number of years a baby born in a particular year is expected to live, based on current death rates. It is a common summary measure of population health and is often used to assess the equity gap between different groups. Over the last 20 years, life expectancy has increased for all ethnic groups, but there has remained a significant equity gap for Māori and Pacific peoples, compared with non-Māori, non-Pacific. Pacific peoples live, on average, six fewer years than non-Māori, non-Pacific, and this gap appears to have slowly widened over the last 20 years (Figure 16).

Figure 16: Life expectancy at birth (years), by ethnicity, Aotearoa New Zealand, 2000–19



Source: Chan WC, Papa D. *Life expectancy at birth in New Zealand from 2000 to 2019 by ethnicity*. Counties Manukau District Health Board, Auckland 2020.

The underlying factors contributing to health inequities, particularly life expectancy, are multifaceted and complex. Many of the drivers are related to the unequal distribution of the determinants of health, including income and housing, as outlined in Chapter 1. A recent analysis found that chronic conditions, including cardiovascular diseases, cancer and diabetes, contribute significantly to the gap in life expectancy between Pacific peoples and non-Māori, non-Pacific.³¹ The origins of these conditions can be found early in life, but opportunities to intervene, prevent and manage such conditions are present throughout the life course.

On the life course: maternity and birth

Pacific women experience barriers to access to midwifery care in New Zealand. This is reflected in low rates of enrolment with lead maternity carers (LMCs) compared with other ethnicities, particularly in DHBs with high Pacific populations. Subsequently, Pacific mothers appear to experience more intensive interventions during and after birth and consistently higher rates of maternal and neonatal morbidity and mortality than other ethnicities. Pacific women have lower rates of regular dispensing of oral contraception and appear to experience barriers to access to contraception choices.

Registration with a lead maternity carer

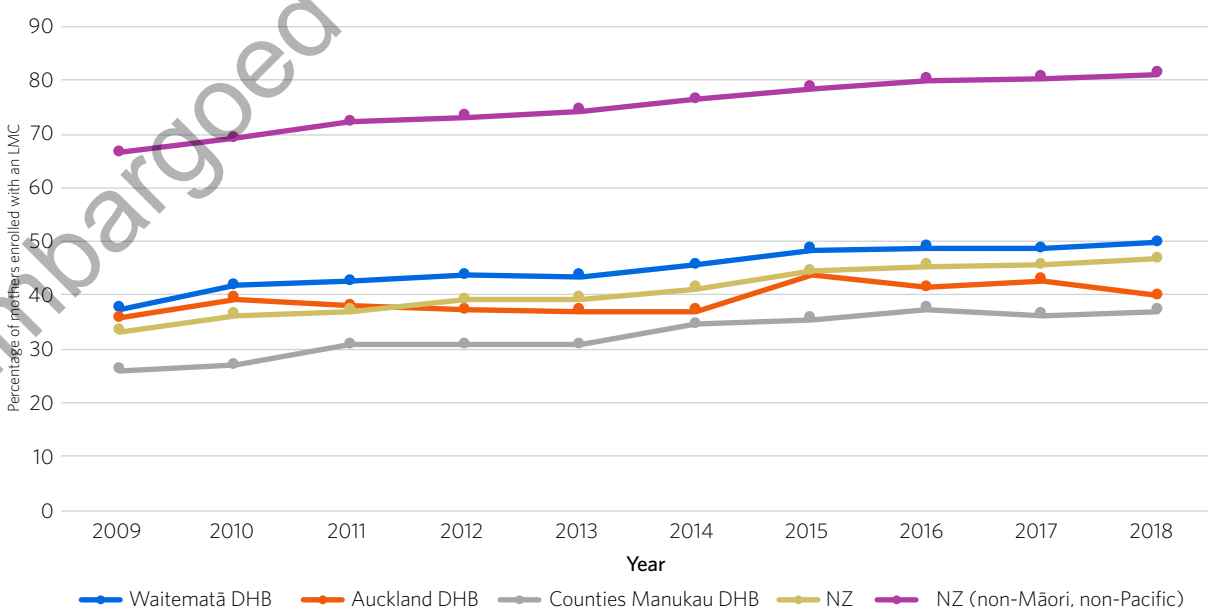
Maternal health in New Zealand follows an LMC system. The LMC, who can be a midwife, obstetrician or specially trained general practitioner (GP), provides a complete maternity service to expectant mothers, including pregnancy assessment throughout gestation, care during labour and birth, and postnatal care for up to four to six weeks after birth. Maternity care is free, unless women choose a private obstetrician.³² There are now only a very small number of GPs who provide obstetric care; most women are therefore cared for by midwives.

The premise of the LMC system is choice. Women are expected to find their own LMC (often through the Find Your Midwife website) and are encouraged to register with an LMC within the first trimester (three months) of pregnancy. However, choice is often limited due to the availability of midwives in certain regions and the very small number of Pacific midwives in New Zealand.³³ The onus on women to find their own carer also presents a major challenge for equity of access, particularly for new migrants or Pacific peoples not born in New Zealand, who may not be familiar with the LMC system. Further, the standardised care requirement of registration in the first trimester also often means that women who register later are left with no option other than the default hospital midwifery service.

If a mother does not have an LMC in the first trimester of pregnancy, she may miss out on key assessments, screening, prevention and early interventions. These may include screening and management of diabetes, iron deficiency and fetal conditions.

Though the rate has been steadily rising since 2009, less than half (47%) of pregnant Pacific women were registered with an LMC in 2018, compared with 81% of non-Māori, non-Pacific women (Figure 17). This figure was even lower in Counties Manukau and Auckland DHBs (37% and 40% of Pacific women registered, compared with 79% and 83% of European/other women, respectively), where there are well-documented shortages of midwives.^{34, 35} The total midwifery vacancies forecast for August 2020 in Counties Manukau DHB amounted to 48 full-time equivalent positions.³⁶

Figure 17: Pacific mothers enrolled with a lead maternity carer, Auckland, Waitematā and Counties Manukau DHBs and New Zealand compared with non-Māori, non-Pacific mothers, Aotearoa New Zealand, 2009–18



Source: Ministry of Health. 2020. New Zealand Maternity Clinical Indicators 2018: www.health.govt.nz/publication/new-zealand-maternity-clinical-indicators-2018.



Therese Stowers and Fa'afana Temese, *Pacific Midwives Wellington*

Therese: A lot of Pacific women end up under the community team, under the hospital. I don't know whether it's because they don't seek LMCs in particular, because it's normally word of mouth. I'm not sure if any Pacific woman would go onto the Find Your Midwife website to look for a midwife. They usually see GPs first to find out that they're pregnant. The hospital midwife team is like a default. LMC care is inaccessible for some of our Pacific women because there are barriers to knowing what you're eligible for and what the process is.

Fa'afana: I think there's a choice for European women, and a choice for the privileged. Not necessarily all these women, but the majority. There aren't choices for Pacific. There aren't choices for Indigenous and minority groups. You get what you get because it's the system, and it's not our system. Women with privilege have a full understanding of what they're getting and what they're into, and it suits their way of living. They're used to that kind of process, and the process is set up for them.

As a mother I'm an example of what they call 'non-compliant'. But it's because I don't see the point in going to see someone who doesn't understand me culturally, and doesn't live the way I live. It's not a system that's built on Pacific values, that recognises the Pacific worldview and context, and ways of living. So we get labelled all the time when we come into the delivery suite. If you're big, if you've got 10 people coming with you. You get a label.

Women do DNA ('did not attend' appointments), but people are voting with their feet. If they've had a bad experience, they're not going to tell someone about it, they're just not going to show up. If someone feels like they've been treated disrespectfully in that health service before, they don't want to be there, and they don't want to access that service again. *

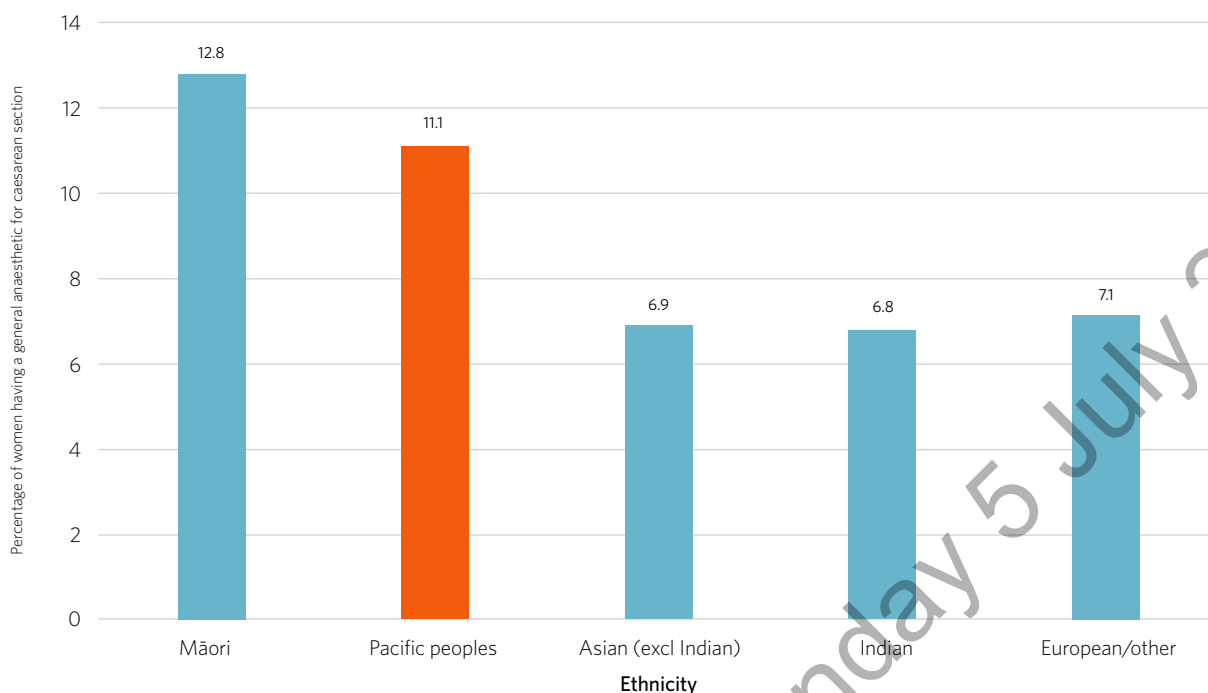
Interventions during birth

Pacific and Māori women are more likely than women from other ethnic groups to have a vaginal birth and less likely to have a caesarean section. This is likely to be linked to the lower LMC rates outlined above. However, whether the birth is vaginal or via caesarean section, Pacific mothers appear to experience more intensive interventions during and after birth.

Published data for many of the Ministry of Health's maternity clinical indicators is available for primiparas (first-time mothers) only, who are generally at lower risk than multiparas (women who have been pregnant before). Only 15% of Pacific pregnant women are primiparas, representing a significant gap in data and monitoring of maternal outcomes for Pacific women.

In 2018, Pacific women were about a third more likely to receive a general anaesthetic for a caesarean section than European/other women (11.1% of Pacific women vs 7.1% of European/other, inclusive of multiparas) (Figure 18). This difference was similar in Waitemātā and Counties Manukau DHBs, but in Auckland DHB the difference was more than double (13.1% Pacific vs 5.9% of European/other).³⁷

Figure 18: Percentage of women having a general anaesthetic for caesarean section, by ethnicity, Aotearoa New Zealand, 2018



Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, maternity domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/maternity.

Pacific women were also more likely than others to receive a blood transfusion, whether they had a vaginal birth or caesarean section. Blood transfusions are a serious intervention signalling major blood loss, and higher levels should trigger investigation of clinical management and intervention.^{38, 39} Across the metro Auckland DHBs, Pacific women received blood transfusions at consistently double the rate of European/other women.

Data shows 4.3% of Pacific women versus 2.1% of European/other women received a blood transfusion after a caesarean section...

... while 3.3% of Pacific women required a blood transfusion after vaginal birth, versus 1.6% of European/other women.

Figure 19: Percentage of women having a blood transfusion after caesarean section, by ethnicity, Aotearoa New Zealand, 2018

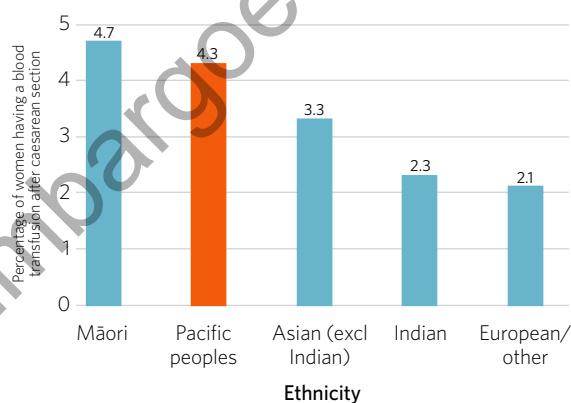
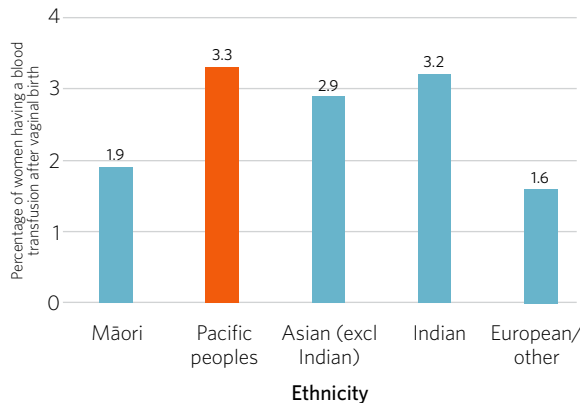


Figure 20: Percentage of women having a blood transfusion after spontaneous vaginal birth, by ethnicity, Aotearoa New Zealand, 2018



Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, maternity domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/maternity.



Published data also shows that Pacific women are more likely to experience perineal trauma during birth, with only 21% of first-time Pacific mothers having an intact perineum and no perineal trauma after giving birth, compared with 40% of Māori mothers and 28% of European/other mothers. At Counties Manukau and Auckland DHBs, these percentages are even lower than the national average for Pacific women – 15% and 13% of first-time Pacific mothers, respectively (compared with 22% of first-time Pacific mothers at Waitematā DHB).³⁷

Some of these complications could potentially have been avoided or lessened with preventive or proactive interventions during pregnancy (eg, management of iron deficiency), underscoring the importance of good antenatal care.⁴⁰



*Dr Teuila Percival,
paediatrician,
Counties Manukau DHB*

We know a lot about the problems with barriers and difficulties enrolling early with an LMC. It's difficult to find an LMC, that's the feedback we get again and again.

Moana Research (a Pacific research organisation) talked with women in South Auckland about birthing experiences and they found that women really prefer consistency in their LMC, having a consistent midwife. Sometimes they just can't find one. It's hard to have a choice when it's difficult to negotiate the system.

So it seems to me we know a lot about what we should be doing to reduce barriers, but we haven't actually done anything. We still have the same system of LMCs, which is set aside from the continuity of care that we should have for patients and families. It's frustrating that it continues to be a problem. A lot of our women miss out on that early antenatal care, and then getting scans is complicated. You think it would be free but there's a charge so we still haven't invested enough into making maternity care more accessible.

We know what to do. But it's just such a big system to change. It needs investment.

We need a lot more midwives, connected better with primary care, so there's continuity between GPs and midwives. If they're in the same building, they work together, and it's really easy for women to find somebody. In the community so they're easily accessible.

As for the higher complications rates in Pacific women: I think you'd have to look at the case mix of women. Is it because there are co-morbidities? Is it high BMI [body mass index]? High BMI puts you at increased risk of haemorrhage and makes haemorrhage more difficult to control. One of the things that worries me about our women in pregnancy who have a high BMI: are we following best practice for these women in pregnancy and labour? They should be getting late scans, for example. Fundamentally, we need more research. ✨

Gestational diabetes

Gestational diabetes mellitus (GDM) is a complication of pregnancy where the mother develops temporary glucose intolerance that usually resolves after delivery.⁴¹ GDM can result in adverse outcomes for both mother and infant, including birth trauma, post-partum haemorrhage, macrosomia and shoulder dystocia.⁴² It is recommended that all pregnant women in New Zealand be screened for both pre-existing diabetes and GDM.¹³ However, recent national data on GDM screening and prevalence in New Zealand is not systematically collected, and there does not appear to have been any national reporting since the GDM guidelines were updated in 2014. Given the higher rates of diabetes among Pacific peoples (see the 'On the life course: adults' section later in this chapter) and the potentially harmful consequences for mother and child, this data gap represents an important area for improvement.

The end result: maternal and neonatal morbidity and mortality

The Perinatal and Maternal Mortality Review Committee (the PMMRC), an independent committee that reviews the deaths of babies and mothers in New Zealand, has collected data on perinatal and maternal deaths and illness (mortality and morbidity) since 2007. The most recent report, consistent with previous ones, finds that Pacific mothers are over-represented in complications during pregnancy, and experience worse outcomes for both mother and baby than other ethnicities.⁴³ Pacific women experience significantly higher neonatal mortality rates (when a baby dies shortly after the birth) compared with European mothers. Other findings include the following:

- Antepartum haemorrhage (bleeding before birth) rates were significantly higher in babies of Pacific (and Indian) mothers compared with other groups.
- Neonatal death rates due to spontaneous pre-term delivery were higher in Pacific compared with all other groups.
- Deaths due to maternal conditions and perinatal infection were significantly higher in babies of Pacific (and Māori) mothers compared with others.
- Spontaneous pre-term labour or rupture of membranes was the leading cause of death for babies of Pacific mothers.
- Barriers to accessing care were frequent among Pacific mothers. Over the past four years of reporting, 100 of the 382 (26%) perinatal deaths of Pacific babies were considered *potentially avoidable* compared with 13.5% of New Zealand Europeans.
- Māori and Pacific women had the highest maternal death rates, with 23.5 and 22.2 deaths per 100,000 maternities, respectively, compared with New Zealand European at 13.2 per 100,000.

In 2009, the PMMRC recommended reviewing barriers to early bookings for LMC care and increasing the number of women who book with an LMC before 10 weeks' gestation.⁴⁴ In 2010, the PMMRC recommended increased research into the increase in perinatal-related death of babies born to Pacific women.⁴⁵ In 2016, late booking of LMCs or infrequent maternity care were considered contributory factors in 27% of perinatal-related deaths, the largest single contributing factor,⁴⁶ and in subsequent PMMRC reports more than a third of mothers whose babies developed neonatal encephalopathy did not have antenatal care in the first trimester.^{47, 43}

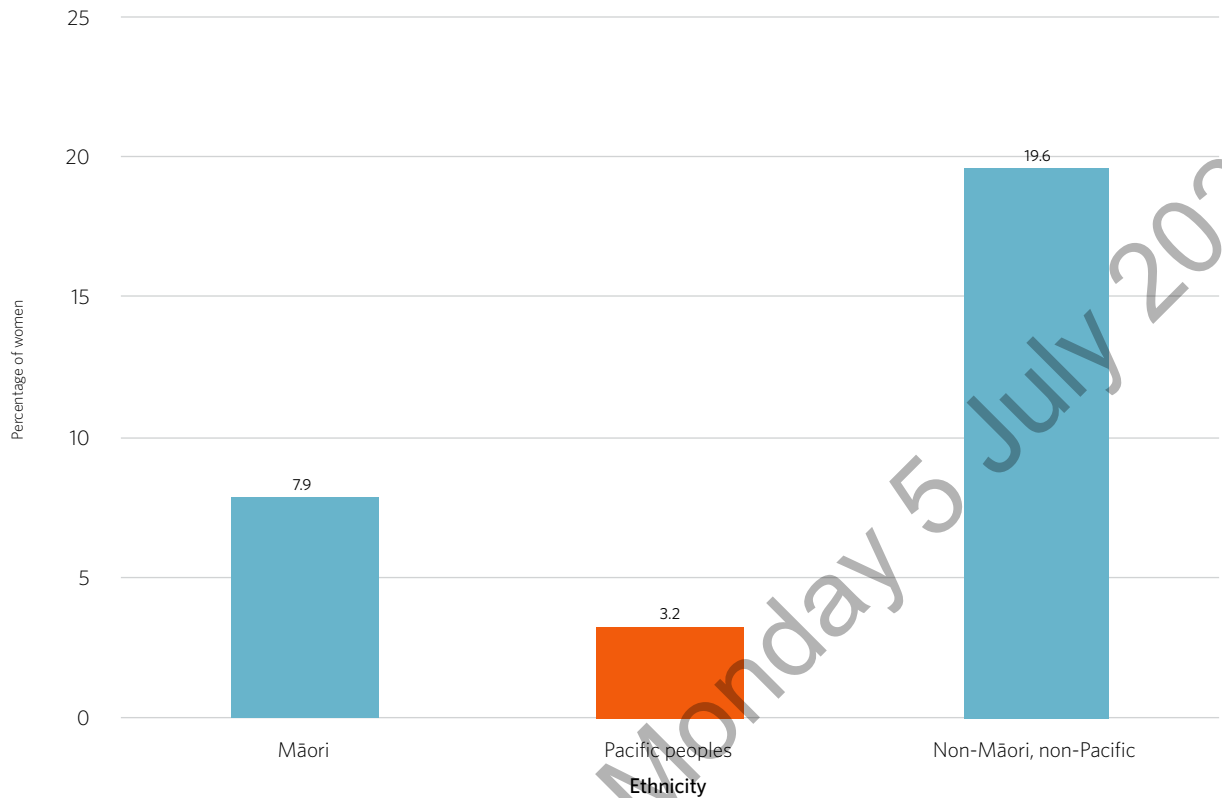
Thus, despite long-standing evidence of inequities in perinatal and maternal outcomes, a proportion of which are related to inequities in access to quality maternity services, barriers to Pacific women having adequate early maternity care remain strong, insufficiently addressed and a direct contributor to poor outcomes.

Access to contraception

Of all ethnic groups, Pacific women aged 15–24 years consistently had the lowest rates of being regularly dispensed oral contraceptives between 2016 and 2018 (Figure 21). This discrepancy – a more than four-fold difference in rates of dispensing of contraception between Pacific and European/other women – has remained static over the last three years.



Figure 21: Percentage of women aged 15–24 years regularly dispensed oral contraceptives, by ethnicity, Aotearoa New Zealand, 2016–18



Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, contraceptive use by women domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/contraceptive-use/.

Pacific women had the highest rates of all ethnicities of dispensing of fully subsidised Jadelle levonorgestrel subcutaneous implants at least once in a year in 2018, but rates are still very low (1% versus 0.5% European/other). Although long-acting reversible contraception is the most effective form of contraception, Jadelle implants have been associated with multiple health issues and complications,⁴⁸ and are widely used only in developing countries (such as sub-Saharan Africa).^{49,50} Funding for the Mirena device is a positive step.⁵¹

A 2013 qualitative study of maternity care experiences of teen, young, Māori, Pacific and vulnerable mothers at Counties Manukau DHB found, of the four groups identified, only engaged Māori and Pacific mothers were able to access contraception information as required and make informed choices.⁵² Young, teen, Māori and Pacific mothers typically:

- got information from a trusted source, friend, teacher or school nurse
- accessed information after the fact
- needed support
- wanted information earlier than currently provided through schools
- experienced complex social and health needs with significant health literacy issues
- had low awareness of the full range of contraception options
- made decisions about contraception based on cultural/religious values.⁵²

On the life course: children

Compared with children from other ethnic groups, Pacific children experience a higher incidence of a range of conditions, including asthma, dental problems, and ear and skin infections, which are often associated with social determinants of health, including poverty and overcrowding. These inequities in child health outcomes are long-standing and highlight gaps and insufficiencies in current models of care. Failures in screening programmes designed to identify issues early, as well as issues with access and quality of care, contribute to these inequitable outcomes. There is a need for evaluation of current service models and resource for locally designed and culturally appropriate solutions. We present examples of this pattern repeating across different conditions and interventions.

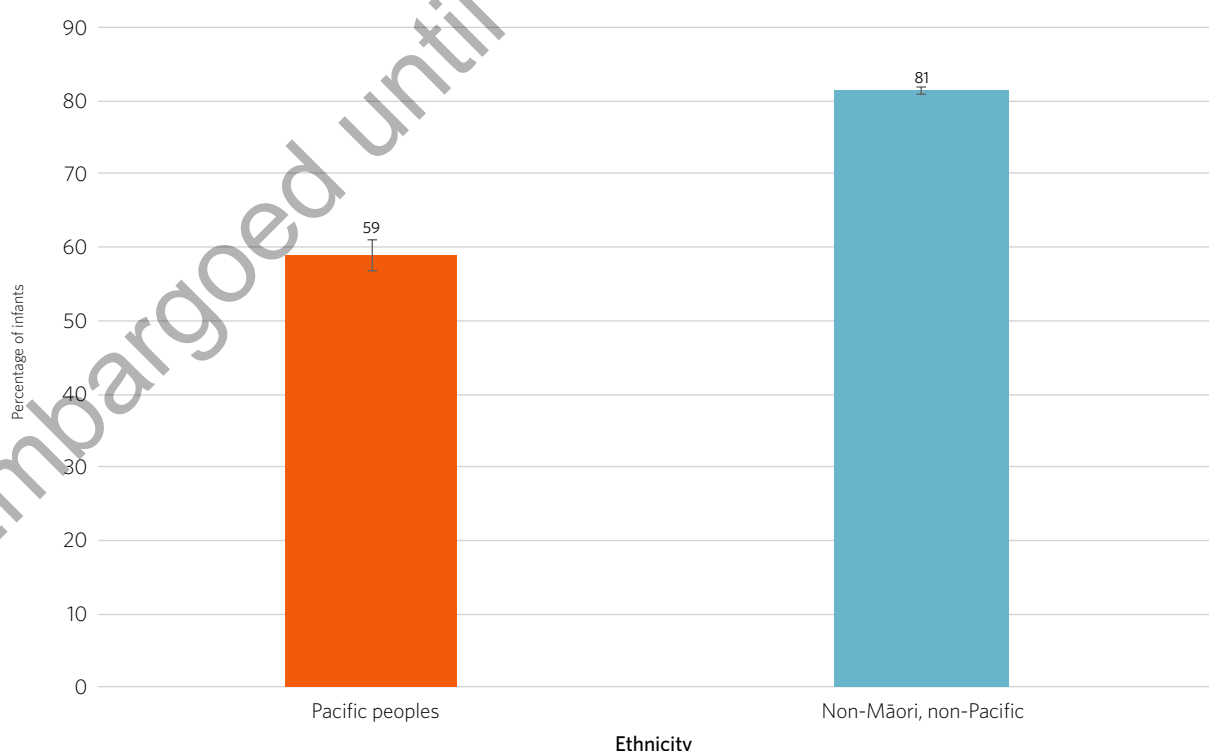
Well Child/Tamariki Ora services

The Well Child/Tamariki Ora (WCTO) programme is a free service provided to all children from birth to five years. It is a series of health assessments, support services and health promotion activities for children and their families. WCTO acts as an important gateway for parents to access primary and specialist health care, education and social services.⁵³ A review of the long-term sustainability of the programme is currently underway.

By the age of one, babies should have received all five WCTO core contacts recommended by the Ministry of Health. These 'core contacts' are WCTO provider visits at 8-10 weeks, 3-4 months, 5-7 months and 9-12 months, for health, physical and developmental assessments, immunisations, breastfeeding status and assistance, oral health (including enrolment in a community dental service), safe sleeping, maternal and parent-child interaction and bonding, family mental health, and parenting support and advice.⁵⁴

In 2018 and 2019, Pacific families were nearly 10 percentage points less likely than non-Māori, non-Pacific families to receive their first core contact on time, with flow-on effects to completion of all core contacts.⁵⁵ There was a 22 percentage point gap between Pacific and non-Māori, non-Pacific families receiving all their WCTO core contacts in their first year (Figure 22). More than 700 Pacific families with one-year-olds did not receive all recommended core contacts in 2019, indicating significant barriers to WCTO services for Pacific families.

Figure 22: Percentage of infants receiving all Well Child/Tamariki Ora core contacts in their first year of life, by ethnicity, Aotearoa New Zealand, January 2018–December 2019



Source: Ministry of Health, Well Child/Tamariki Ora.



Dr Teuila Percival, paediatrician, Counties Manukau DHB

The WCTO programme has limitations. It's fine if you've got good health literacy and you're well-resourced and you don't need a lot of care but it's a bit inflexible in the way it's contracted, which is transactional. There's little focus on relationships. There's little holistic care that's provided. Eighty percent of care is provided by Plunket, but they probably don't have the same ability to respond to determinants and social wellbeing that the smaller Pacific providers do.

There's a lot of focus on Western models of care and screening tools and there's not been a lot of work done with Māori and Pacific finding out what's important for them. The Harvard Centre for the Developing Child has looked at all the science around early childhood and what's really important is responsive relationships and language-rich environments. Language-rich experiences for children and responsive relationships are what we should focus on. Not what we do now.

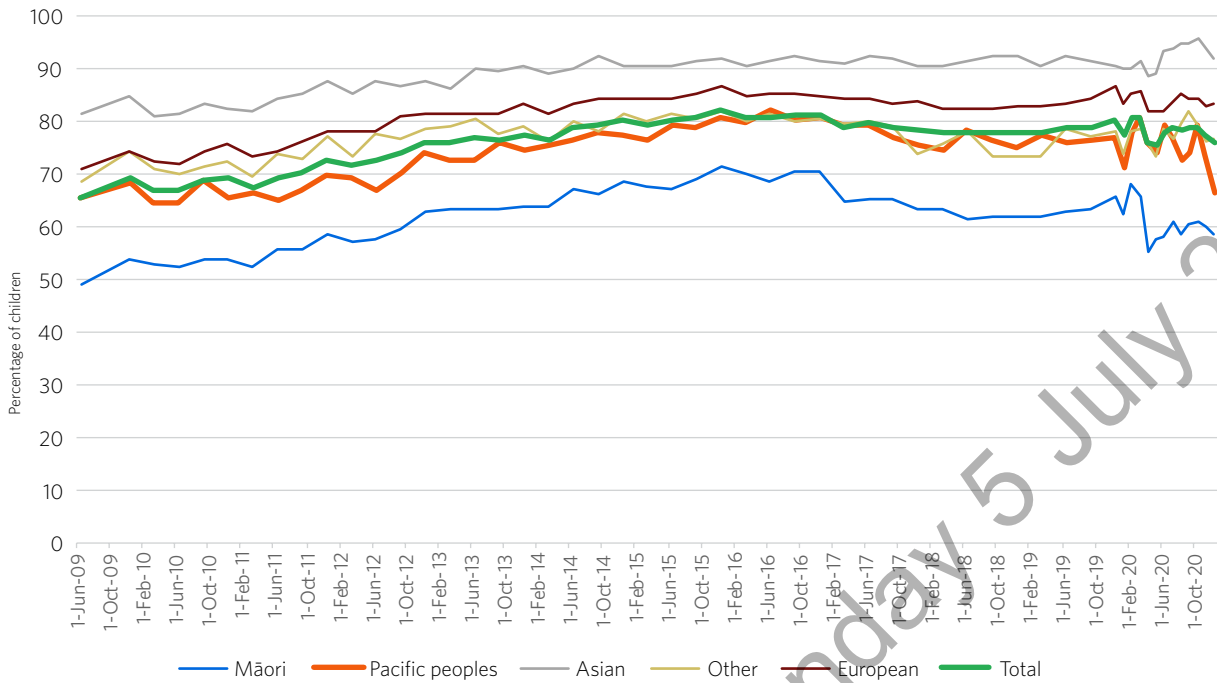
There's a real need to be transformational with WCTO and there's a review on at the moment, it's been going on for two years, and I think hopefully when that comes out they'll find a way to have a framework for Well Child but enable flexibility at a local level. So you can have Māori, Pacific and rural providers able to develop a flexible service that meets the needs of families. The data we collect on WCTO is enrolment and the number of children that receive their core contacts. It tells us something about access, but it doesn't tell us about quality and effectiveness and doesn't make much difference. That said, we know we have poor access for Pacific and Māori and it's pretty persistent.

The other thing with WCTO is the B4 School Check programme at age four. They again use Western tools which haven't been validated in Pacific populations. Pacific children don't have the same access to screening at the B4 School Check, and then when they do have the screening, research tells us that the tools aren't picking up serious problems like speech or behavioural issues. And then, when and if they do pick up problems, getting children from that pathway of referral to adequate intervention is limited so most of these kids aren't getting any help at all. So it would be nice to have a Well Child service that's much more capable of picking things up earlier rather than waiting till they're starting school. ✨

Immunisations

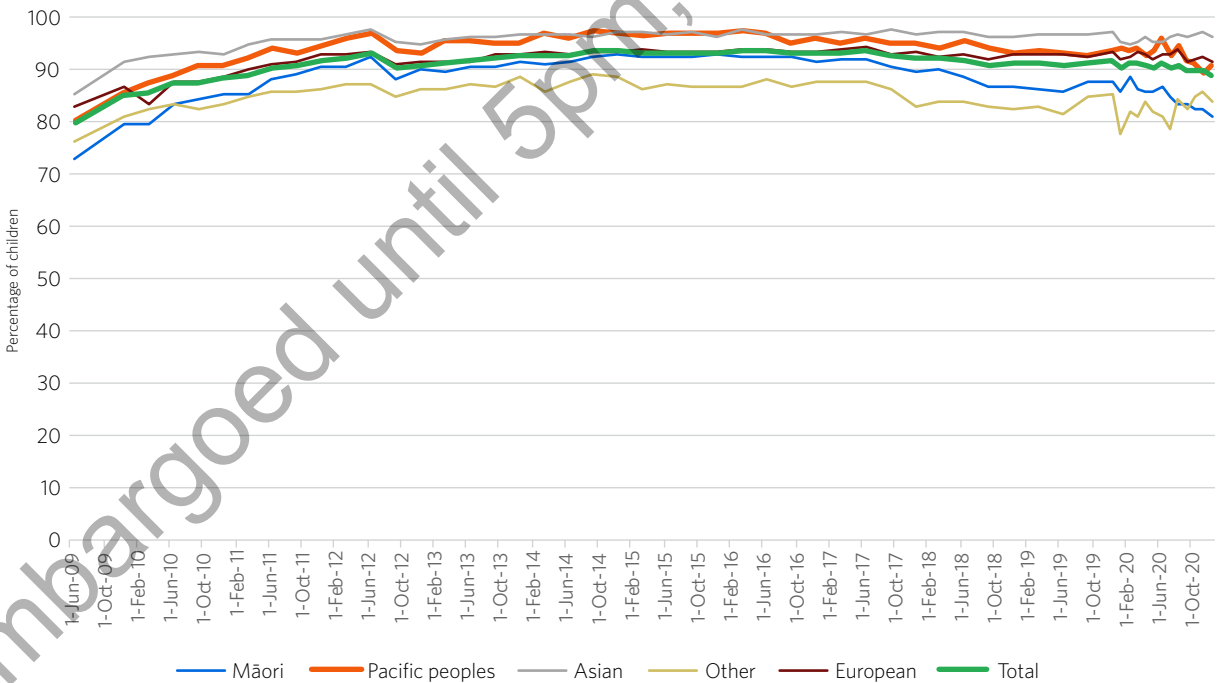
Approximately 70% of Pacific children are fully immunised by the age of six months (down from a high of 80% in 2016), suggesting a gap in preventive care for the very young (Figure 23). However, immunisation rates are more than 90% for children aged two and five years, indicating that a large majority of Pacific children are fully immunised (Figures 24 and 25). There has been a decrease in immunisation coverage rates over the last three years, which in 2020 has been exacerbated by COVID-19 lockdowns leading to reduced presentations to primary care and some temporary closure of outreach.

Figure 23: National immunisation coverage of six-month-old children, by ethnicity, Aotearoa New Zealand, 2009–20



Source: Ministry of Health. National and DHB immunisation data. www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data.

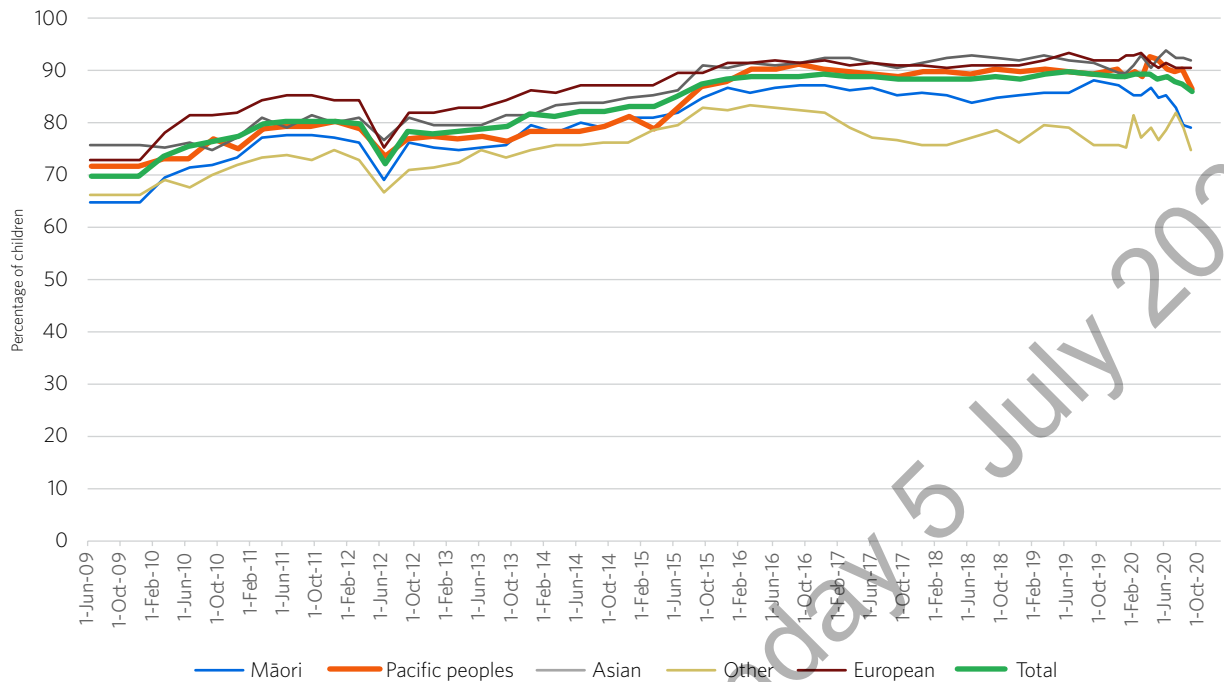
Figure 24: National immunisation coverage of two-year-old children, by ethnicity, 2009–20



Source: Ministry of Health. National and DHB immunisation data. www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data.



Figure 25: National immunisation coverage of five-year-old children, by ethnicity, Aotearoa New Zealand, 2009–20



Source: Ministry of Health. National and DHB immunisation data. www.health.govt.nz/our-work/preventative-health-wellness/immunisation/immunisation-coverage/national-and-dhb-immunisation-data.



**Dr Maryann Heather – GP,
South Seas Healthcare, Otara,
Auckland; senior lecturer Pacific
health, School of Population Health,
University of Auckland**

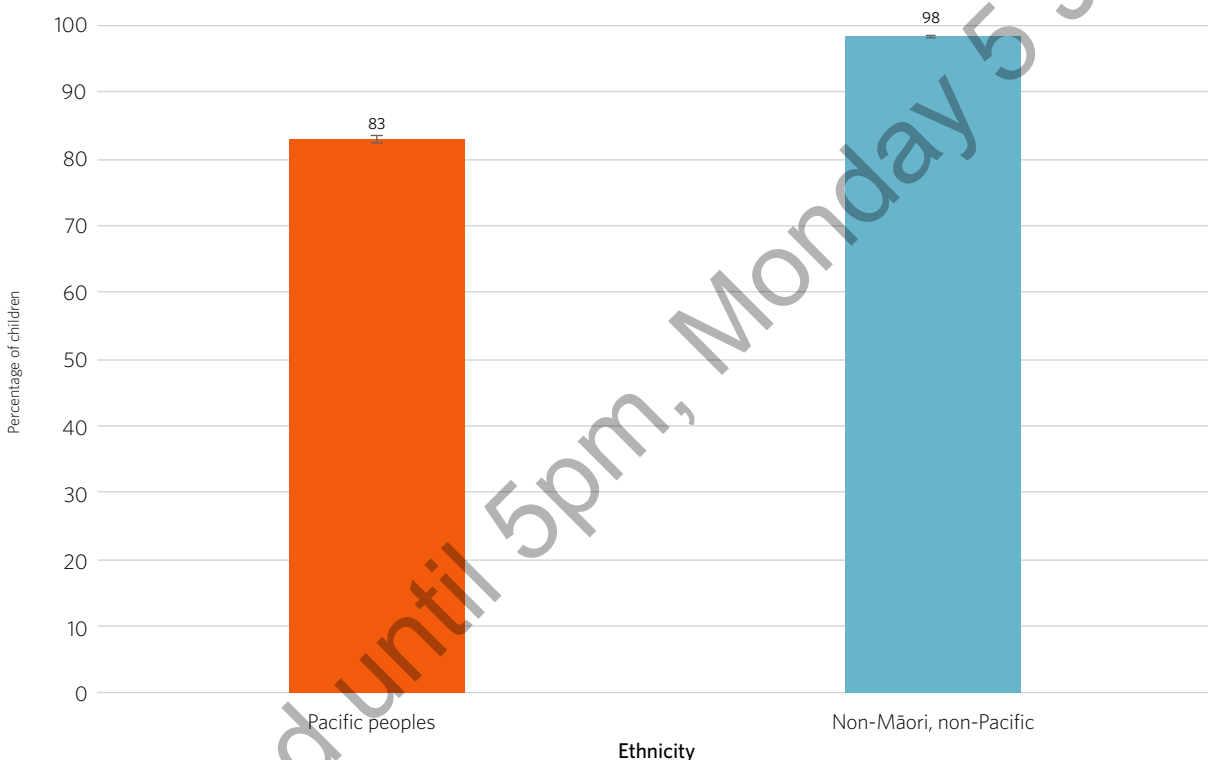
In terms of our high rates of immunisations for children, I give credit to our practice nurses because they're the ones that make sure that all our kids get the immunisations. They try and get it all on time. They do the recalls. They'll call, they'll send people around. That comes down to relationships. Our parents and our grandparents know the benefit of vaccinations. Often, a lot of the time when we ask them, we tell them why it's important, and they really listen. We do well in the younger age group, but it's the older age group that's difficult to engage. ✨

Child oral health

In New Zealand, children are entitled to free basic oral health care, from birth until their 18th birthday, in regional community oral health services. Standard treatments include routine examinations and x-rays to check for issues, preventive treatments, cleaning and, where necessary, fillings and extractions.⁵⁶ Children and families also receive oral health promotion, advice and education from dental therapists and community dentists at the community oral health service, representing important opportunities for prevention and early intervention.

Evidence from recent oral health promotion evaluations shows high awareness of the importance of child oral health in Pacific parents and caregivers,⁵⁷ but community dental services appear to present barriers: a lower percentage of Pacific children aged 0–4 years were enrolled in 2018 than non-Māori, non-Pacific children (Figure 26).

Figure 26: Children aged 0–4 years enrolled with community oral health services, by ethnicity, Aotearoa New Zealand, 2018



Source: Ministry of Health, Well Child/Tamariki Ora framework.



Lower access to dental services potentially contributes to the long-standing lower percentages of five-year-old Pacific children reported as caries (decay) free than non-Māori, non-Pacific children...

... and higher mean numbers of decayed missing and filled teeth in five-year-old Pacific children in 2018.

Figure 27: Percentage of five-year-olds caries-free, by ethnicity, Aotearoa New Zealand, 2018

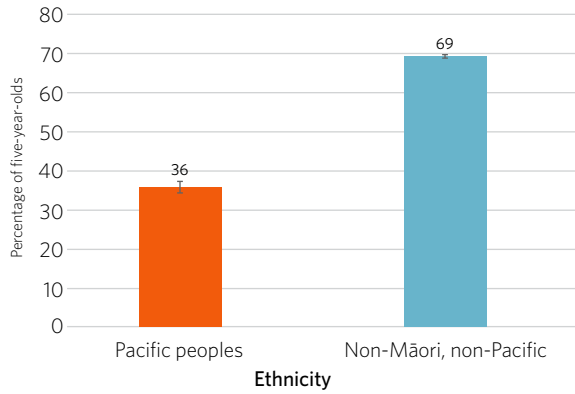
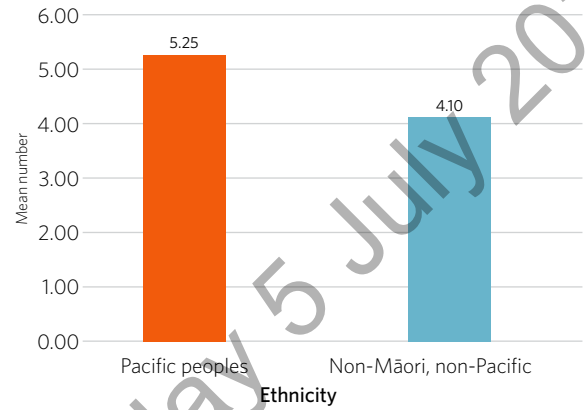


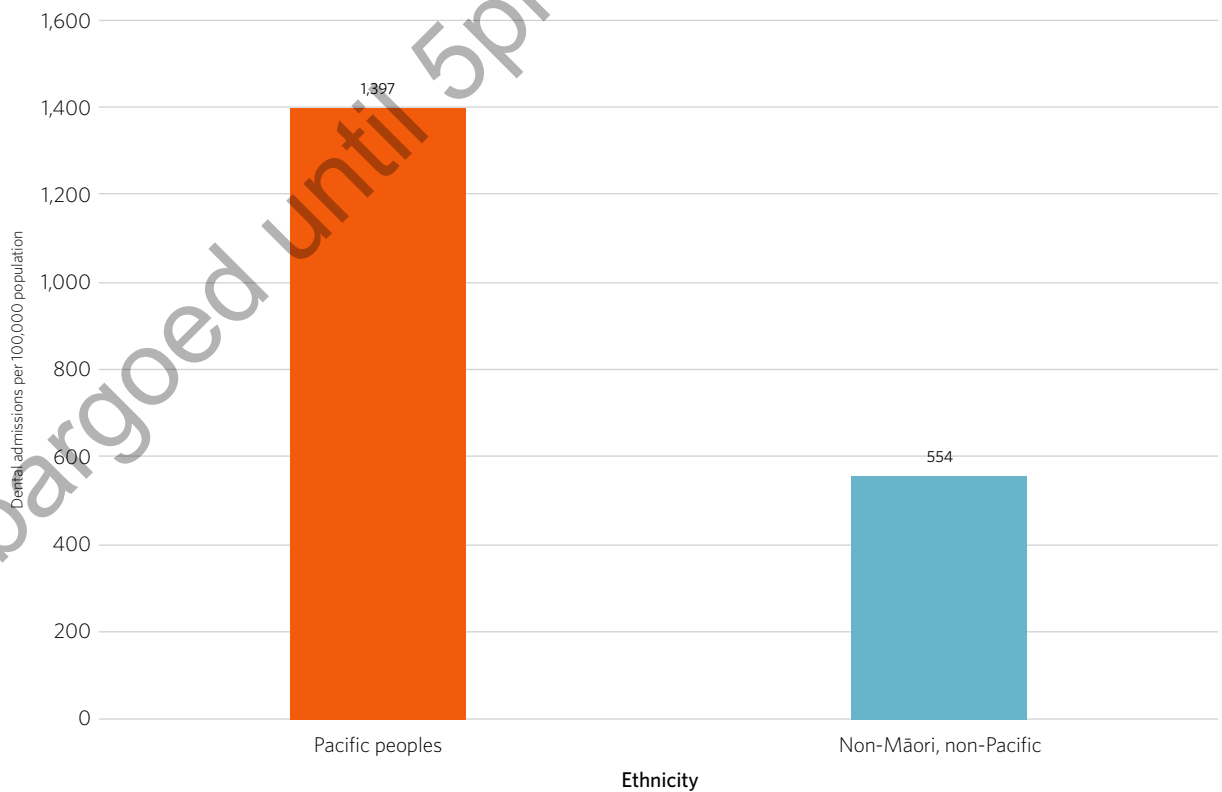
Figure 28: Mean number of decayed, missing and filled teeth in five-year-olds, by ethnicity, Aotearoa New Zealand, 2018



Source: Ministry of Health. Community Oral Health Service; Well Child/Tamariki Ora framework.

These accumulating, inequitable, serious and progressively worsening outcomes for Pacific children's oral health lead finally to vastly differing rates of hospitalisations for dental conditions, which are long-standing (Figure 29).

Figure 29: Potentially avoidable hospitalisations for dental conditions, rate per 100,000 population aged 0–4 years, by ethnicity, Aotearoa New Zealand, 12 months to March 2020



Source: Ministry of Health, ambulatory sensitive hospitalisations.

Self-reported New Zealand Health Survey data supports these findings. In 2018/19, Pacific children aged 1-14 years were nearly twice (adjusted odds ratio 1.89; 95% confidence interval (CI) 1.26-2.84) as likely as non-Pacific children to have had teeth removed due to decay, an abscess, infection or gum disease in the past 12 months. Yet Pacific children were less likely (adjusted odds ratio 0.91; 95% CI 0.86-0.97) to have visited a dental health care worker in past 12 months.⁵⁸

Data on oral health regularly reported to the Ministry of Health includes the proportion of children enrolled in community oral health services and rates of caries-free and mean decayed, missing and filled teeth at age five and at school year 8. However, there are many other indicators that could be monitored to better understand the quality of care received, and how services could be adapted to better respond to the needs of children and families - for example, utilisation of services, preventive care and treatments given (including fluoride applications and fissure sealants), and locations with better uptake of care. This data is not currently monitored routinely or reported, but should be, particularly given the shutdown of all community oral health services during the COVID-19 lockdowns. In addition, in-depth evaluation and research is needed to identify models of care that work best for Pacific children and families.



Dr Tule Fanakava Misa,
*public health dentist, Canterbury DHB
Community Dental Services; president,
New Zealand Society of Hospital and
Community Dentistry*

Before [the reconfiguration of community oral health services, over 10 years ago] I used to travel around schools and see children. If they needed treatment, I was able to treat them right at school. I didn't have to call the parents or have the parents come in while their treatment was done. Now, parents have to bring their children in for treatment. Access is a problem for some of our people because parents are working in companies where it's hard to ask for time off work to be able to bring children in. That's a barrier for a lot of our children, because they end up not having the treatment that they need.

We know that Māori and Pacific have the worst outcomes in terms of oral health. Most of those children are on the waiting list for general anaesthetic because we can't really treat them, it's hard to manage them under local anaesthetic. That's because it's not just one tooth that's problematic. Often, there's quite a lot of teeth that need treatment, and a lot of them have already reached a state requiring extraction rather than filling.

When the children are suffering, the whole family is suffering as well: sleepless nights, not eating well. It's sad when you see children walking in with this swollen face, because you know it's preventable, it's treatable. They didn't have to go through that.

I would like to see (adult) dentistry become affordable for our people, because it's a huge barrier to our people accessing dental care. It's sad to see that some are using their own tools to take a tooth out because they can't afford to see a dentist. There is help for emergency dental care for people with community services cards, but for those people and many others who are working really hard, but have other obligations to look after, they can't even afford to see someone for emergency dental care.

A lot of our families are suffering because of their poor oral health. *



Asthma

Asthma in Pacific children presents a story comparable to that of oral health: inadequate management leading to worse outcomes, including hospitalisation.

Window 2019⁵ identified inadequate control of asthma in younger Māori children as seen in higher levels of prescriptions of reliever medication (short-acting beta agonists, SABA) with no preventer medication (inhaled corticosteroids, ICS) compared with non-Māori, non-Pacific children.

The pattern is the same for Pacific children.

Pacific children were more likely to be regularly dispensed an asthma reliever but no preventer...

... potentially contributing to the stark disparities in rates of admission to hospital for asthma or wheeze in children aged 5–14 years, more than double those of young European/other children.

Figure 30: Percentage of children aged 5–9 years with asthma regularly dispensed reliever but not preventer, by ethnicity, Aotearoa New Zealand, 2014–18

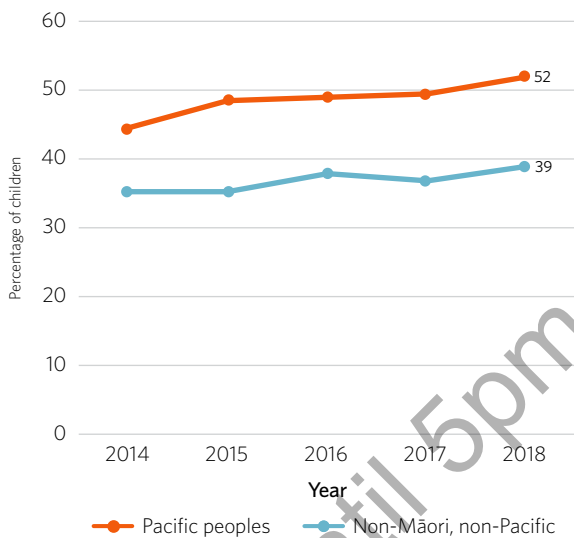
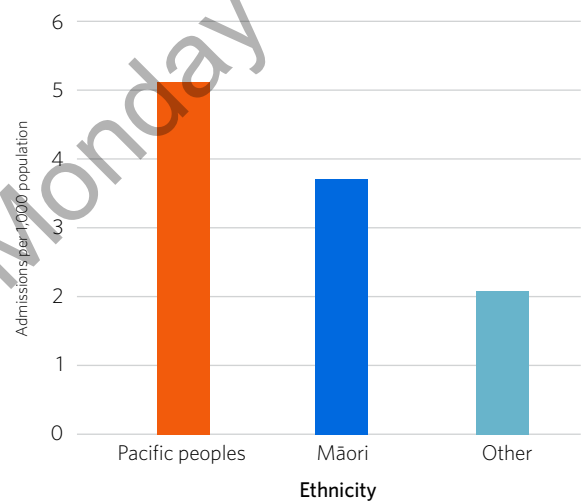


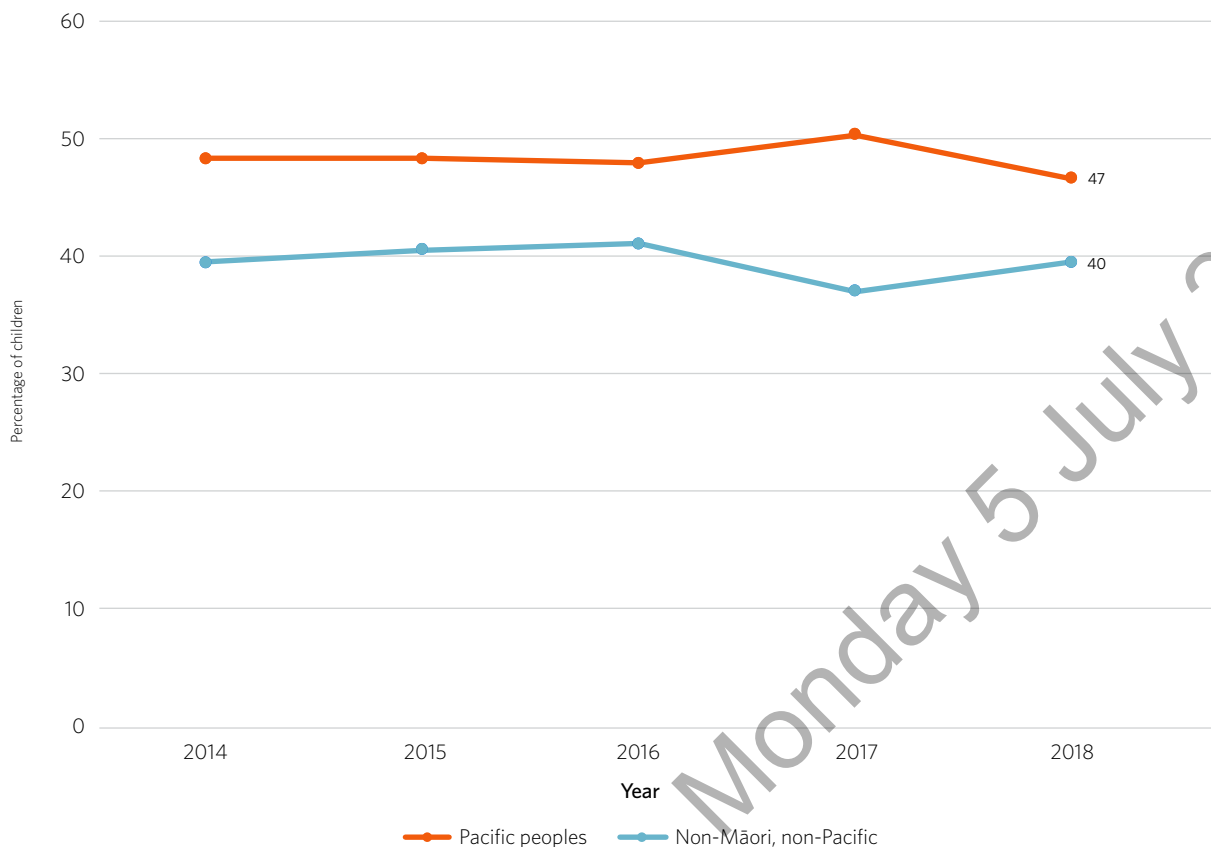
Figure 31: Asthma paediatric hospital admissions per 1,000 population, aged 5–14 years, by ethnicity, Aotearoa New Zealand, 2018



Source: Health Quality & Safety Commission, Atlas of Healthcare Variation, asthma domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/asthma.

This inadequate control appears to extend beyond the hospital admission, with Pacific children aged 5–9 years still less likely than non-Māori, non-Pacific children to be regularly dispensed a preventer even after hospitalisation for asthma (Figure 32).

Figure 32: Percentage of children aged 5–9 years with asthma not dispensed inhaled corticosteroid regularly year after admission, by ethnicity, Aotearoa New Zealand, 2014–18



Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, asthma domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/asthma.

Dr Teuila Percival, paediatrician, Counties Manukau DHB

The thing that I found really worrying is the percentage of children aged five to nine with asthma not dispensed inhaled corticosteroids after admission to hospital. So, children have been in hospital, presumably have been seen by paediatric teams, and we either haven't prescribed or they didn't pick it up from their chemist. I suspect we probably don't do a good job in hospital for these children in terms of best practice. We're just not implementing evidence-based practice for children, Pacific children in particular, in the community and after being in hospital, which is a real worry. I think we tend to think asthma is easy and just sort of get busy doing other things which are more interesting. But you know, it's significant. It's common and can lead to death. So, we need to pick our game up here. *



Hearing

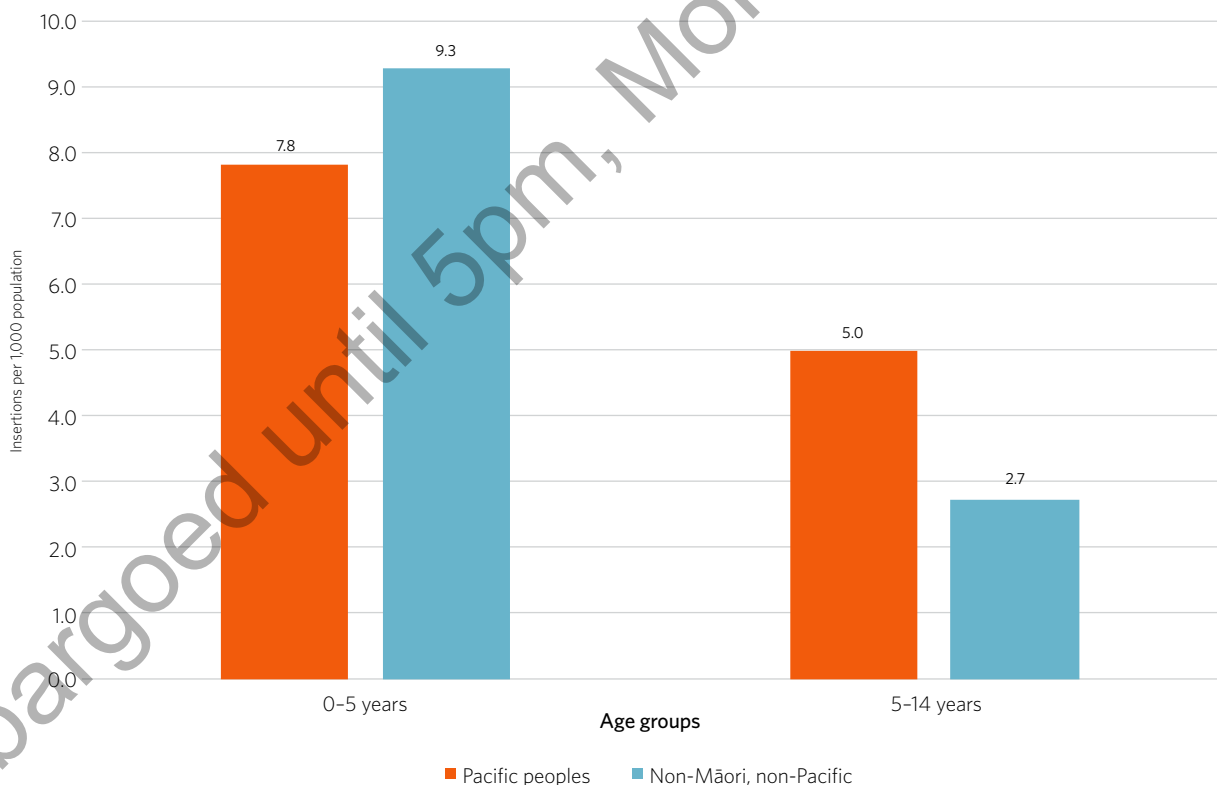
National data on hearing loss is limited, although there were 1,561 notifications of permanent hearing loss in children and young people between 2010 and 2017, mostly among those from areas of high deprivation, and especially among Māori and Pacific children.⁵⁹

Large-scale studies suggest these formal notifications of hearing loss are likely to hide a high proportion of unsuspected hearing loss in Pacific children, not detected through the WCTO programme.

The Pacific Islands Families study, a longitudinal study tracking the health and development of a birth cohort of 1,398 South Auckland Pacific children since 2000,⁶⁰ estimated that more than a quarter of Pacific two-year-olds were affected by acute otitis media.⁶¹ This is a condition that results in hearing loss of variable severity and is the most common cause of acquired conductive hearing loss in children. A smaller 2018 study supported this finding, concluding that, 'There is a high proportion of children in South Auckland with unsuspected hearing loss'.⁶² This unsuspected hearing loss in younger Pacific children was found to be attributable to environmental risks.⁶¹

This burden appears not to be alleviated by health care. Despite Pacific children being more affected by conditions that may benefit from grommet insertions (to relieve middle ear pressure and prevent effusion/fluid build-up), Pacific children aged 0-4 years were less likely than non-Māori, non-Pacific children to receive the procedure, but this is reversed at the ages of 5-14 years (Figure 33), suggesting possible delays in identification of hearing/ear conditions.

Figure 33: Ventilation tube insertions per 1,000 population, by age and ethnicity, Aotearoa New Zealand, 2018



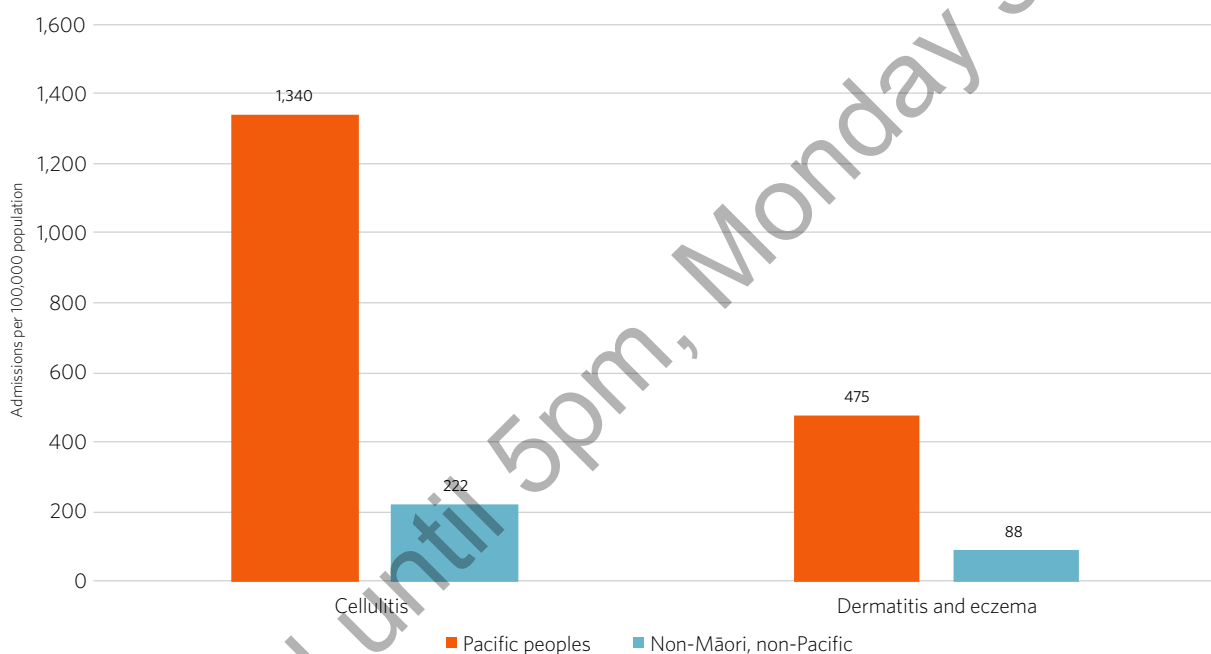
Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, surgical procedures domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/surgical-procedures.

This interplay of risk factors, unidentified hearing loss and inequitable access to care contributes to the inequitable rates of acute hospitalisation of Māori and Pacific children for otitis media,⁶³ and to later hearing abnormalities. The Pacific Islands Families study found Pacific children with confirmed middle ear disease at age two years were twice as likely (adjusted odds ratio: 2.00; 95% CI 1.56–2.50) to have an abnormal ear test at age 11.⁶⁴ Hearing impairment has been associated with mild and moderate problem behaviours in these children,⁶⁵ and in general even relatively low levels of hearing loss are associated with educational and communication difficulties for children of this age group.⁶⁶ Hearing loss associated with otitis media in childhood increases risk of hearing loss in adulthood.⁶⁷

Skin infections

New Zealand has one of the highest rates of childhood skin infections in the world, with Māori and Pacific children most affected.⁶⁸ Serious skin infections can lead to hospitalisation and the need for intravenous antibiotics and even surgery. These hospitalisations of Pacific children for cellulitis, dermatitis and eczema are largely preventable, and the inequities between ethnicities are stark (Figure 34).

Figure 34: Hospital admissions for skin infections (cellulitis; dermatitis and eczema) per 100,000 population aged 0–4 years, by ethnicity, Aotearoa New Zealand, 2018



Source: Ministry of Health.



Ellaine Ete-Rasch

Ellaine Ete-Rasch has an extensive background in primary health care nursing, public health and child health, and is a nurse lecturer and recipient of a Pacific Health Research PhD Scholarship, focusing on avoidable hospital admissions of Pacific children (ambulatory sensitive hospitalisations, or ASH).

It was disheartening to witness first hand in my role as a Plunket nurse (over 20 years ago) the poor health our Pacific children were experiencing. It was shocking to

have seen some families living in very poor living conditions in New Zealand. In the clinic where I worked, health files were piling up for children who did not attend their core health check appointments. I would say that 99% of those files were for Pacific children. Pacific mothers and children weren't accessing the health care they needed; they distanced themselves from the mainstream services despite the effort from staff.

When a Pacific provider was established in Wellington, I saw an opportunity to support and work closely with Pacific families. It is encouraging to see that things have improved for our Pacific children and families but there is still a lot of work to be done to reduce health inequalities among New Zealand children.

I was shocked to see the high rates of serious skin infections or cellulitis for Pacific children in New Zealand. I thought it was something so simple and easy to treat, yet children became seriously unwell if not effectively treated in the community. The research results identified the need for education for health workers and parents. While causes of skin infections for some children can be complex, it was important for nurses to refocus the care on the basics of skin care especially in primary care settings. The training held in Wellington for health workers, mainly nurses, focused on that basic care information to avoid complications and need for antibiotics.

Important health topics such as skin infections should be on the agenda for Pacific health constantly until it is no longer an issue affecting our children's health. It may be difficult, given that almost all health conditions affect the health of Pacific peoples. The Healthy Skin project through the three DHBs in Wellington was a good example of how an important health issue such as serious skin infections should be addressed at a population health level working collaboratively across the three DHBs.⁶⁹ Health projects for health conditions such as serious skin infections that can negatively impact our children's health need concentrated effort and continuation in order to see better outcomes. ✨

Maryann Heather, GP, South Seas Healthcare

At our clinic we have the Mana Kidz programme, so we have a team that goes into about seven South Auckland schools. They provide clinical advice or clinical support for the nurses. They are finding things like scabies, skin infections and all the other social problems as well. They are doing the treatment and they're picking it up, but how do you treat it in terms of children's homes? You're treating kids, but they go back into an overcrowded, poor environment and there is reinfection again. It's a vicious cycle that we never really get on top of. A big problem. *

An investigation of the factors underlying these high rates of hospitalisation cited barriers associated with costs of primary health care, understanding of the importance of early presentation, perception of skin infections being normal, and poor management and treatment of skin infections.⁷⁰ However, qualitative work with Pacific mothers of children admitted to hospital with cellulitis suggests many were surprised and distressed by their child's deterioration, sought primary care, were committed to active steps to prevent spread of infection, and wanted more information but didn't recall receiving it or didn't understand it.⁷¹ Research funded by the Ministry of Health suggests access to good quality, acceptable information is a major barrier, and the assumptions behind how skin infections should be treated assumed access to resources that many affected families simply don't have.⁶⁸

Alternative models of care – Mana Kidz (National Hauora Coalition)

Reaching children in primary and intermediate schools in South Auckland, Mana Kidz (managed by the National Hauora Coalition) provides care to more than 34,000 children, representing 97% of the enrolled school population. Fifty-nine schools have a nurse and whānau support worker in school each day (a Mana Kidz Level 1 service) and 29 schools have a nurse in school once a week (Mana Kidz Level 2 service). Approximately 55% of all children enrolled in the Mana Kidz Level 1 programme are Pacific.

The programme delivers across three key areas: rheumatic fever prevention through timely sore throat management, skin infection management, and child health assessment and management (including ear and eye health, diabetes, bed-wetting and other health concerns). In the last 12 months, 6,813 Māori and 13,371 Pacific children with sore throats were assessed.

Each Mana Kidz provider has at least one community nurse prescriber, who can prescribe at least 30 medicines for common and long-term conditions, so whānau and their tamariki have free access to a wider range of medications for which they would otherwise require a visit to their GP.

As acting health care professionals in school, with access to families, Mana Kidz health teams work to improve wellness and education, including throughout the COVID-19 pandemic and lockdowns, working remotely, virtually and under the home-visiting guidelines of the Ministry of Health to deliver care. *



Rheumatic fever

Acute rheumatic fever, a delayed auto-immune response to an untreated sore throat caused by group A streptococcal bugs, can cause permanent damage to heart valves.⁷² Rheumatic fever and rheumatic heart disease have all but been eliminated in most high-income countries,⁷³ but rates in Pacific and Māori children and young adults remain unacceptably high for a developed nation, and have worsened with time.

Rheumatic fever was the target of a high-profile national 2011 programme to reduce incidence by two-thirds by 2017. The programme failed to reduce rheumatic fever rates in Pacific peoples, and rates remain high.



*Sinia Saafi, community health worker,
Alliance Health Plus Primary Health
Organisation (PHO)*

The key for me, particularly with the rheumatic fever programme I worked on, was working through the churches. You need that time for the health worker to go in there and work with the community from the inside out. To get them to act, you actually need to be with them, because at the same time, you're building up their confidence. People are hungry for personal connection, because the personal connection with a health worker gives them confidence. We can identify the strengths and the personality traits of each health worker so we can successfully send them to targeted communities.

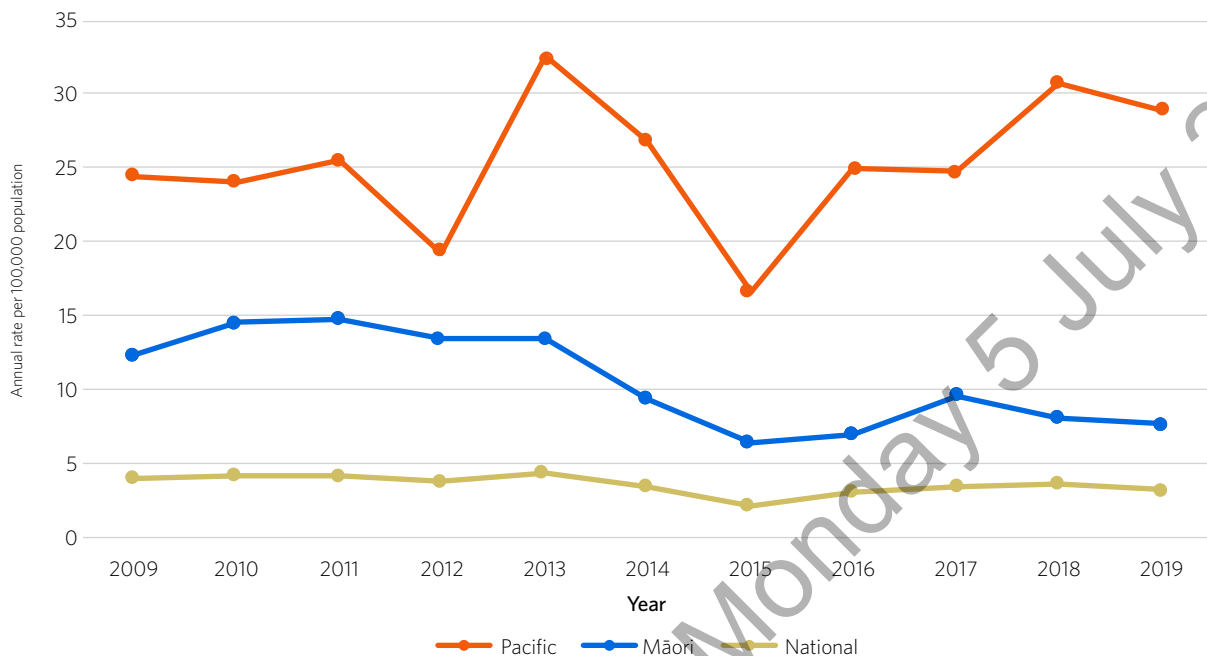
What I've seen is a lot of health projects will start and won't be finished or seen to the end. I have seen many projects started by different people, three managers, for example. And each manager will come with a different style. It's stop, start, stop, start.

It's really hard engaging with our community. Because they might look at us, knowing we are well educated, and they might think we are coming to them to colonise their thinking, to make them Palagi. Even though they may initially have that mindset, when they get to meet us and work with us, they know we are far away from that. We are able to help to dismantle that kind of perception. And of course our communities want what they see in us. We are role models as well as delivering these services to them. And I think that's what our community loved about our engagement.

We are very flexible as well. We go whenever the community are ready, as long as it's going to be within a particular week. So, if they say after hours, or they say Sundays, Saturdays, we fit into their time. Being flexible like that gains us respect. They are so busy and us being flexible to their needs and their situation means the mutual respect and the relationship gets stronger and deeper. Because you're weaving the values of the community into the work. ✨

Pacific peoples were hospitalised for rheumatic fever at higher rates in 2019 than in 2009, indicating that more work is needed to understand what strategies and interventions would be effective for reducing rheumatic fever rates in Pacific communities (Figure 35).

Figure 35: First episode rheumatic fever hospitalisations, annual rate per 100,000 population, by ethnicity, Aotearoa New Zealand, 2009–19



Source: Institute of Environmental Science and Research Ltd (ESR).

Dr Teuila Percival, paediatrician, Counties Manukau DHB

Sore throat clinics are a great idea, and they can treat skin infections as well, as that is another association with rheumatic fever. They're doing the best they can, but we haven't fixed overcrowding and the lack of hot water and not enough beds and those are things we need to be addressing.

I think we probably should have the same approach as in Fiji, Samoa and Niue, where they screen the whole child population of a certain age – usually intermediate school age group – and screen that age group every year. We should be mass screening with echocardiograms. Research studies in South Auckland have had a pick-up rate of about 3% of children screened had rheumatic heart disease. We will pick up significant cardiac lesions in kids who've never had noticeable symptoms. The other thing we could do, which would be a bit cheaper, would be to screen people with a family history of rheumatic fever or rheumatic heart disease. Because there's a higher risk of other people in their family having sub-clinical lesions or rheumatic heart disease. We could do targeted screening.

For children with rheumatic fever, we need a wraparound support service – because often the family has had issues with time off work, money problems, and other siblings traumatised because their brother or sister has been in a hospital and they think they're going to die. There's all that sort of stuff going on, which we don't even really touch. We need to spend time talking with the young person about their life and what their condition means, and we don't do that a lot. We think we do. But when people do research, asking them how we do, they say, we didn't do very well, we didn't tell them what was going on and they don't understand and the best information they got about rheumatic fever was from another parent. So, yes, we need to do better. ✨



In conclusion, Pacific children experience a range of conditions our health system is designed to identify and treat early, yet is failing to do so. While there are indications of some parts of the system working relatively well (eg, immunisations), current models of care are clearly not resonating with many Pacific peoples, presenting barriers to access and, even when services are able to be accessed, failing to provide appropriate referral and management. Work to better understand and act on the needs and expectations of Pacific children, families and communities is of utmost importance.

On the life course: youth

Though there is a lack of data on youth Pacific health, we know from survey data there are mental health and wellbeing issues connected with increasing complexity of ethnic and other identities. Data suggests rising rates of depressive symptoms and attempted suicide in Pacific youth, in particular associated with living in high deprivation areas, though rates of actual suicides are falling. Pacific peoples who died by suicide were less likely to access health care or to be dispensed mental health medication before their suicide, and generally Pacific youth were less likely to be able to access health care than youth of other ethnicities, especially if they were from high deprivation areas. The 2019 measles outbreak affected Pacific youth in particular, though vaccinations for human papillomavirus (HPV) in young Pacific women appear high.

In general, the health of Pacific youth is characterised by a lack of substantive national data, with the gap partially, but by no means completely, filled by survey information.

Mental health in young people is a complex picture with little concrete data. Survey data reveals more complex and multiple ethnic identities are associated with lower self-esteem, wellbeing, cultural connection and greater likelihood of being diagnosed with a mental illness. Better understanding of the meaning of identity, cultural connectedness and wellbeing among Pacific young people is needed.

The 2019 Welfare Expert Advisory Group report⁷⁴ singled out the improvement of outcomes for Māori and Pacific young people as an area of importance in the restructuring of the social security system in New Zealand, and in particular, better opportunities for young people to participate in healthy relationships with peers and in whānau life and to engage in education, training or work.



**Doana Fatuleai, general manager
Pacific, Counties Manukau DHB**

We have a young population. And data is scarce. For example, in dealing with measles we're targeting our 15-30-year-old Pacific age group. That tells us what a challenging target group it is, because you've got people who are working, you've got people who are at school and people still under mum and dad that still need consent for them to have their measles immunisations taken.

We need to look at other ways of engaging with this age group. For example, how do we use social media and technology to help support our youth? There's a lot of great champions out there that use social media. We've got to change our way of communicating. We're so used to putting the normal ads out, doing flyers and conducting workshops. But I think we need to utilise social media, TikTok, all these new ways, to grab their attention. We almost need a Pacific youth representative or a youth group to advise us decision-makers where we need to invest. They're so intelligent and we underestimate the advice they can give us. We need to shift our focus to the younger age groups, to hear the voices of our young people. *

Pacific identity and mental wellbeing

Pacific youth in New Zealand grow up in a variety of cultural, social and environmental settings and the concepts of identity, health, mental health and wellbeing are diverse and complex. Understanding the interplay between ethnic identity (the degree to which a young person sees themselves as a member of a particular ethnic group), and cultural orientation (one's feelings towards and level of engagement in different cultures) is important, as well as considering the impact of other factors, such as birthplace, acculturation and socioeconomic factors.⁷⁵

Sinia Saafi, community health worker, Alliance Health Plus PHO

Deep down within our children, they are so proud of being Tongan. But it's a culture that they're only seeing and experiencing at home. They run away from that, and that's a sad situation to be in. The way that a lot of our traditional churches are doing their church services, or what they call the Tongan culture, it's put off our young people.

I love trying to get both worlds to understand each other.

We find out what our parents have done really well, and we keep it. And then we find what's working really well from the Palagi system. And we put it together to find a way that will fit our children who are growing up here in this country, to make sure they are successful. So, in terms of valuing cultures, to be successful in New Zealand, you've got to marry those two cultures in a new way. Regardless of how long we live here, we will never be Palagi. So, we have to make up a new culture for us. ✨

The 2018 *Te Kaveinga – Mental health and wellbeing of Pacific peoples* report presented results from the New Zealand Mental Health Monitor and the Health and Lifestyles Survey related to the mental health and wellbeing of Pacific peoples.⁷⁶

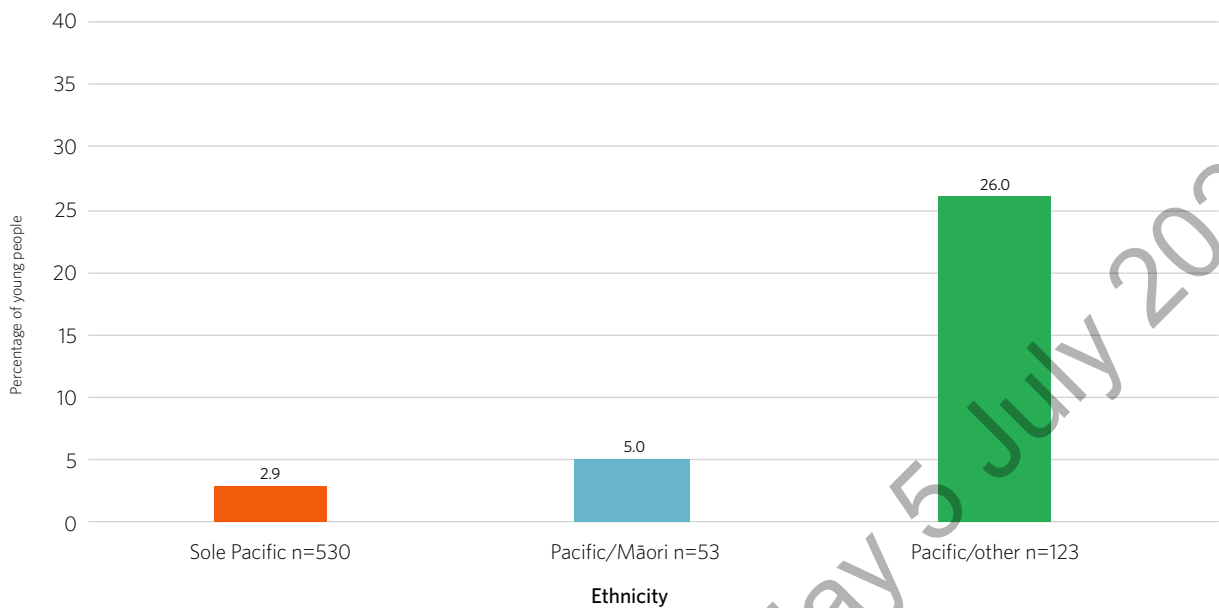
The number of Pacific peoples, particularly children and youth, identifying with multiple ethnic groups is increasing. *Te Kaveinga* reported that 37% of Pacific young people reported being 'multi-ethnic'.⁷⁶

There is some evidence that multi-ethnic Pacific peoples with mixed Pacific/non-Pacific ancestry report experiencing lower self-esteem and wellbeing than sole-Pacific peoples and multi-ethnic Pacific/Pacific peoples.⁷⁶ Some researchers attribute this to tensions over identity and to internalised negative stereotypes over authenticity of identity.⁷⁷ A smaller percentage of multi-ethnic Pacific/other (56%) and multi-ethnic Pacific/Māori (69%) peoples than sole-Pacific peoples (93%) reported strong connections to their culture. Pacific peoples with ancestral ties to Pacific islands that have constitutional agreements with New Zealand (Cook Islanders, Niueans and Tokelauans) were also less likely to be able to hold an everyday conversation in their Pacific language, which may affect their perceptions of cultural identity.⁷⁶

The adjusted odds of ever being diagnosed with a mental illness was 12 times higher in multi-ethnic Pacific/other peoples than in sole-Pacific peoples (adjusted odds ratio: 12.2; 95% CI 5.4-27.4) (Figure 36).



Figure 36: Percentage of Pacific young people aged 15–24 years reporting ever being diagnosed with a mental illness, by ethnicity, Aotearoa New Zealand, 2016



Note: prevalence adjusted for age and gender, n=706.

Source: 2016 Health and Lifestyles Survey.



Josiah Tualamali'i, Pacific Youth Leadership and Transformation Council (PYLAT)

For a growing number of the Pacific young people I'm alongside, to be 'Pacific', to be 'Samoan' or 'Niuean' (for example) is more about being 'Pacific' or being an 'Ubernesian.' Across government, DHBs and PHOs I do not see that the various identities of who Pacific young people are is well understood. There is a strongly rooted view of us as homogenous. We need clinicians and decision-makers to

know how to ask how we want to be supported. If you're Samoan and want to be supported as a Samoan, or as a Samoan New Zealander, or as a New Zealand-born Samoan or as a Pacific person who is also Samoan, a rural Pacific person etc - the support in each of these instances has to be specific, because they are different. We've got to give people the options they deserve. A deeper focus on this will enable greater belongingness and addressing of health inequity.

We have a persistent challenge around balancing our cultural practices alongside the value of young people's voices participating in their health, and health decision-making. And so sometimes it's difficult for young people to be able to say how they're really feeling and what's going on.

Probably the one lesson that I would suggest for health, from what happened with PYLAT⁷⁸ was that government and community saw there was a problem where Pacific young people weren't being mentored to the next stage of where we needed them to be and the wellness statistics weren't improving. Instead of addressing it in a health paradigm, they went at it with a leadership approach. We can grow leadership and grow a community of young leaders and mentor them. That will be the way young people can have a role in decision-making and help address wellbeing challenges. ✨

Rates of self-harm and suicide in young Pacific people

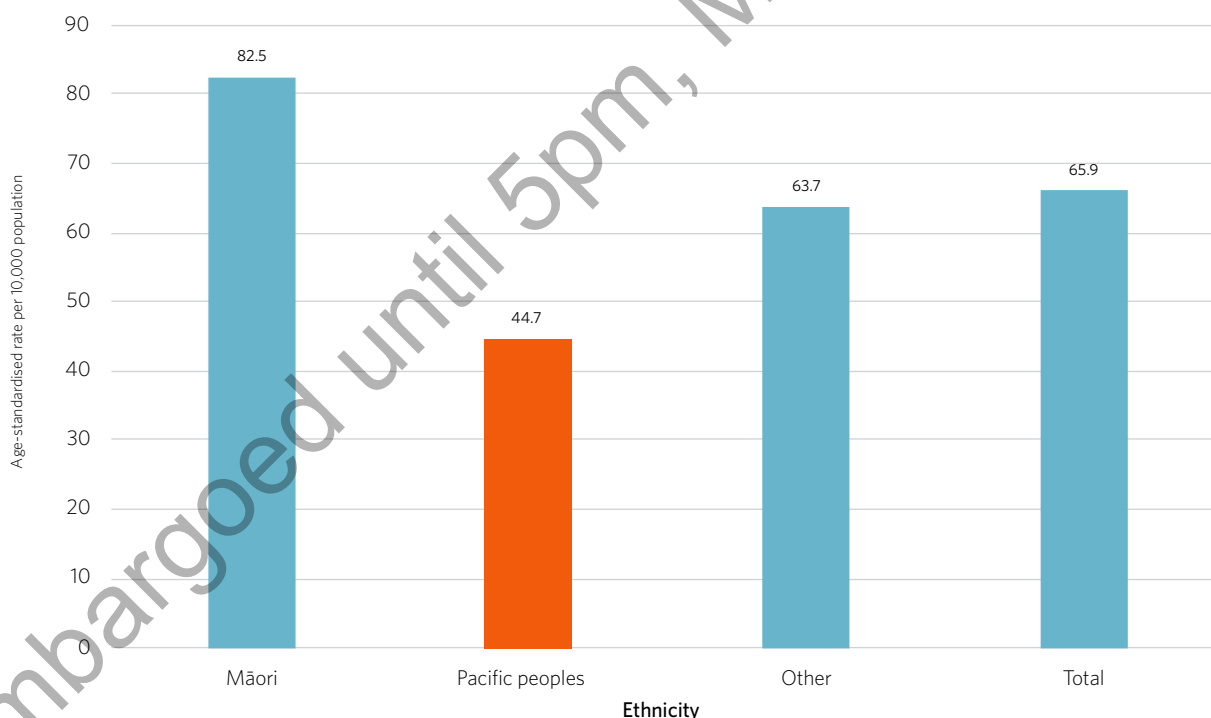
Recent survey data from the Youth19 Rangatahi Smart Survey⁷⁹ showed high rates of significant depressive symptoms among Pacific students, especially females (33% compared with 15% of Pacific males). Living in areas of high deprivation was associated with a higher prevalence of depressive symptoms (25% of Pacific students who lived in high deprivation areas compared with 15% of those in low deprivation areas), and higher proportions of Pacific students who attempted suicide in the past 12 months resided in high deprivation areas (14%) relative to low deprivation areas (2%), indicating the important impact of socioeconomic factors on youth mental wellbeing.

Overall, a greater proportion of Pacific youth report attempted suicide in the past 12 months (12%; 99/854) than their European/other peers (3%).

There has been a worsening trend between 2012 and 2019 for emotional and mental wellbeing among Pacific youth, with the proportion reporting significant depressive symptoms increasing from 14% to 25%, and those attempting suicide in the past 12 months increasing from 7% to 12%.

Despite reporting high rates of attempting suicide in the last 12 months, young Pacific people aged 15–24 years had the lowest rate of hospitalisation for intentional self-harm of all ethnicities in the year to September 2018 (Figure 37). These apparently contradictory findings suggest that hospital services for Pacific youth who have self-harmed are, for reasons that are not yet clear, not perceived to be accessible or acceptable.

Figure 37: Age-standardised self-harm hospitalisation rate per 10,000 population aged 15–24 years, by ethnicity, Aotearoa New Zealand, year to September 2018



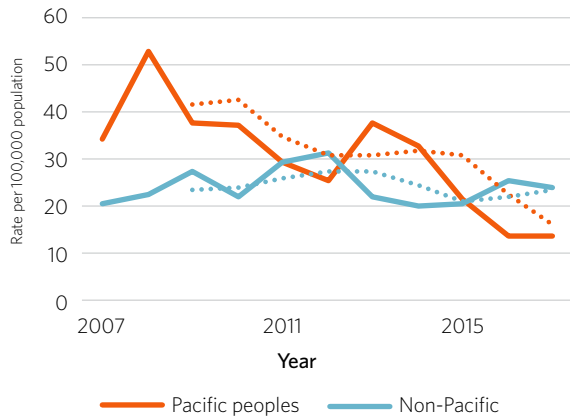
Source: Health Quality & Safety Commission routine data analysis.

Between 2008 and 2018, nearly half (43%) of all Pacific peoples who died by suicide were aged 15–24 years.



Nearly three-quarters of Pacific youth who died by suicide were males. Over time, the suicide rate in Pacific male youth has declined to near parity with non-Pacific male youth...

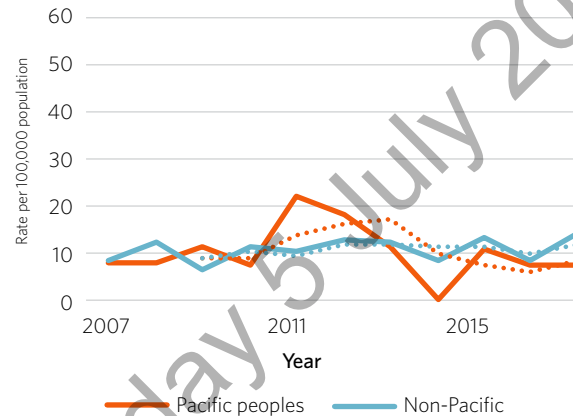
Figure 38: Age-specific suicide rates per 100,000 population for males aged 15–24 years, by ethnicity, Aotearoa New Zealand, 2007–17



Notes: The dotted line represents the three-year rolling average.
Source: New Zealand Mortality Collection.

... and to near parity with the lower rate of Pacific female youth. However, this rate has remained nearly static for 10 years.

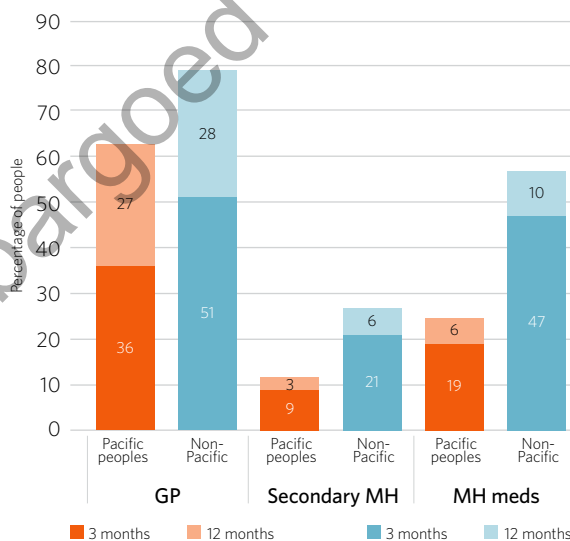
Figure 39: Age-specific suicide rates per 100,000 population for females aged 15–24 years, by ethnicity, Aotearoa New Zealand, 2007–17



Between 2007 and 2017, Pacific peoples who died of suicide accessed care (their GP or hospital-based mental health services) in the 12 months before their death at lower rates than other ethnicities. They were also less likely to be dispensed mental health medication before their deaths than non-Pacific peoples. It appears Pacific peoples who die by suicide face barriers to accessing care designed for these needs.

Pacific peoples of all age groups accessed care before their suicide less than non-Pacific people...

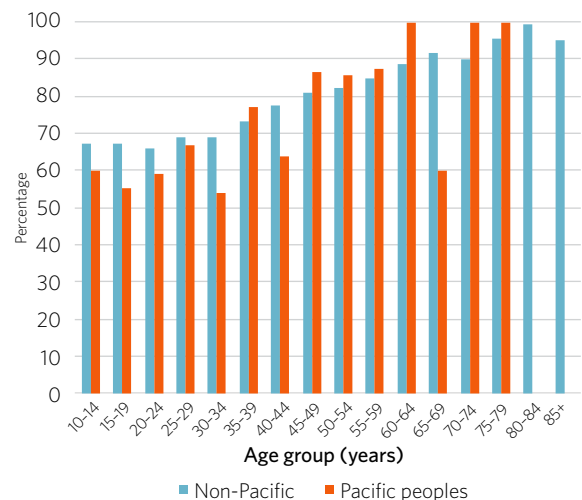
Figure 40: Percentage of people who had contact with primary health or secondary mental health services in the 12 months before their suicide, by ethnicity, Aotearoa New Zealand, 2007–17



GP = general practitioner; MH = mental health
Source: Suicide Mortality Review Committee.

... and Pacific young people were about 10 percentage points less likely than non-Pacific young people to visit a GP in the 12 months before their suicide.

Figure 41: Percentage of people who died by suicide and visited their GP in the 12 months before their death, by age group and ethnicity, Aotearoa New Zealand, 2007–18



Access to health care

The Youth19 Rangatahi Smart Survey found 74% of Pacific youth accessed health care in the previous year – most from a family doctor, medical centre or GP clinic (69%), school health clinic (31%) or an after-hours or 24-hour accident and medical centre (17%). A higher proportion of Pacific youth from more affluent areas visited a family doctor, medical centre or GP clinic (76%) than their peers from less affluent areas (65%).⁸⁰

Twenty-five percent of Pacific youth were unable to access health care when they needed or wanted it in the previous year (European 17%, Asian 19%, Māori 27%). A greater proportion of Pacific youth from high (29%) and medium deprivation (24%) areas were unable to access health care when needed than from low deprivation areas (9%).⁸⁰

Josiah Tualamali'i, *Pacific Youth Leadership and Transformation Council (PYLAT)*

A major challenge and opportunity for our health system is being truly able to listen to Pacific young people's needs and listening with cultural empathy. A lot of the young people that we work with often have to use particular language (formal, or not their normal vocab) or have to escalate things which can feel difficult with the relationships between young people and decision-makers in their health. We hear from some Pacific young people often problems that they come with when they seek help might not be accepted in the outcomes they want or there might be other things that are focused on, that aren't really the thing that's most important to them.

In health I often hear it is not easy for someone to bring all of who they are, particularly for rainbow Pacific young people. I am consistently told that the rainbow part of their identity is what the health professional thinks is driving the problem, but really it's just other cultural problems or just general life stressors. And it's not the bit the young person wants to talk about... and then sometimes those professionals don't have the right tools to explain and understand how all those different parts of their life come together and it comes across as faux empathy.

Success is whatever someone defines it to be and what works for them. So if we took someone to five sessions of go-kart racing to feel satisfaction and joy, and to be free of the distressing environment they might live in – great, I'm for that. I think we have to be much more like the disability support model. A person could choose the best intervention for them. 'Mycare' – you get given your disability support money, and then you choose who you want to come... and maybe you just want someone to come play chess. *

Measles and vaccinations

In 2019, New Zealand experienced the largest measles outbreak since 1997. The majority of cases were reported in the Auckland region, with 2,185 notified cases. The outbreak lasted more than a year and two-thirds of cases were from the two highest deciles of deprivation (9 and 10). Māori and Pacific populations were disproportionately affected, with incidences 4 times and 14 times (respectively) the incidence in the European population. Forty-one percent of all measles cases were among Pacific peoples.⁸¹

The risk of a serious measles outbreak in New Zealand was well known and reported in academic publications and health system reports prior to the 2019 outbreak. Although New Zealand had achieved World Health Organization 'measles and rubella elimination status' in 2017, the WHO had cautioned that significant immunity gaps remained and urgent action was required to fill the immunity gap for under-served and under-immunised older adolescents, young adults and Māori.⁸² Analysis of a measles serosurvey (survey of blood samples) conducted in 2014–15 showed that the lowest measles immunity in the 15–44 year age group was in the Pacific population (72%).⁸³



A review of New Zealand's response to the measles outbreak found that the health sector's commitment to equity in health policy was not reflected in the response. This included the failure to implement a national immunisation programme to address immunity gaps, and the lack of involvement of Māori and Pacific peoples in providing strategic advice, outreach services and communication strategies during the outbreak response. The review noted that a pro-Pacific equity response needed to improve communication to families, including timely provision of translated material as well as providing access to translators. Additional support was required for wage-earning families in deciles 9 and 10 (who could not access Work and Income New Zealand support during the required two-week stand-down period) to comply with quarantine requirements.⁸¹

A measles, mumps and rubella (MMR) immunisation catch-up campaign was set out in four phases and began in 2019.

Phase 4 of the campaign aims to equitably improve measles immunity in people aged 15–30 years across New Zealand to reduce the risk of future measles outbreaks. It was launched in July 2020 as the Measles Immunisation Campaign 2020 and will continue through to August 2021. Unfortunately, there is currently no data on measles immunity in this age group, although a review of New Zealand's response to the recent measles outbreak noted that Pacific people in this age group were disproportionately affected, indicating a significant immunity gap.⁸¹

The Measles Immunisation Campaign is being led by DHBs, supported by the Ministry of Health. The campaign was delayed by COVID-19, but since November 2020 DHBs across the country have commenced local Measles Immunisation Campaign activities. DHBs are planning a variety of ways to close the immunity gaps within their populations, which include alternative ways to deliver immunisation and forms of outreach immunisation, including school-based programmes.

Maryann Heather, GP, South Seas Healthcare

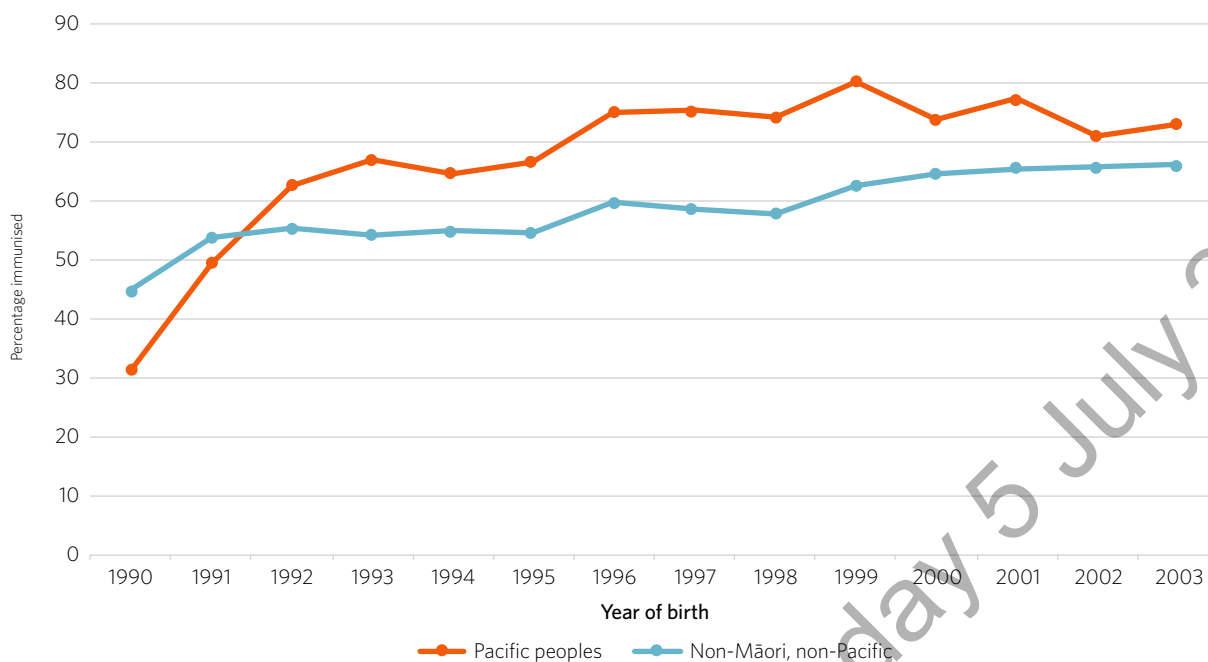
There's a gap in immunisations for young adults. That age group is a real struggle, and we're not engaging them as much. The measles outbreak we had was a good example. It was managed, but it was pretty messy. We established pop-up clinics for immunisations, but people panicked, and we had people that got two or three MMRs when they didn't need to. But again, that comes down to systems and monitoring, and it comes down to understanding, education and getting the right messages out there. ✨

Access to human papillomavirus (HPV) vaccinations

Young Pacific women have high rates of vaccination for HPV (Figure 42).

The Ministry of Health recommends vaccination for HPV and funds it on the National Immunisation Schedule for children and young people aged 9–26 years. A school-based vaccination programme is available in most areas,⁸⁴ and incidence of genital warts has decreased by 75% since the vaccine became available in New Zealand in 2008.⁸⁴ The vaccine is 'highly effective' in preventing infection with the most common types of HPV, including variants of the virus associated with oral and genital cancers (including cervical cancer).⁸⁴

Figure 42: Percentage of girls and young women who received the first HPV vaccine, by their birth year, Aotearoa New Zealand, 1990–2004



Source: Ministry of Health, HPV immunisation programme: www.health.govt.nz/our-work/preventative-health-wellness/immunisation/hpv-immunisation-programme.



Dr Api Talemaitoga, GP, chair of the Pacific General Practitioners Network

Rates of vaccination for HPV in Pacific peoples improved in 2008/09 when the Ministry of Health and the Health Promotion Agency worked to ensure messages and messenger were culturally appropriate.

A campaign tailored for Pacific peoples was developed with pictures of Pacific families (Fijian, Tongan and Samoan) with three sisters sitting in focus and a brother or two and parents in the background. The message was reframed from appealing to the individual teenager to one about future protection and health of Pacific families.

Posters and pictures were developed for general release and associated with a song 'It takes three, baby' to draw attention to the three doses required for the full schedule, and included photos of young girls out having fun shopping.

Coupled with this was the delivery of the messages in Samoan, Tongan and Fijian languages. Immunisation messaging focused on families worked. ✨



'It takes three' ...in a family!



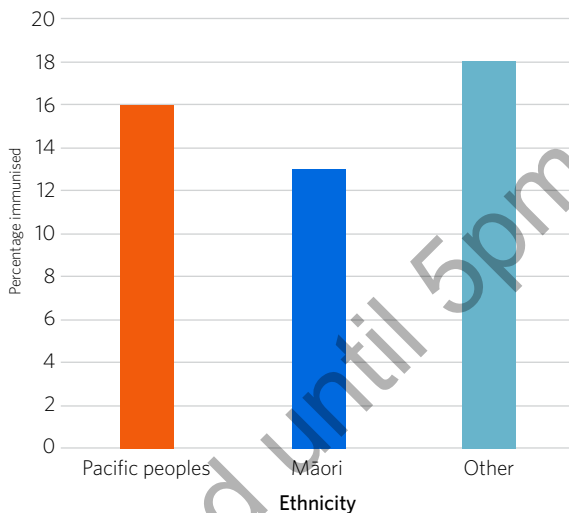
On the life course: adults

Some aspects of preventive health care – notably flu immunisations – seem largely to perform well for Pacific peoples, but cancer screening rates reveal some notable issues and trends of inequity, which are of particular concern given the higher rates of incidence and mortality of some cancers. Long-term conditions for Pacific peoples are a major issue, with diabetes presenting a striking example of the complexity and poor outcomes involved even when access appears better than might be expected. This section includes disability as part of the life course.

Flu immunisations

Pacific adults aged 20–64 years were vaccinated for flu at comparable rates to non-Māori, non-Asian ethnicities in 2020, and at a higher rate than Māori...

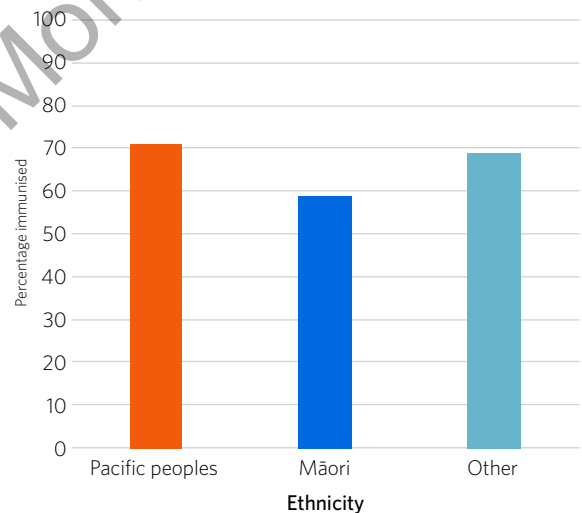
Figure 43: National Immunisation Register influenza immunisations of adults aged 20–64 years (percentage), by ethnicity, Aotearoa New Zealand, 1 March 2020 to 21 August 2020



Source: National Immunisation Register.

... while a higher proportion of Pacific elders were vaccinated for influenza than other ethnicities in 2020, and that proportion increased by 12 percentage points from 2019.

Figure 44: National Immunisation Register influenza immunisations of adults aged 65 years and over (percentage), by ethnicity, Aotearoa New Zealand, 1 March 2020 to 21 August 2020



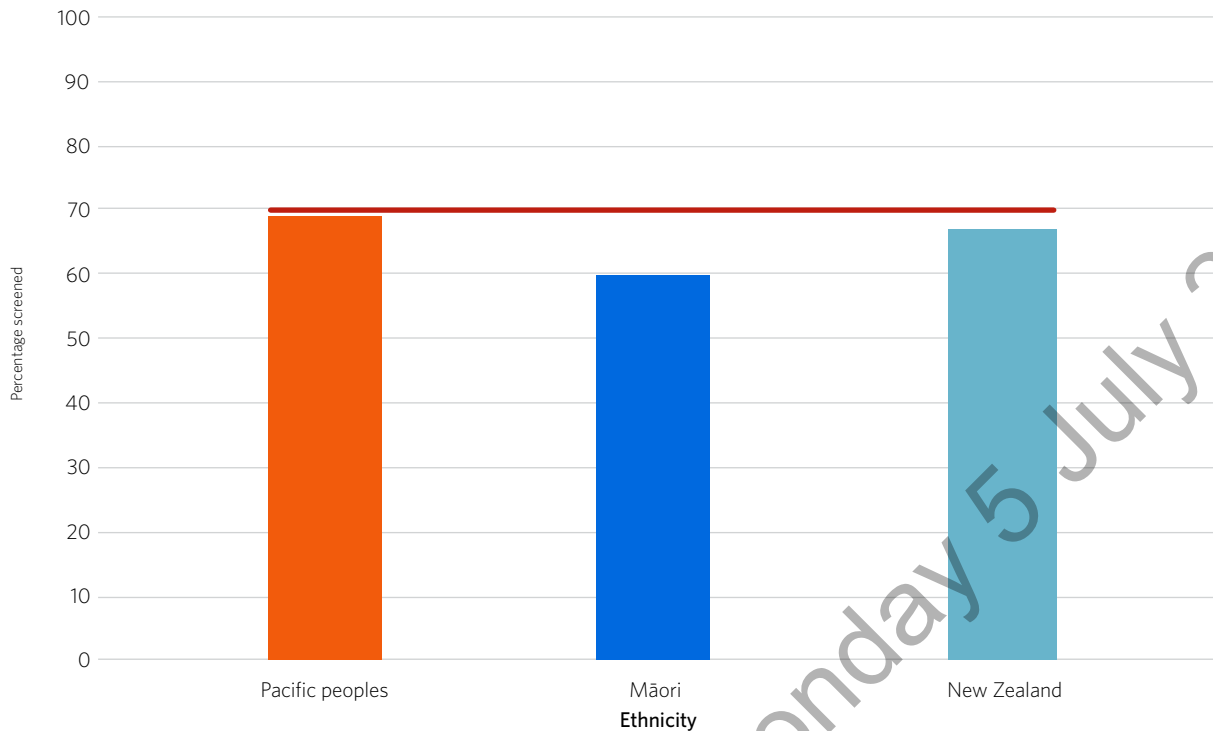
The relatively high rates of flu immunisations this year may have been related to the additional Pacific-specific messaging developed as part of the COVID-19 response, as well as the focus applied by the primary care sector.

Cancer screening programmes

Pacific peoples experience higher incidence and mortality rates of breast, lung and uterine cancers than other ethnicities.^{85, 86} New Zealand has three national cancer screening programmes: BreastScreen Aotearoa, the National Cervical Screening Programme and the National Bowel Screening Programme.⁸⁷

Most recent data shows Pacific women are covered by BreastScreen Aotearoa at rates better than or comparable with women from other ethnic groups (Figure 45).⁸⁸

Figure 45: Breast screening coverage, women aged 45–69 years, by ethnicity, Aotearoa New Zealand, at October 2020

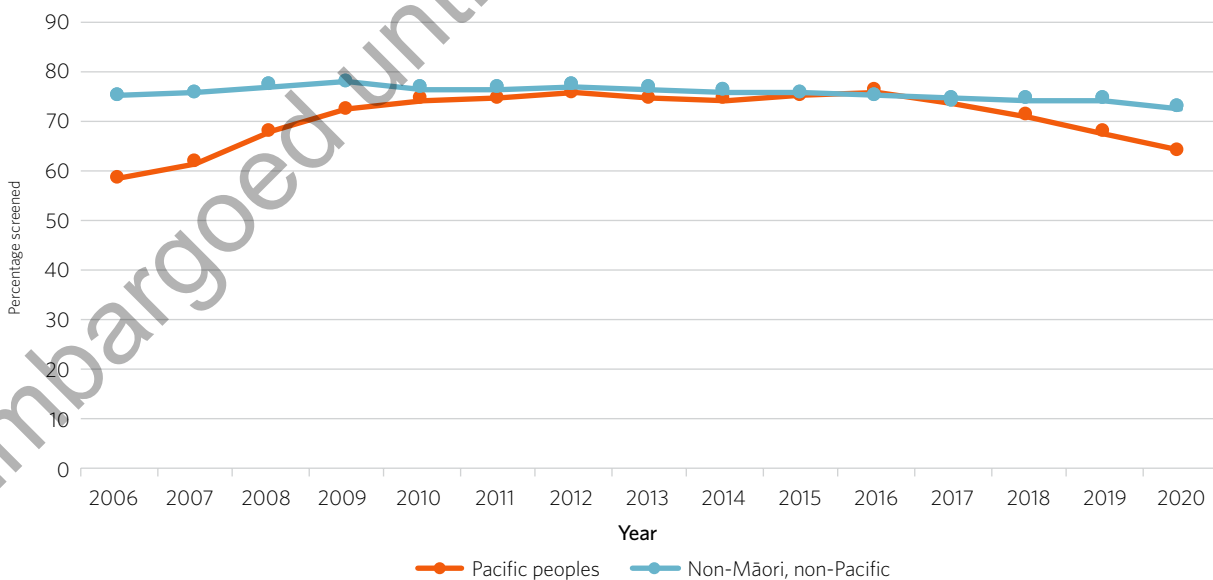


Note: Target is in red.

Source: National Screening Unit (NSU). 2020. BreastScreen Aotearoa DHB Coverage Report.

The rate of cervical screening of Pacific women has steeply declined since 2016 from 76% to 64% in 2020 – a 10 percentage point equity gap with other groups (Figure 46).⁸⁹ The reasons for this decline are unclear, but require attention, particularly given the added barriers (perceived or otherwise) presented by COVID-19.

Figure 46: Cervical screening coverage (three-yearly), by year and ethnicity, Aotearoa New Zealand, at September 2020

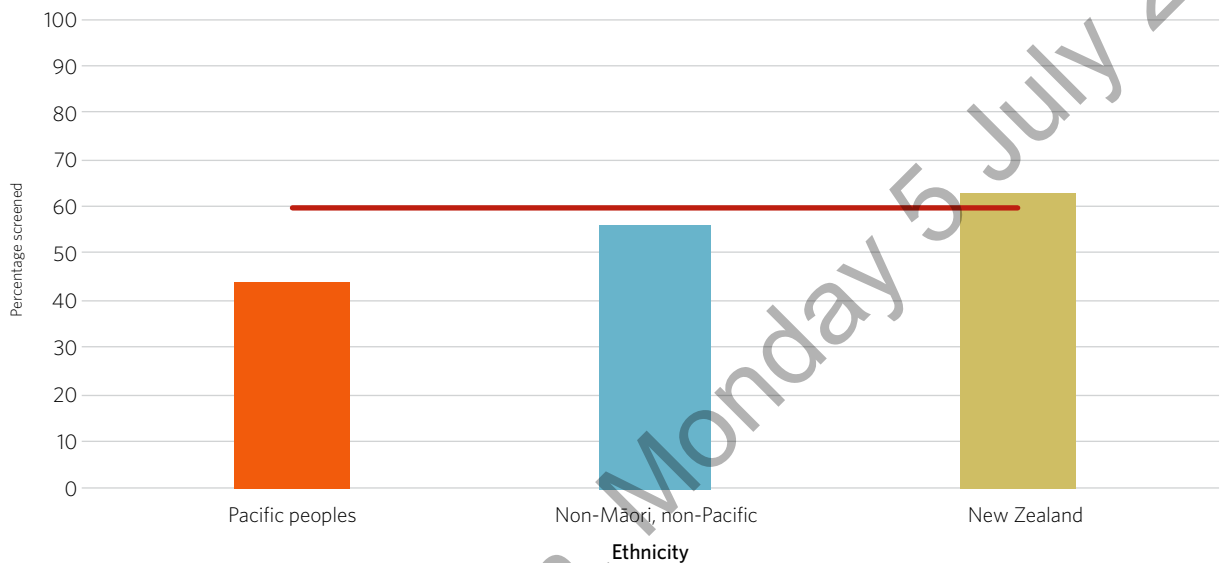


Source: National Screening Unit (NSU). 2020. National Cervical Screening Programme Coverage Report.



The National Bowel Screening Programme remains under a scheduled rollout throughout the country, but monitoring data for DHBs that are currently active shows that screening uptake is lowest among Pacific peoples (Figure 47).⁹⁰ Pacific peoples had the lowest screening participation rates in the bowel screening pilot at Waitematā DHB in 2012–15, and an evaluation of the pilot in 2016 noted that research was needed to understand the barriers to participation.⁹¹ Since then, a number of studies have been published, showing that telephone follow-up for non-responders and a community laboratory drop-off option for bowel screening test kits can increase participation rates,^{92,93} particularly in Pacific peoples. However, these strategies are not mandated nationally, nor routinely employed by participating DHBs, likely due to a lack of resource.

Figure 47: National bowel screening coverage, Aotearoa New Zealand, at August 2020



Note: Target is in red.

Source: Te Aho o Te Kahu, Cancer Control Agency 2020.

Long-term conditions

Pacific peoples in New Zealand bear a disproportionate burden of long-term conditions including diabetes, gout, cardiovascular disease, kidney disease, cancer and asthma. Long-term conditions are the most important contributors to the life expectancy gap between Pacific peoples and non-Māori, non-Pacific.³¹ There is also increasing prevalence of multimorbidity (the occurrence of more than one long-term condition) among Pacific peoples,⁹⁴ emphasising the importance of coordinated care that manages multiple risk factors and associated long-term conditions, rather than taking a siloed, condition-specific approach. In this section, we use diabetes as a case study of a long-term condition requiring urgent action to address inequities in Pacific health.

Long-term conditions: diabetes

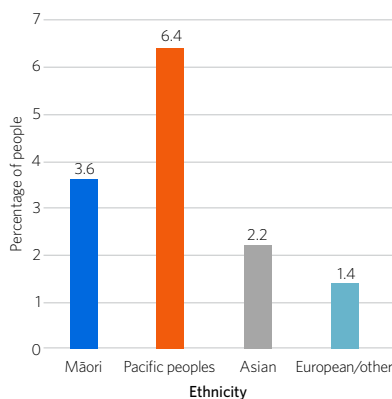
The experience of diabetes in Pacific populations in New Zealand is characterised by very high prevalence and earlier onset of disease relative to other ethnic groups, often resulting in more severe disease and earlier onset of complications. Despite relatively high rates of regular testing, Pacific peoples with diabetes often have poorer glycaemic control compared to other ethnic groups. There is evidence of inequities and unexplained treatment gaps in control of glucose levels, effective management of diabetes and cardiovascular risk. These are amenable but have led to an unacceptably higher incidence of chronic kidney disease, kidney failure and dialysis in Pacific peoples.

Prevalence of diabetes

Approximately 6% of adult New Zealanders have type 2 diabetes, increasing annually by 7%. The elderly, those living in areas of high deprivation, and Pacific peoples, Indian and Māori have higher prevalence. Data from 2014–18 shows that overall 10.8% of Pacific peoples had diabetes, more than double the percentage of other ethnic groups. That is more than 34,000 Pacific peoples, nearly half of whom are in Counties Manukau DHB.⁹⁵

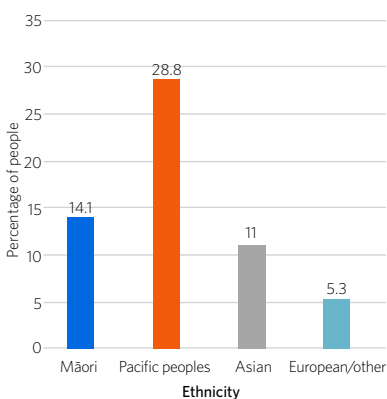
Younger Pacific adults have double the prevalence of diabetes compared with Māori, and five times the rate of European/other ethnicities...

Figure 48: Diabetes prevalence, age 25–44 years, by ethnicity, Aotearoa New Zealand, 2018



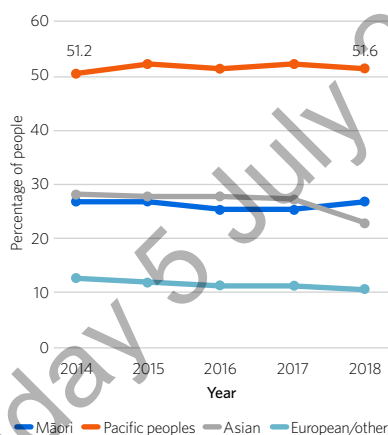
... one-third of Pacific peoples over the age of 45 have the disease...

Figure 49: Diabetes prevalence, age 45–64 years, by ethnicity, Aotearoa New Zealand, 2018



... and for the last five years half of Pacific people age 65 and above have had diabetes.

Figure 50: Diabetes prevalence, age 65 years and over, by ethnicity, Aotearoa New Zealand, 2018



Source: Health Quality & Safety Commission. Atlas of Healthcare Variation, diabetes domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/diabetes.

These large numbers of Pacific peoples with diabetes experience a trifecta of issues:

- earlier onset leading to earlier and worse complications
- inadequate management and control of diabetes
- worse hospitalisation rates relative to other ethnic groups.⁹⁶

Projections of diabetes prevalence

Recent projections from *The Economic and Social Cost Of Type 2 Diabetes 2021* report suggests prevalence of type 2 diabetes among Pacific peoples will rise to 12.4-16.2% of the population in the next 20 years.⁹⁷ However, once age-standardised the projected prevalence of type 2 diabetes in Pacific peoples in 2040 reaches a 'staggering' 18.4-25.4%, 'meaning that a quarter of all New Zealand's Pacific peoples could be diagnosed with type 2 diabetes in 20 years' time'.⁹⁷

The report also makes clear the economic impact of diagnosis of type 2 diabetes in the young, a growing trend among Pacific peoples. The lifetime cost associated with the disease - incorporating health costs, lost productivity and inability to work, as well of value of lives lost early - of a 75-year-old with newly diagnosed type 2 diabetes is \$44,000. For a 25-year-old that cost is \$565,000, a 13-fold difference.⁹⁷



Dr Sirovai (Siro) Fuata'i, GP, Baderdrive Doctors, Māngere and Manurewa, and Cavendish Doctors, Manukau. Enrolled population about 80% Pacific.

The data supports the high levels of gout, diabetes and cardiovascular disease amongst the Pacific population. And it's always been looked at from what I would call a Palagi research lens that a lot of these things are part of the way that Pacific peoples live: 'it comes from lifestyle,

food as a form of social norm'... and we have to accept that. The approach through the years was to try and change lifestyles, but that's easier said than done. It's very hard for us to say to communities that you've got to try and become something that you're not.

At the clinics we see people at the end of that continuum where they present with complications or when we start to manage them with high blood sugar, high weight, gout playing up. It would be better to manage them earlier on: upstream rather than downstream, younger rather than older.

We should roll out programmes that support people and help them understand that they can still enjoy life, live socially in a way that their communities naturally happen, but support them in a way that we can say, 'These are the things you can do, that you can manage and control. And we'll support you if you reach this end point.' *

Doana Fatuleai, general manager Pacific health, Counties Manukau DHB

There are rising rates of diabetes and diabetic complications. It's challenging because we've got lots of qualified people and great minds and we're all asking the question, what do we do? A lot of resources have been put into prevention. There's a lot of diabetes education sessions, self-management sessions. There is a lot of prevention and a lot of promotion and I've been trying to do that and get translations into the different languages. It's challenging because we're talking about changing mindsets, changing lifestyles. It's trying to understand our Pacific community, and where they're at. We have to understand that there are New Zealand born, there are Island born so we've got these different aspects of where people are at and we can't just do one thing, one approach for all. There needs to be a different approach with different people under the Pacific umbrella. We've used churches in the past and I think that's still a great way in that we need to use, but then we've got a lot of people who are not attending churches now. So we have to ask ourselves, how do we engage with that population? *

Testing and treatment

Optimal management of diabetes requires packaged care that includes foot care, retinal (eye) care, and management of glucose, blood pressure, protein in urine, and other cardiovascular risk factors such as tobacco smoking. Blood glucose must be kept within certain parameters (known as glycaemic control), which is monitored by regular testing of glycated haemoglobin (HbA1c). HbA1c measures average blood glucose levels over the most recent three months.⁹⁸ Management involves an individually tailored 'treatment to target' approach via medication and lifestyle interventions to achieve and maintain a healthy HbA1c level. The goal is to limit complications of diabetes, including damage to the nerves, heart, eyes and kidneys.^{99, 100, 101}

HbA1c testing rates for Pacific peoples living with diabetes appear good relative to other ethnic groups. Though this appears to provide a platform to inform proactive and opportunistic glucose and diabetes management, this has not translated into HbA1c levels within target range.

Despite high rates of regular HbA1c monitoring for Pacific peoples in New Zealand...

... in metro Auckland, more Pacific peoples with diabetes have HbA1c levels higher than target (≥ 75 mmol/mol) than other ethnic groups, with the greatest disparities between younger people, who are at risk of more advanced complications.

Figure 51: Percentage of people with diabetes having regular HbA1c monitoring, by ethnicity, Aotearoa New Zealand, 2018

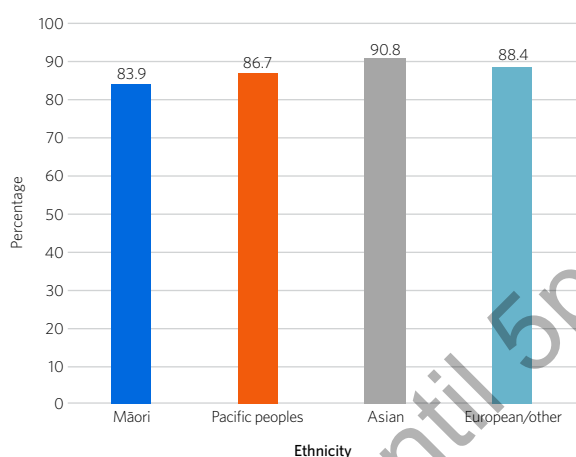
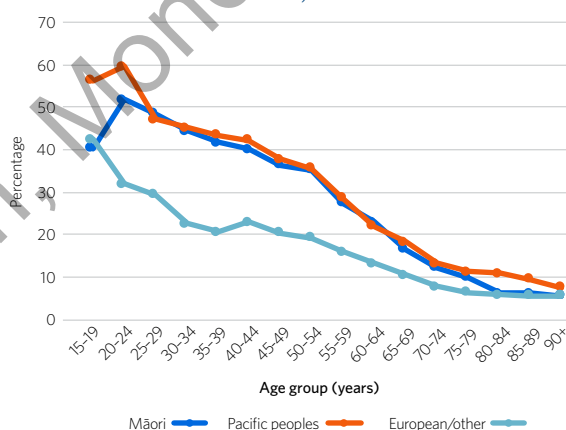


Figure 52: Percentage of people with diabetes with last test ≥ 75 mmol/mol HbA1c, metro Auckland, by ethnicity, Aotearoa New Zealand, 2018



Sources: Health Quality & Safety Commission. Atlas of Healthcare Variation, diabetes domain: www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/atlas-of-healthcare-variation/diabetes; adapted with permission from Chan WC, Lee M (AW), Papaconstantinou D. 2020. *Understanding the heterogeneity of the diabetes population in metro Auckland in 2018*. Auckland: Counties Manukau Health. https://countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Diabetes/2020_Understanding_the_Heterogeneity_of_the_diabetes_pop.pdf.

A separate study from Counties Manukau DHB emphasises this point. More than 96% of people living with diabetes attended primary health care for some reason at least once in 2018, with 80% attending in at least three out of four quarters of the year. The issue, therefore, is not access to or attendance at primary care, but the need for opportunistic care and ongoing proactive follow-up and engagement, particularly with those people with high and complex needs.¹⁰³

In December 2020, PHARMAC made the long-awaited decision to fund two new types of medicines for type 2 diabetes for 2021: empagliflozin and empagliflozin with metformin, and dulaglutide (subject to MedSafe approval). Empagliflozin in addition to first-line medicines (such as metformin and statins) has been shown to reduce the risk of renal and heart disease in people with type 2 diabetes and with known cardiovascular disease, or nephropathy. These medicines will be funded subject to patients meeting funding criteria. In a precedent-setting decision, PHARMAC included being of Māori or Pacific ethnicity as one criterion for obtaining special authority.¹⁰⁴ The decision was warmly welcomed by Māori and Pacific health advocates, who had strongly advocated for these medicines being widely available.¹⁰⁵



Dr Jade Tamatea (Ngāti Maniapoto, Ngāti Kahungunu), endocrinologist, Waikato DHB; senior lecturer, Te Kupenga Hauora Māori, University of Auckland

PHARMAC announced that they will be funding two new medicines for type 2 diabetes – an SGLT2 [sodium-glucose co-transporter-2] inhibitor and a GLP1 [glucagon-like peptide-1] agonist – which will be a game changer in the options for the treatment of diabetes. We've been asking for PHARMAC to fund both those medicines for

about 10 years now, so it really is a great moment to know that they're going to be available and give us much more options in what's available for treating type 2 diabetes.

When PHARMAC made the announcement last year that it was planning on funding these, it asked for feedback on its proposed special authority to control funding of these medications. A number of groups, including ours, fed back that there was concern that the special authority as it was set up was not going to be pro-equity and not acknowledge both the increased need for these medicines for Māori and Pacific peoples with type 2 diabetes, but also the fact that we work within a racialised health care system, and that PHARMAC is not excluded from that. The decisions PHARMAC makes impact that system and have to flow through that system. There was a need to acknowledge those two factors.

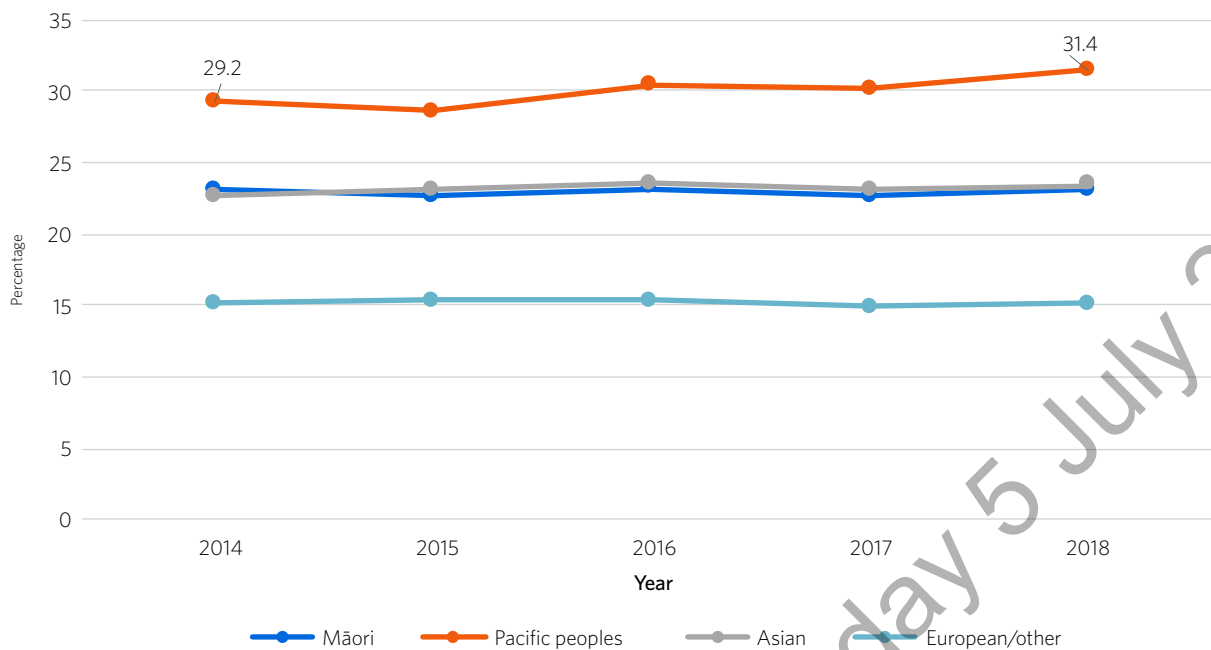
PHARMAC has now acknowledged both of those factors, and the special authority includes being Māori or any Pacific ethnicity. This is the first time it has made a decision to include ethnicity as a criterion to make a decision about funding. So we think this is a really great decision, and the right decision. And particularly for those two reasons, that if we look at the communities of increased need, but also the communities that get the least access for that need, then this is just one more step in improving access. *

The acute burden of diabetes

Diabetes has a massive impact upon individuals and on the health care system itself.

Nearly a third of all medical or surgical bed-days occupied by Pacific peoples in 2018 were for people with diabetes (Figure 53). The slow rise in percentage hides a rise of nearly 9,000 bed-days since 2014, to a total of nearly 46,000 days spent in hospital beds by Pacific peoples with diabetes in 2018.

Figure 53: Percentage of bed-days occupied by people with a diabetes diagnosis, by ethnicity, Aotearoa New Zealand, 2014–18



Source: National Minimum Dataset.

Complications of diabetes

Complications of poorly controlled diabetes are serious and result in lost quality of life, productivity and earnings.¹⁰⁶ Microvascular complications include retinopathy (eye disease), neuropathy (nerve disease) and renal (kidney) failure, along with lower-extremity amputations. Macrovascular complications of diabetes include coronary heart disease, stroke and peripheral vascular disease.¹⁰⁶ The earlier the onset of diabetes, the earlier the onset of these life-changing complications.¹⁰⁸ Earlier onset of disease and major complications have been shown to affect younger Pacific adults.¹⁰⁹

Kidney disease

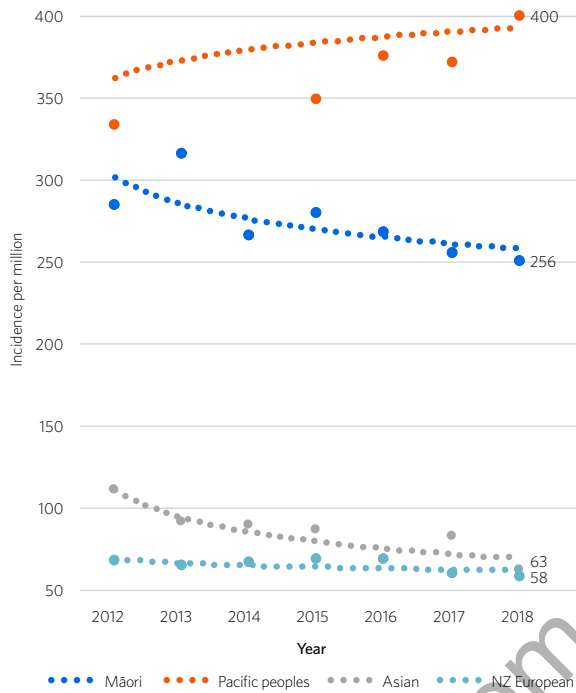
Poorly controlled diabetes can lead to damage to the blood vessel clusters in kidneys, and kidney failure, where the kidneys can no longer properly remove fluid and wastes from blood. Patients must then be treated with some form of kidney replacement therapy. Sixty-four percent of Pacific peoples who started kidney replacement therapy in 2018 had diabetes, compared with 18% of European/other people.

Pacific peoples require kidney replacement therapies (dialysis or kidney transplantation) more often and earlier than other ethnic groups.



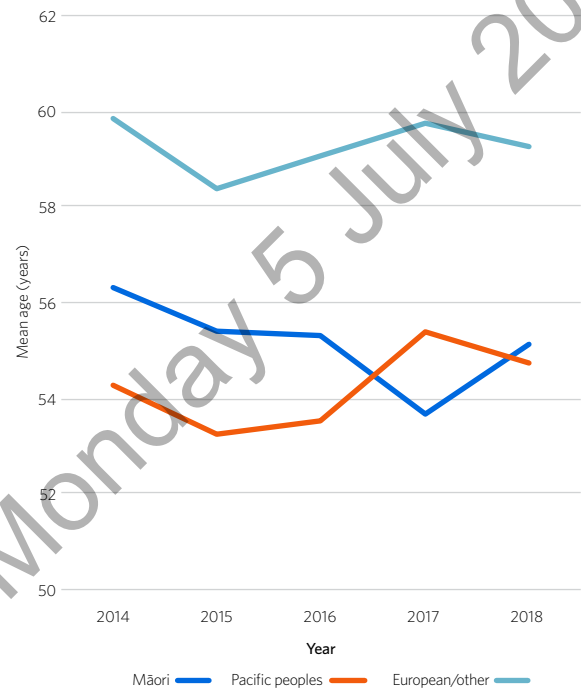
Since 2012, Pacific peoples have consistently had a seven-fold higher – and growing – incidence rate of starting kidney replacement therapy compared with New Zealand Europeans...

Figure 54: Incidence of starting kidney replacement therapy per million population, by ethnicity, Aotearoa New Zealand, 2012–18



... and lower mean age at starting renal replacement therapy by five years, a consistent trend since at least 2014.¹¹⁰

Figure 55: Mean age at starting kidney replacement therapy, by ethnicity, Aotearoa New Zealand, 2014–18



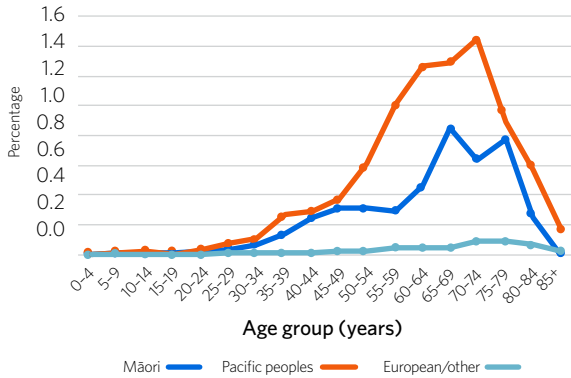
Source: National Renal Advisory Board. (nd). *Aotearoa New Zealand Nephrology: 13th Annual Report*. www.health.govt.nz/system/files/documents/pages/2020_nrab_nephrology_activity_report_2018_data.pdf.

Data from the metro Auckland area shows that more Pacific peoples with diabetes had early signs of kidney damage in 2019, indicated by very high levels of albumin in the urine (albuminuria), compared with people with diabetes from other ethnic groups: 38% of Pacific, 33% of Māori and 14% of European patients with diabetes had severely increased albuminuria, and 60% of Pacific, 55% of Māori and 34% of European patients with diabetes had moderately increased albuminuria.¹¹¹

More Pacific patients also experience kidney failure younger (loss of most kidney function, where a patient's estimated glomerular filtration rate (eGFR) goes below 15 mL/min/1.73 m²).

Pacific peoples were over-represented in those receiving dialysis in 2019, a trend rapidly accelerating in patients over 49 years of age...

Figure 56: Age-specific prevalence of people who received dialysis in metro Auckland, by ethnicity, Aotearoa New Zealand, 2019

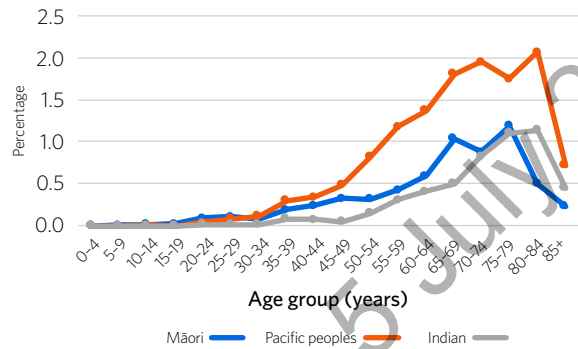


Note: Denominator: health service utilisation population in 2019 in metro Auckland.

Source: Chan WC. 2020. Diabetes care in the context of SGLT-2 inhibitor and GLP-1 agonist: How many people in Auckland metro are meeting clinical criteria in the context of multi-morbidities?

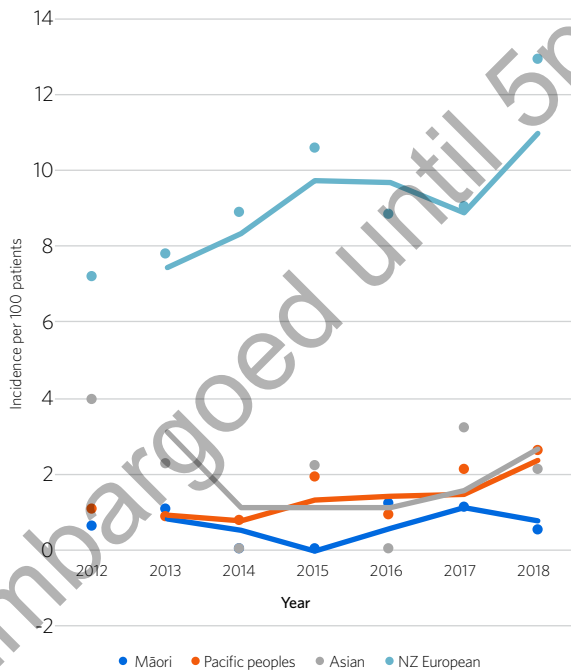
... with a strikingly similar pattern in poor outcomes where patients experience kidney failure.

Figure 57: Age-specific end-stage renal failure prevalence (eGFR < 15 mL/min/1.73 m²), metro Auckland, by ethnicity, Aotearoa New Zealand, 2019



Pacific and Māori patients were far less likely to receive a kidney transplant as their first treatment for kidney failure than New Zealand Europeans...

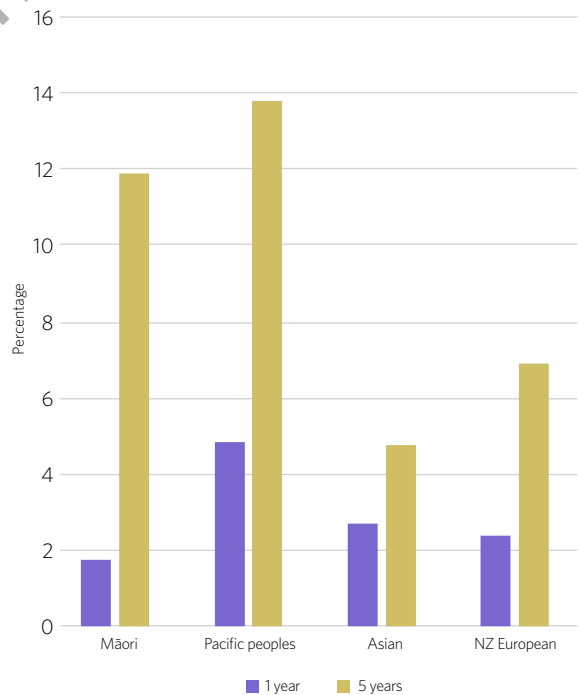
Figure 58: Incidence of pre-emptive kidney transplantation, by ethnicity, Aotearoa New Zealand, 2012–18



Source: National Renal Advisory Board. (nd). Aotearoa New Zealand Nephrology: 13th Annual Report: www.health.govt.nz/system/files/documents/pages/2020_nrab_nephrology_activity_report_2018_data.pdf, p 15, p 32.

... and when they do get transplants, Pacific patients have a higher, earlier risk of transplant failure.

Figure 59: Graft (transplant) failure at one year and five years after transplant, primary deceased donor kidney-only transplants, Aotearoa New Zealand, 2009–18





**Dr Jade Tamatea, endocrinologist, Waikato DHB; senior lecturer,
Te Kupenga Hauora Māori, University of Auckland**

[The higher rates of renal complications and dialysis among Māori and Pacific peoples living with diabetes] have been a quiet disaster for years now without clear acknowledgement of the problem. We've known for a long time that Māori and Pacific peoples typically get more renal disease and other complications above and beyond the increased prevalence of disease. It's only been in the last couple of years that people have started shouting about how much of an issue this is in renal, and that's really critical. We need to be making a much bigger fuss because this is an epidemic, this is a disaster, and we need to understand it better, and do something about it.

We know what leads to progression to renal disease, or any secondary complication in diabetes, and that, oversimplifying, is glycaemic control at target, and management of the secondary risk factors for those complications, and proactive management of blood pressure, cholesterol, all of the other factors that are going to drive these diseases as well.

And we know that the system does poorly at doing all of those things. Does more poorly for some groups than others, and coincidentally those are the groups that seem to have more of the complications. So it seems to me that I hear a lot of narrative about particularly renal disease, about this being something inherent to us. But I rarely hear an acknowledgement of the fact that we know that our HbA1c levels run higher for longer. We know that our high albumin levels are less likely to be managed. We know that until very recently, we were less likely to be on renal protective medication.

The clinical inertia in diabetes is huge, but I argue that there is an ethnic inequity in clinical inertia. A group here recently published a paper which is the first I've seen to show that there is an ethnic gap in clinical inertia with prescribing of metformin. We know that there is a large proportion of patients out there with an HbA1c over 100. It's measured every three months, as it should be, and yet it does not move off that because there is an inertia among clinicians to start a new treatment. There's an inertia among clinicians to get people onto insulin. There's inertia in increasing insulin. And insulin in particular, but all of the management, requires an active process. You need a starting dose, someone needs to monitor the response to that rather quickly, needs to be up-titrated quickly. It requires quite an active process, so it doesn't take very much inertia for that not to happen.

How do we overcome clinical inertia? I think systems are the way to drive that. Firstly, good guidance. The NZ Society for the Study of Diabetes is updating its diabetes guidance, and that's coming out in the new year. I'm hopeful that alongside the new medication, this will drive us to revisiting how we approach diabetes as a model of care. I do think the whole model needs to change. Realistically, the funding and the plan has gone into just monitoring rather than actively doing things.

And so, it needs to change. We need to actively be managing complications and risks of complications. I think algorithms need to be built into general practice care that say, okay, this patient has an HbA1c balance of 100, what are we doing about it? What wraparound additional supports does this person and their whānau need? And who's best placed to deliver that? And that may not be general practice. In fact, I'd argue it probably isn't. But someone also needs to actively be making clinical decisions about the next treatment step. ✨



**Manogi Eiao, pre-dialysis nurse specialist,
Renal Services, Counties Manukau DHB**

Money is a big problem. One of my patients had a car break down, so she had to rely on her mum's car. But her mum's got other business. She came late to her appointment today. I thanked her that she still turned up. It's those kinds of pressures that people have in their everyday lives. Those are the kinds of things that our population is dealing with.

I had a gentleman who came into clinic yesterday at 2:30pm, and this was a fourth appointment for him because he'd DNA'd three appointments before, and he said he just couldn't get time off work. But yesterday he finished at 2:00pm... he normally finishes at 2:30pm... just so that he could come in for his appointment. It's congratulating patients when they do turn up. It's saying thank you and acknowledging how hard it is for them to make that time to come in, because they have to pay the bills to feed the family. That's what holds a lot of people back - they have no time off work or they don't have any sick leave. They need to go to work to get that money, to pay the bills, to feed the family and they 'neglect' their health. They 'neglect' their appointments.

We're open 8:00am to 4:30pm, but if I recognise that a family is struggling, I'll go out and do a home visit at 6:00pm, just so that I can give them that information, to say, 'This is the timeline (for dialysis). We want to plan. We want to prepare you.' It takes them a little while to get into that mindset that they do have to plan for the year. Some people, they get it, and they're able to take time off to get to the appointments. A lot of people don't have that luxury.

Our nurse practitioner does Saturday clinics. She'll see a lot of patients who can't make it during the week, so she'll see them on Saturdays. We start at 8:00am, but some of the other nurses know patients who start work at 8:00am, so they might come in at 7:00am. It's trying to work with our patients and fit in with their lives. ✨

Long-term conditions: gout

Gout is a debilitating but treatable, largely genetically determined chronic disease and the most common form of inflammatory arthritis affecting adults.¹¹² The burden of gout in New Zealand falls particularly on Māori and Pacific populations and is characterised by mismanagement, misunderstanding and victim blaming, disability and loss of productivity and quality of life.¹¹³ In 2008 South Auckland was referred to as the 'gout capital of the world'.¹¹⁴

Pacific adults, particularly men, in both younger (20-44 years) and older (45-64 years) age groups are diagnosed with gout at rates twice as high as Māori and 5-7 times higher than non-Māori, non-Pacific populations, and those rates are increasing. There is likely considerable unidentified and unmet need on top of this large identified burden.^{116, 117, 118}

The treatment for chronic gout is regular receipt of urate-lowering therapy (such as allopurinol) to reduce urate levels to the point uric acid in the joints dissolves. This requires primary care management and frequent testing to bring urate levels to target. However, Pacific adults aged 20-44 years regularly received urate-lowering therapy at rates lower than non-Māori, non-Pacific adults consistently over time, despite being most affected by gout, a pattern repeated for older Pacific adults - although the equity gap appears to be narrowing since 2017.¹¹⁵



The rate of hospitalisations of Pacific adults with gout remains highest of all ethnicities, but there is promise: hospitalisations of Pacific elders aged 65 years and over have now declined for the third year in a row, from around 600 admissions per 100,000 population to under 350.¹¹⁵ This improvement has been driven strongly by improvement at Counties Manukau DHB.

Maryann Heather, GP, South Seas Healthcare

So many Pacific peoples suffer from gout and end up in hospital, yet they are not on allopurinol. It's really hard, to be honest. In Auckland, we've got the lowest rate of prescribing preventive gout medications in the country.

When I see patients with gout often they're using Voltaren or something similar. They won't come back again for another 6 or 12 months, and we start all over again. So it's a vicious cycle that, again, comes down to what they understand about gout. A lot are in denial.

We are trying to look at ways of trying to address that. I really try and make sure education is there. I talk to them early about allopurinol, but a lot don't want to be taking medicine or sometimes they'll borrow medication from family. They'll come in and tell us, 'Oh, this one works. Can I have some?' And I have to say, 'No. Your kidney function is too low,' or, 'You've got a stomach bleed from Voltaren.' You've got to really make sure you stay on their case, have a good recall system, have some sort of system in place. We've got to tailor it to our patients because not everyone's one-size-fits-all.

The whole demographic looks different for our Pacific patients. Most are quite complicated, and on 10 other different medicines, and some are really young. I'm conscious of giving them stuff that's translated into Samoan or Tongan. I'm basically on their case just to try and get them thinking about it.

You have to be opportunistic with everything that people come in with and try and make sure that you don't lose them and that they come back. It's hard, though. Gout is one of the tough ones. ✨

Long-term conditions: cardiovascular disease

Among all ethnic groups, Pacific peoples and Māori have the highest age-standardised rates of acute coronary syndrome (ACS) (heart attacks and unstable angina) but the lowest rates of receiving angiography (investigation to check for blocked or narrowed blood vessels in the heart) and coronary revascularisation (procedures to unblock obstructed or disrupted blood vessels, restoring blood flow to the heart, reducing chances of long-term damage and improving chances of survival).

Pacific peoples and Māori also have the highest rates of death or recurrent myocardial infarction (ie, a heart attack) within a year of their initial ACS. Among Pacific peoples who had experienced an ACS in 2016/17, more than one in three died or had another heart attack within a year. The data shows Pacific peoples and Māori bear the greater burden of bad outcomes for cardiovascular disease, receive proportionately less treatment and suffer worse subsequent outcomes.¹¹⁹

A recent study found that three-quarters of the inequity in deaths up to a year after a first heart attack for Pacific peoples was associated with differences in preventable or modifiable clinical factors present at, or prior to, presentation. These clinical factors included diabetes, high BMI, smoking and congestive heart failure. These inequities in outcomes following a heart attack could therefore be reduced by improving prevention strategies in the community and in health care delivery in primary and secondary care.¹²⁰ Another study reported inequities in evidence-based medication use following hospitalisation.¹²¹

In summary, the high rate of flu immunisations in older Pacific peoples in 2020 indicates that some aspects of preventive care are working well; however, other aspects (eg, some cancer screening programmes) show

significant equity gaps, highlighting missed opportunities for early intervention. Long-term conditions are an important contributor to the life-expectancy gap for Pacific peoples; however, models of care for these conditions may not be meeting the needs of Pacific communities, as evidenced by the significant inequities in prevalence and outcomes. This appears to be the case for diabetes, where high rates of complications are impacting on Pacific peoples, many of whom are still of working age. The recent decision by PHARMAC to explicitly include ethnicity as a criterion for diabetes medicines not previously funded in New Zealand is an equity-positive step that must be supported by strategies to increase confidence and decrease clinical inertia within the health sector caring for Pacific peoples with diabetes.

Barriers and enablers to care

There are well-documented barriers to accessing timely, high-quality health care for Pacific peoples, including cost, location and availability of services, appointment times, cultural and communication factors, and family and other commitments. Good communication between health professionals and their patients is a fundamental component of high-quality health services. Communication barriers, a clash in cultural worldviews and, at times, discriminatory and culturally insensitive behaviour have all been shown to affect the way Pacific peoples experience care and influence their health-seeking behaviour.⁹⁴

Access



Ma'ukakala Ofa, obstructive sleep apnoea nurse specialist, Auckland DHB

There are issues with access to care. There's a general lack of understanding among providers of the context in which Pacific peoples live, and the struggles and challenges that they actually have to access care in the first place.

We see high DNA specialist appointment rates. We try hard to get the patient to come in, to make the patient

understand the importance of booking a specialist doctor, but on that day, they often don't turn up. After three times, what do we do? We discharge them back to their GP. The GP does not follow up and the patients DNA again and again until they are admitted to ED and we've had a failure. Then providers wake up and everyone points at the patient. But we don't know what the situation with the patient is.

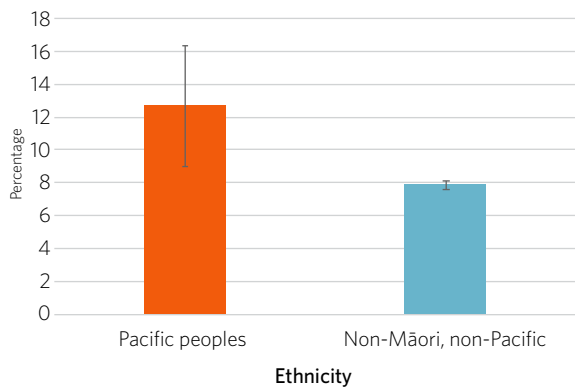
Pacific peoples, especially in this time of COVID-19, are struggling at home to buy their medication, struggling to come into follow-up appointments, struggling with transport because there's no one to look after the younger ones at home. Services need to look at how we are going to support those people. I think there is a need to reach out. Services need to go out to the community rather than sit in the hospital and let the patient come to the service. Think about the time it takes to come to the hospital, the car parking, the time they take off from work – it's a huge burden for a patient with very minimal wages. I believe there is a need for the service to go out, reach out to those people. ✨



Unmet need for a GP appointment or prescriptions due to cost

Pacific elders were more likely than non-Māori, non-Pacific older people to choose not to see a GP due to cost...

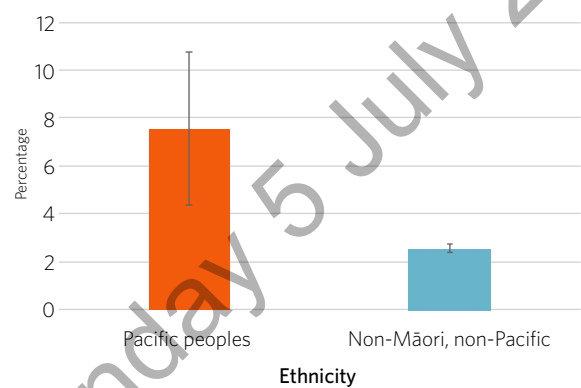
Figure 60: Percentage of Pacific peoples and non-Māori, non-Pacific aged 65 years and over that answered 'Yes' to the question 'In the last 12 months was there a time when you did not visit a GP or nurse because of cost?', by ethnicity, Aotearoa New Zealand, 2019



Source: Health Quality & Safety Commission. 2019. Patient experience survey.

... and cost was also more likely to be a barrier to picking up a prescription.

Figure 61: Percentage of Pacific peoples and non-Māori, non-Pacific aged 65 years and over that answered 'Yes' to the question 'Has cost stopped you from picking up a prescription?', by ethnicity, Aotearoa New Zealand, 2019



Ellaine Ete-Rasch, *public health, primary care, child health nursing*

We know a high number of Pacific people are registered with primary health organisations, which is a great accomplishment. The increase in funding subsidies may have contributed to this. It is also good to see the developments of Pacific health providers which I believe have also made a big difference in Pacific peoples' access to health care. However, we still see evidence of poor health statistics for Pacific peoples compared with the total New Zealand population. Are they actually receiving and accessing quality health care?

In Wellington in the early 2000s, the majority of Pacific peoples our Pacific nursing team contacted had no idea that they were supposed to be taking medications on a regular basis for diabetes or hypertension. Individuals did not know they were diagnosed with diabetes and/or hypertension. Some were in denial and did not want to know. Some did not know they needed to see their doctor on a regular basis. Some knew they were supposed to go back to the doctor but didn't understand why. As long as they were feeling fine and ok, they did not see the need for a health check. Sadly, some needed to commence dialysis treatment because of poorly controlled or untreated diabetes/hypertension for years. That picture has changed. More Pacific peoples are going to their GP for regular follow-ups and are more in tune with their health needs.

We know some Pacific peoples' poor health is deeply rooted in poverty. For families we worked with, health education, made available in a language and context that was easy to comprehend and they could relate to, made a difference. But most importantly, gaining the trust and building and strengthening relationships with families was key to the success achieved with some families.

The responsibility lies with health workers to educate and support Pacific communities regarding health issues. 'People are destroyed from lack of knowledge' (Hosea 4:6). Access to health care does not guarantee good health outcomes for some communities. Higher-quality and more productive interactions are needed with Pacific families. ✨

Communication

Communication barriers relate to how, what and where information is relayed, and who is relaying the information. Pacific families have reported feeling they lacked information from health care providers, leading to difficulties negotiating processes within the hospital system, such as knowing the support services available, their eligibility for these services, and what to expect at various stages of care.¹²² Use of medical jargon can also lead to patients and families feeling alienated, particularly for speakers of English as a second language. Resources for families to better understand their condition, treatment options and strategies for self-management are frequently limited, and where they are available, they are often only in English and not necessarily written with health literacy principles in mind.⁹⁴

Dr Tule Fanakava Misa, *public health dentist, public health, primary care, child health nursing*

The majority of our oral health workers are Palagi. I'm the odd person out. Whenever there is a Pacific family, they'll call me and say, 'Oh, this family, we have tried so many times and they're not turning up.' If they are Tongan or Pacific, I give them a call, they turn up when they hear that this is another Pacific person talking to them.

As soon as I start talking to a Pacific child or parent there's already connection. The outcome is already starting. If I tell them, 'Hey, you really need to come back on this day, because this is so important. This is an adult tooth. You look so handsome. We do not want you to have that tooth extracted.' It's amazing how these kids usually turn up.

I think there will be a huge improvement if Pacific oral health workers are able to provide for our people. I was talking with my children the other day and I was asking them, 'Why do you think that we have all these bad health and education outcomes?' The first thing they said was, 'Because the system is setting us up to fail.' I'm thinking, what do you mean by that? My 17-year-old said, 'You know what? I didn't realise I was Tongan until I went to school and the expectation that everybody else had of me was that I will be a rugby player. That I will be good at dancing, not education.' It seems to him that it's already set up, that this is who he should be. That's probably another thing that most of our people are facing out there, that the system, it's already saying to them, 'This is who you are. You're not going to achieve this or that.' ✨

Interpreting services for Pacific peoples

Communication is a particular challenge for families where English is a second language.

Right 5 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 states that every consumer has the right to effective communication. 'Where necessary and reasonably practicable, this includes the right to a competent interpreter.'¹²³ This language – with its lack of specificity on who determines 'competence' and how – has not been updated since the Regulations were passed into legislation. Commentators have recommended it be amended to 'the right to a professional interpreter'.¹²⁴

Despite hospitals clearly stating that all patients have a right to access interpretation and translation services, research with Pacific families has found that offers of an interpreter were rarely made, and never in urgent or emergency situations. The same study found that some Pacific families were asked to translate private health information for other families that they were uncomfortable being privy to.¹²²

The three metro Auckland DHBs provide interpreting services in Pacific languages through three separate providers.^{125, 126, 127} These services are, in general, free to those eligible for publicly funded health and disability services, and charged to the service provider.



At Waitematā DHB, Pacific languages made up less than 5% of all interpreting jobs in the financial year 2019/20, over half of which were for Samoan.¹²⁸ At Auckland DHB, 14% of the Auckland DHB interpreter service's 58,466 requests were for Pacific languages in 2020.¹²⁹ The two most requested languages at Auckland DHB were Mandarin and Cantonese, making up 46% of Auckland DHB's interpreter requests.¹³⁰ In Counties Manukau in 2020, 26% of all interpreting jobs (approximately 58,000 jobs per annum) were completed by Pacific language interpreters.¹³¹

Outside Auckland, not-for-profit organisation Interpreting New Zealand provides phone, video and on-site services to Capital & Coast and Nelson Marlborough DHBs among others, as well as PHOs, general practices and emergency departments. In the financial year 2019/20, of nearly 16,000 interpreter requests, 4% were for Pacific languages.¹³²

Healthline, the free national telehealth service funded by the Ministry of Health and provided by Homecare Medical, provided for 377 interpreter requests in 2020. Three percent were provided by Pacific interpreters.¹³³

Australian for-profit firm Ezispeak has recently been contracted to provide on-demand telephone interpreting services for government agencies out of their organisational budgets (including DHBs but not general practices). The service is free to patients and accessible 24 hours a day, 7 days a week, in over 180 languages.^{134, 135}

However, services via phone and video only are unlikely to offer the same interpreter twice for the same patient/doctor encounter. Of particular relevance to Pacific populations is that this may inhibit the building of trusting confidential relationships in which sensitive (and locally relevant) information can be disclosed. Furthermore, uptake by Pacific peoples may be inhibited by concerns about privacy and acceptability of telephone interpreting.¹³⁶

During the August 2020 COVID-19 outbreak in Auckland, public health unit contact tracing teams were supplemented with Pacific speakers under Pacific governance after contact tracing during the March lockdown 'was hampered... by a lack of Pacific language speakers who could undertake the work in a culturally appropriate fashion.'¹³⁷

Despite communication being a fundamental aspect of high-quality care, there is no independent central monitoring or quality assurance of interpreting services in New Zealand.

Ma'ukakala Ofa, *obstructive sleep apnoea nurse specialist, Auckland DHB*

Even when people are able to access care, there are issues with communication. Treatment is all delivered in English. Pacific people really need to understand the relationship between their illness and the treatment, and language is a real barrier to that. Providers will say that translating stuff is too expensive. But it's so important to have that face-to-face interaction because that's how Pacific people tend to take on information. Not over the phone, but face-to-face, through discussion and visual information.

If at a central facility there are high DNA rates, there should be a mobile clinic that runs through that area. Not only that, they need to communicate with the patient. It's no good if there's a reach-out service and no patients there. There needs to be better communication. How can they reach out to the patient to make the service available, not for the service's hours, but for the patient's availability? There should be nurse-led clinics for example, a mobile nurse-led clinic running in the community, to facilitate that resource, to run a nurse-led clinic or a satellite clinic, according to the patients' requirements. The system is thinking about DNAs like it's the patient's choice.

I work with a support group for Tongan people, who use CPAP [continuous positive airway pressure] machines for sleep apnoea. This group is run by patients. The good part of this is that they are sharing important information, and they go to church, and they talk there too. They learn

and I share with them, but I also learn from my patients how they accommodate little things to make things easier at home. The system can label a patient as non-compliant, but there is no way they are non-compliant. There is a barrier, or an obstruction. We need to dig into that, by knowing your community, knowing your people.

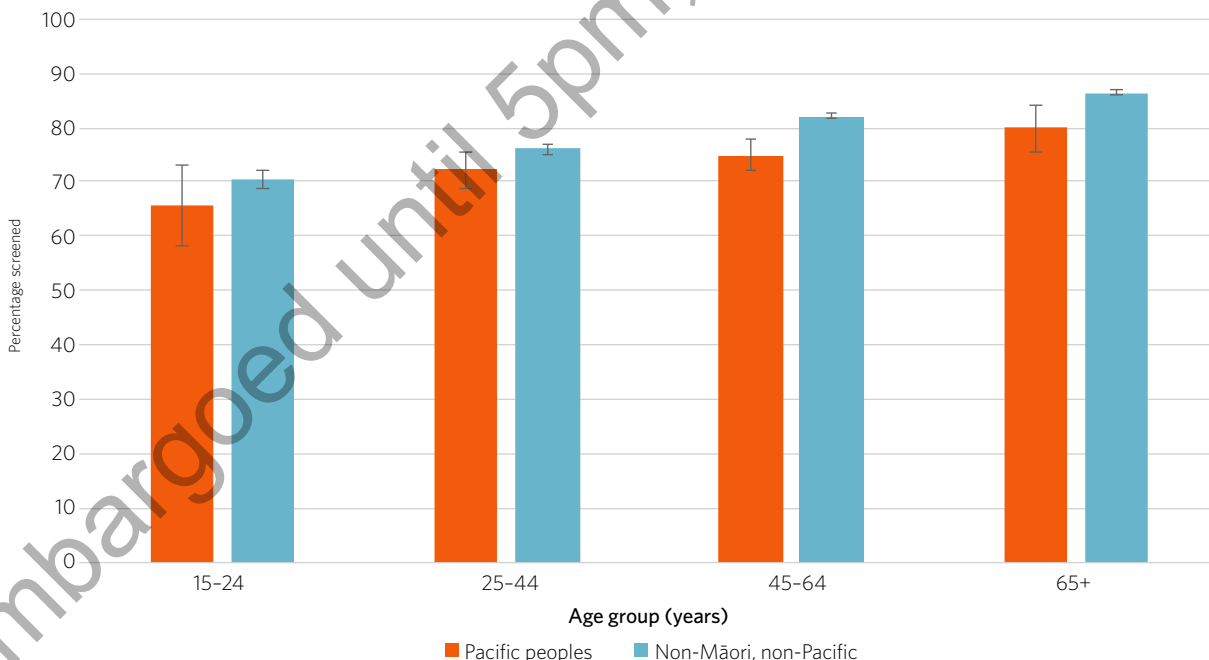
With the Pacific community you need to involve family in all follow-up. Family are the top value and we need to be aware of that. When I involve the whole family I learn who supports each other in what they do at home.

The son of one of my patients told me, 'Nurse, every night, I say, "Papa, you need to go to bed now at 10 o'clock, and I will help you put the mask on."' That's the good part of involving the family. The younger teenagers help the older people to understand what to do. I know I can't change the world, but slowly, a lot of people having the same mind, the same enthusiasm about working together – you can bring the mountain down. *

Patient involvement in care and decision-making

Patient experience survey data reveals Pacific adults and older people did not feel as involved in their care and treatment in primary care as much as other ethnicities. A statistically significant smaller percentage of Pacific adults and older people than that of non-Māori, non-Pacific answered 'Yes' to the question, 'Have you been involved in decisions about your care and treatment as much as you wanted to be?' (Figure 62).

Figure 62: Percentage of Pacific peoples and non-Māori, non-Pacific who answered 'Yes' to the question 'Have you been involved in decisions about your care and treatment as much as you wanted to be?', by age group, Aotearoa New Zealand, 2019



Source: Health Quality & Safety Commission. 2019. Patient experience survey.



Diana Phone, Pharmacist, clinical lead, professional practice fellow, vice president of the Pacific Pharmacists' Association

We all know there are medicines issues and health literacy issues that need to be addressed in the Pacific community. A lot of the focus so far has been on general practice, but somehow we need to get all allied health professionals, not just pharmacy, but midwives, physios and dieticians, working as partners, because ultimately it's the person, the Pacific patient, their whānau and the community at the centre of everything, and it's about empowering them. All health professionals are part of their journey, but they don't own it. It's the patient that owns the journey.

Part of health literacy is getting Pacific peoples to understand their medicines. What is the medicine for? Why are they taking it? What's going to happen if they don't take it regularly? What are some things they need to watch out for? And how can they deal with that? It's really important, given the multiple medicines that Pacific peoples with chronic conditions end up on. But also other things such as minor ailments – being aware that if they have a cough, or if they've got an eye infection or a urinary tract infection, and aren't able to access their GP, they can definitely go into a pharmacy. So, instead of having to just bear with it, they can come to a pharmacy for treatment.

Multimorbidity and polypharmacy go hand in hand. Recent data shows older Pacific peoples lead all ethnicities in the two highest categories of polypharmacy.¹³⁸ One of the key things is to get people to take charge of their own health and their own medicines – empowering them to ask questions about their medicines, about their health, so that they are informed and they can make informed choices for themselves. It's having rapport, taking the extra 10 minutes to just talk to people, build rapport so they can have that conversation with me. It's also about understanding what their issues are, getting to understand them on a personal level and then designing a plan for them. ✨

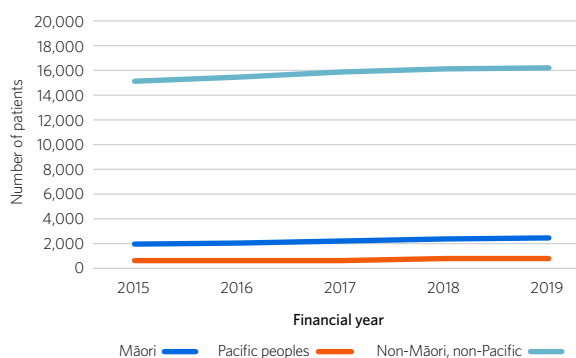
On the life course, end of life

The most common conditions leading to adults requiring palliative care at the end of life are also the leading causes of mortality and morbidity in Pacific peoples: cardiovascular diseases, cancer and chronic respiratory diseases.¹³⁹

Hospice care provides palliative care catering for psychosocial and spiritual as well as physical needs at the end of life. Most deaths in European populations in New Zealand occur after age 65 years, whereas 44% of deaths among Pacific populations occur among those under 65, at home or in secondary or tertiary care facilities.^{139, 140}

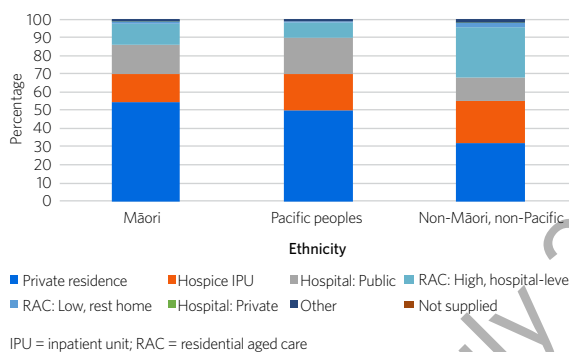
Hospice NZ data, representing all hospice service admissions in New Zealand, show use of hospice services is increasing for all ethnicities. Pacific peoples use hospice services at a lower rate per 100,000 people than all other ethnicities, and despite a very small year-on-year increase (640 in 2015 up to 846 in 2019) (Figure 63), the rate (221 per 100,000 people in 2019) remains essentially the same. Half of all Māori and Pacific patients admitted to a hospice service die at home, compared with a third of non-Māori/non-Pacific patients (Figure 64). It is unclear which of a number of factors lie behind this, including informal caregiver availability, financial and living situations, cultural and personal preferences, diagnosis, symptom management and acute events, among others.

Figure 63: Number of patients admitted to a hospice service, by ethnicity, Aotearoa New Zealand, 2015–19



Source: Hospice NZ.

Figure 64: Place of death of patients admitted to a hospice service, by ethnicity, Aotearoa New Zealand, 2019



It appears that palliative care services and hospice care are not well known among Pacific populations, and there are strong barriers to access to hospice services (including lack of proximity, language barriers, and negative perceptions and misconceptions related to cost, eligibility and the philosophy of care).^{139,140} The philosophy, goals and activities of hospice services were not familiar to many Pacific peoples; however, once accessed, the services provided good experiences for many. The Review of Adult Palliative Care Services in New Zealand found that effective communication and Pacific staff who speak Pacific languages are key for better experiences.¹⁴⁰

Across the life course: disability

Data on disability is poor but suggests Pacific peoples experience relatively high rates at lower ages than other ethnicities.

Up-to-date national data on disability and health service access, utilisation and experience of care is lacking. The most recent estimates of the prevalence of disability come from the 2013 Disability Survey, which reported that the age-adjusted disability rates for the four main ethnic groups were 32% for Māori, 26% for Pacific peoples, 24% for European and 17% for Asian.¹⁴¹ However, there are significant differences in the median age of disabled people by ethnic group, with Pacific peoples and Māori experiencing disability, on average, at younger ages than others: 39 years for Pacific peoples, 40 years for Māori, 45 years for Asian and 57 years for New Zealand Europeans.

Disability remains a relatively neglected area in terms of data, research and evaluation, and ethnic-specific data is very limited. In 2008, a paper on Pacific peoples' experience of disability (part of a series of papers for the Pacific Health and Disability Review) noted that Pacific peoples with disabilities were less likely to have received a needs assessment than non-Pacific with disability.¹⁴² The same paper cited some evidence suggesting Pacific peoples with disabilities often did not access recommended support services after needs assessments due to a lack of coordination between disability providers and health services, and the difficulties experienced navigating a complex disability support system.¹⁴²

In 2019, the Welfare Expert Advisory Group also made specific note of the fact that people with disabilities faced difficulties accessing health services, and received much less generous means-tested payments than those eligible for accident compensation.⁷⁴ The group also noted the significant cost associated with having a health condition or disability or being a carer of a person with a health condition or a disability, but that the system response had been inadequate. People with disabilities are expected to navigate the complexity of the health and welfare systems and it is often challenging to understand and obtain the supports they are entitled to.⁷⁴



Tunumafono Fa'amoetauloa Avaula Fa'amoe MNZM (Ava) is chair of the board of directors of Vaka Tautua and Vice Chair of Pacific Information Advocacy and Support Services (PIASS) Trust. He is the managing director for Dauntless Blue Limited.

Resourcing of the Pacific disability sector

The Pacific disability sector hasn't received the appropriate support under the banner of equity. We're still fighting over peanuts. The Pacific health sector gets crumbs and peanuts, but then it drops down further with Pacific

disability. You're getting less than crumbs. Sometimes you're getting the dust off those crumbs.

Disability in general is not a sexy topic. That's why not many pay any interest and that's why some of us who have been pushing that agenda for a while get tired of pushing it. And also, those that we've been pushing it to grow deaf ears because there are competing interests.

What should we be doing for Pacific peoples with disability?

Number one, you've got to work with disabled people, right from the beginning. You've got to value their experiences when you're designing services and look at how you can tell that services are working for them rather than just trying to meet funders' outcomes.

We've got it wrong in this country for a long time. We've always done it top-down. We need to have a bit more faith and engage in true partnerships. And that starts from the beginning. Some of our government departments and organisations would rather engage evaluators from the beginning, but don't see the same importance of the relationship with those you're trying to build the service for.

It's about recognising disabled people as equal citizens entitled to have aspirations and dreams like anybody else. Attitudes need to change. Working alongside disabled people, working alongside Pacific peoples to design services, but much more than that: monitoring services to make sure that they are achieving for those groups as they say they are. People with disabilities should have a role in auditing all providers from a lived experience perspective.

It's about re-addressing the power relationship. At the moment, providers are only accountable to funders. But what about the accountability to those you're supposed to be delivering your services to? This is one of the reasons why Tōfa Mamao wrote a petition to the government to create a Ministry for Disabled People by combining the office of disability issues with the disability support services directorate. Tōfa Mamao is an independent grass roots organisation, made up of Pacific disabled people, their families and carers, that advances the voices of Pacific disabled people. The overarching principle of our petition is that the future workforce of a Ministry for Disabled People be drawn from our diverse population.

That's the way that you can have an overarching monitoring role, not just a service delivery role - to make sure that taxpayer money going to these services to support disabled people is going where it should and that it's working. ✨

Chapter 3: The Pacific health workforce | Upoko 3: Te ohu mahi hauora Pasifika

Pacific peoples are significantly under-represented across the entire health workforce while representativeness is widely understood as crucial to effective engagement with the population and to address inequities in health outcomes.^{143,144} Positive initiatives exist but lack a coordinated and systematic overall approach.

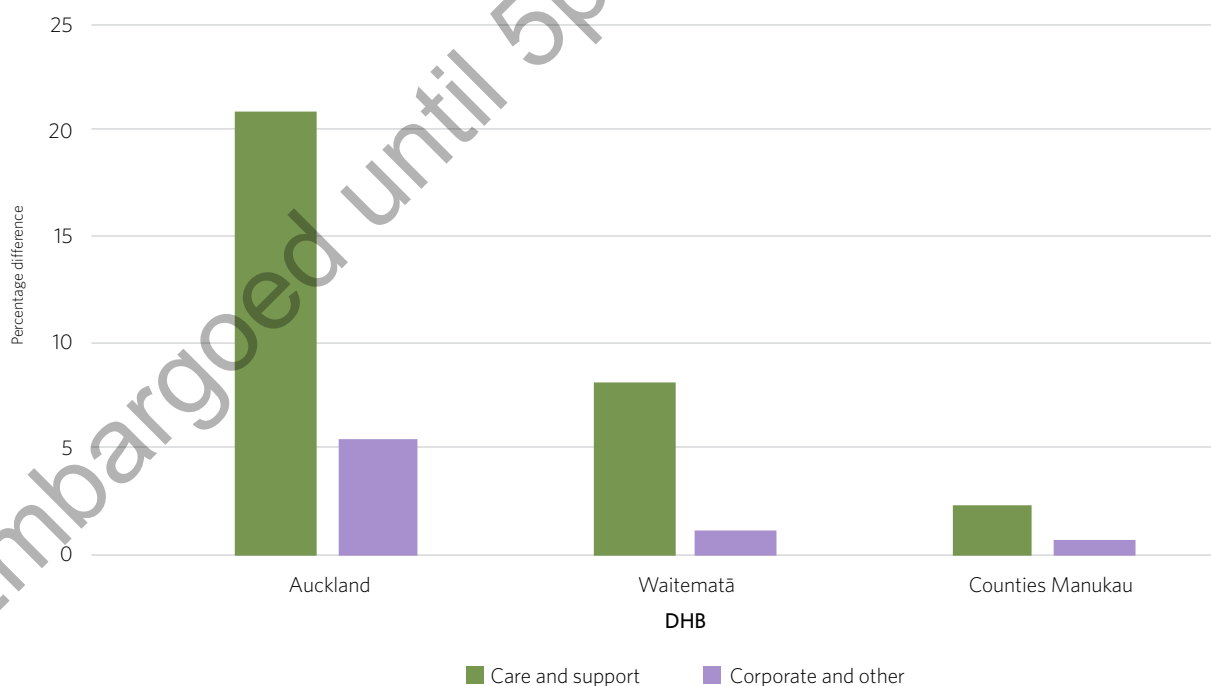
A lack of representation

A stocktake of the Pacific health workforce in 2011 showed that Pacific peoples are significantly under-represented in the health workforce, comprising approximately 2.3% of the registered or health professional workforce.¹⁴³ The report highlighted the limited national data that was available about the Pacific workforce.

More recent analyses of the Pacific workforce employed in the metro Auckland DHBs show that these trends persist. Pacific peoples are under-represented in terms of the resident DHB population in every workforce category, including allied and scientific, midwifery, nursing, resident medical officers and senior medical officers.

The only categories where the Pacific workforce matches or over-represents the population are care and support roles (including hospital orderlies, cleaners and health care assistants), and corporate and other (including administrative support staff) (Figure 65). Within care and support roles, nursing support, community workers and hospital orderlies were the only roles that appear to over-represent the Pacific population by more than 10 percentage points in the three metro Auckland DHBs as a whole.

Figure 65: Difference between DHB-employed Pacific workforce and DHB resident Pacific population by occupation group, metro Auckland DHBs, Aotearoa New Zealand, as at 30 September 2020



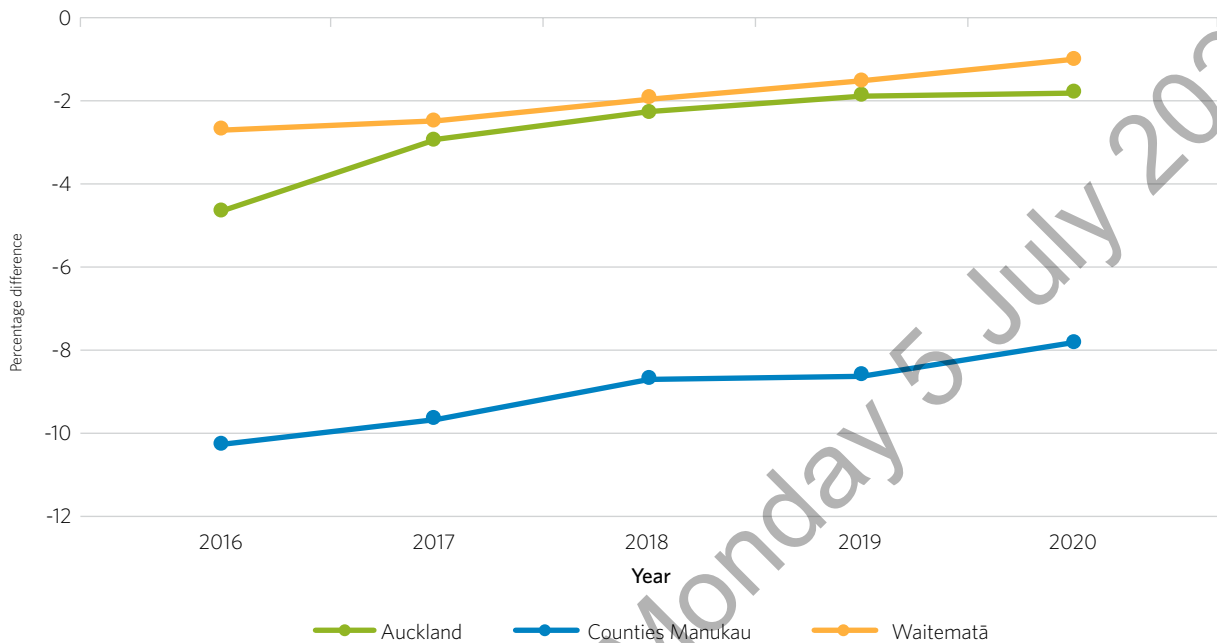
DHB = district health board.

Source: Workforce data from Central Region's Technical Advisory Services Limited report Health Workforce Information Programme (HWIP): <https://tas.health.nz/employment-and-capability-building/workforce-information-and-projects/health-workforce-information-programme-hwip>. 2020. All rights reserved.



There is a general trend toward greater Pacific workforce representation in all three metro Auckland DHBs over the last five years, but none have reached parity with DHB Pacific populations (denoted by 0% difference at the top of the graph in Figure 66).

Figure 66: Five-year trend in metro Auckland DHBs' difference between employed Pacific workforce and resident Pacific population, Aotearoa New Zealand, 2016–20



DHB = district health board.

Source: Workforce data from Central Region's Technical Advisory Services Limited report Health Workforce Information Programme (HWIP): <https://tas.health.nz/employment-and-capability-building/workforce-information-and-projects/health-workforce-information-programme-hwip> 2020. All rights reserved.

In 2019, 17 students identifying as Pacific graduated from Auckland medical school with an MBChB degree in 2019 (7% of all graduates). This percentage of graduates identifying as Pacific has remained consistent since 2015.¹⁴⁵

Five percent of graduates from Otago Medical School identified as Pacific in 2019 (3% in 2015).¹⁴⁶

Increasing the Pacific health workforce will be a fundamental component of any plan to address Pacific health equity, a perspective echoed by the Health and Disability System Review's findings.⁶ All of the experts interviewed, who work in diverse areas of health, brought up, unprompted, the constraints that result from having a limited Pacific workforce.

A limited Pacific workforce

We don't have enough Pacific workforce to help support the work that needs to be done. Also there's a lack of cultural competency and lack of cultural awareness. If we want to improve Pacific health outcomes, there really needs to be an influx of Pacific workforce and understanding of Pacific culture into all departments, because I feel that people come to us for cultural questions when we need everyone to be surrounded with more Pacific culture.

Doana Fatuleai, general manager Pacific Health

We need more of our workforce. We need more of us in those positions that can make changes and decisions that will impact on the health of our Pacific community and improve it.

Dr Maryann Heather, GP

There isn't much awareness of the needs of Pacific peoples within services. We had a speaker come to talk to the DHB about institutional racism and unconscious bias. He was really awesome, and I think actually got through to a lot of our colleagues because they spoke about it for days after that. It's a start, and it's made them think about stuff, and that they've kind of improved culturally. If we had a Pacific version, that would be awesome.

Therese Stowers, midwife

This need for increased Pacific representation spans almost every area of the workforce.

A lack of nurses, midwives and doctors

Over 20 years ago we had four Pacific psychiatrists, and we now have 14. In 20 years, they've managed to increase it by 10 psychiatrists, three of whom have registered in the last 18 months. That is a shameful indictment on mental health, and even with the mental health review and the new mental health strategy, none of that has changed and there are no resources going into that area even though we are a high-need, high-priority population. The other indictment is a lack of Pacific public health specialists, which was absolutely critical for the second COVID-19 response – yet we have fewer than 10 Pacific public health specialists. This is a serious matter.

Debbie Sorensen, chief executive

Pacific peoples make up about 8% of the population, but we're only 2% of the GP workforce. There's a huge gap. And there is fatigue and burnout, mental health issues. A lot of us are getting tired, taking a break and quitting, some people walking away from medicine. This has been a tough year, but even more so for general practice. Some clinics have had to close because of COVID-19. The pressure is increasing, and demands are increasing. It's just not balanced at the moment in terms of equity and providing good health care – we want to do that but not at the expense of our health.

Dr Maryann Heather, GP

The major challenge for our workforce, nurses and young doctors is the nature of working with people with long-term conditions and seeing no light at the end of the tunnel. The medical management of people with long-term conditions is probably the easiest part. But the young GPs are trying to manage their social issues, their benefits, their transport issues. Having people who can offer that support service is crucial. If you don't have that support, then everything you do just falls apart, disintegrates in front of the family.

Dr Siro Fuata'i, GP, Baderdrive Doctors

There's a major shortage of midwives. Study is part of it, because it's hard, especially when we all have family and financial commitments. Not only is the health system not set up for Pacific pregnant women, but the learning environment is not set up to encourage Pacific peoples to get through midwifery study. So it's another system failure for us. It can be an environment that's cold, sterile for Pacific learners. It's quite a hard field. The failure rate for Pacific students was really high. There's an improvement now, but it's taken a long time. They've got so many more women applying in Auckland for midwifery but they are not getting through and graduating. They need support, because we learn differently as well. The midwifery environment is not supportive of Pacific midwives. We need to have the right people in those spaces that know Pacific peoples. You need to actually connect us with those students, so we can do the work and work with them. That hasn't happened.

Therese Stowers, Fa'afana Temesese, midwives



More Pacific peoples are needed in allied health

We need more Pacific in every area, not just GPs, but nurses, physios, OTs [occupational therapists], we need social workers, we need pharmacists, we need specialists, we need people in the Ministry and DHB. We need people there every step of the way that will have the heart and the compassion to work for our people and to make a change. The numbers are improving, but there's still a long way from where we are in general practice, because we know that many of our GPs are going to be retiring in the next 5-10 years, and there's going to be a shortfall.

Dr Maryann Heather, GP

Out of the approximately 100,000 pharmacists in New Zealand, only 30 or 40 are Pacific with knowledge about Pacific peoples and their culture and values. How do we get the rest of the pharmacy population to understand how Pacific peoples work, to understand their culture and values so they're able to approach those patients and deal with them accordingly? If we really want an effective, efficient workforce, it needs to represent the population it serves. And that's an objective of the Pacific Pharmacists' Association, to get our younger ones to think about pharmacy as a career. You don't have to be a pharmacist. You can also be a technician or a pharmacy assistant. Being able to walk in a pharmacy and see a Pacific face and have that instant rapport - that's why we need more in the profession.

Diana Phone, pharmacist

In my last 16 years working with community dental service, there's only been a few oral health workers, from dentists to oral therapists, graduating. I have been to quite a few sessions with high schools and advertising a career in dentistry, but quite a lot of our people are not studying science subjects in high school. It's not an easy thing to get them interested in dentistry, and I have spoken with quite a lot of professors in the dental schools talking about how we can increase our intake with specific students to take up dentistry, because we need a Pacific workforce that could work with our people.

Dr Tule Fanakava Misa, public health dentist

More Pacific peoples in non-clinical roles

The type of care that we aspire to is involving other professionals than the doctor. The doctor should be at the lower end of this management continuum. We need to involve people with social service skills to make sure that people have good housing, some input on their benefit if they need it, helping kids with education, transport access (which is a major problem, particularly for many elderly), employment, social support and linking with other people. Then many of these issues can be addressed earlier on.

Dr Siro Fuata'i, GP

I think we don't do well in growing our workforce into leadership. But also growing our workforce into other non-clinical roles to support the work, like data analysts. It's great having nurses and doctors, but we also need analysts. Data is really integral, and I don't think we have done well to help emphasise those kind of roles for our Pacific peoples.

Doana Fatuleai, general manager Pacific health, Counties Manukau DHB

Positive workforce initiatives

There are good examples of positive workforce initiatives in the sector (see boxes below); however, a widespread systematic approach is needed. This approach would build on successes and address significant gaps in current strategies across the entire workforce pipeline, from secondary school, through tertiary and other training, right through to recognition of prior learning. This approach also needs to focus on upskilling, leadership training and creating opportunities for the Pacific health workforce to be involved in decision-making and governance.

Upskilling the unregulated workforce

Workplace literacy, support, training and accreditation are major opportunities for providers.



**Hamish Crooks, chief executive,
Pacific Homecare**

Pacific Homecare is a charitable trust organisation providing home-based health care services throughout South Auckland to the disabled and the elderly. We have about 225 staff, about 190 support workers who look after elderly out in their own homes, about 650 homes a day, about 85% Pacific.

Our workforce reflects our population. One of our strategic goals is empowering and supporting our staff. At the end of the day, mama still needs to have a qualified person who has the capabilities to respond to her specific health needs. So, our journey over the last 10 years has been a very heavy investment in terms of training and development, and qualifications.

Support workers play such an important role, especially going out into the community and seeing people day to day. Credentialing helps them to get that respect. We use the national curriculum, the assessments levels 1-6, and we try to move them at least two levels up from where they start.

Because English is a second language for most, there are lots of learning barriers, so one of the underrated kinds of support we added right at the very outset was workplace literacy. Health and safety, for example: for a speaker of English as a second language, what's a 'hazard'? What's an 'incident'? My workforce always carries around notebooks to write words that they don't understand. That helps them participate and knock their qualifications over, with good support around the office from co-workers. Even if they struggle with English, they can break out in Samoan for a moment and then come back with the English - they've then got the words. That's what contributes to the high rate of qualifications that we get.

You've got to create a culture for people to participate and feel accepted, and a lot of that is how we communicate with one another. If there are barriers to learning and developing, it's no different to how they communicate with the customer out in the field, as communication's really important to them.

Over the next 30 years, I hope we can continue to pursue making a difference as a Pacific for Pacific-run organisation that is a well-oiled machine, adds a lot of difference that I think even mainstream can learn from, both in the cultural differences, but also in the models of care. We start with the customer at the centre, then find out what it is that they need. ✨



Pacific nursing support and development

Support and development of Pacific nursing is crucial to increase numbers of Pacific graduates.



Dr Debbie Ryan, principal, *Pacific Perspectives*

The Aniva Nursing Leadership Programme

The Aniva Nursing Leadership programme is a Pacific workforce initiative commissioned by the Ministry of Health 10 years ago. The programme supports senior Pacific nurses and midwives to achieve postgraduate qualifications with a focus on responding to the challenges facing health care in order to better serve Pacific patients and their families. The design and

delivery of the programme has involved collaborative partnerships between Pacific Perspectives and nursing leaders Fuimaono Karl Pulotu-Endemann, Dr Margaret Southwick and Dr Adi Alisi Vudiniabola. The qualifications are delivered through Whitireia Polytechnic.

The Aniva programme has made a significant contribution to developing New Zealand's Pacific nursing workforce, with over 250 enrolments as part of the Master's pathway since 2012. Analysis of Ministry of Education data shows that in 2019, Aniva learners made up around one in six (15%) of all Pacific health-related postgraduate and Master's enrolments, and two in five (39%) of Master's degree programme completions in New Zealand's tertiary education system. Aniva learners complete their programmes more than two times faster than other Pacific learners (with a cohort-based completion rate of 80% compared with 29%). The number of Pacific nurses with the qualifications, skills and knowledge for leadership in the health sector is growing on the back of these excellent results.

A strength of the Aniva programme has been the support provided by alumni as teachers and mentors. Aniva graduates formalised their network with the establishment of the Pan Pacific Nurses Association (PPNA) in 2015. The PPNA has grown, supporting a national and international network of Pacific nurses and contributing to advocacy for Pacific health and contributing submissions to major national health and social sector policy developments. ✨

To'a Fereti, clinical nurse director, Division of Medicine, Counties Manukau DHB; chair of the New Zealand Nursing Council; president of the Pan Pacific Nurses Association (PPNA)

In the Division of Medicine at CMH [Counties Manukau Health] there are around 720–750 nurses that report to me professionally, and I lead and advise on professionalism, quality and safety for our patients. I work in a triad partnership model with our clinical director and also the general manager for the Division of Medicine. Our division covers all the chronic diseases, and we have a high number of Māori and particularly Pacific peoples utilising our services.

My passion lies in increasing our Pacific nursing workforce and helping develop career pathways for our up-and-coming Pacific nurses. I'm also involved in mentoring our Pacific undergraduate, new graduate and postgraduate nurses.

Because my role sits within the mainstream, I'm well positioned because I have my feet in both doors to influence our non-Pacific staff, but also to add that cultural lens. But also to help staff understand that health literacy is also about the health literacy of health care professionals who don't really understand our Pacific communities and why they would put their health last and their family first.

I have always pushed all the nurses to continue with postgraduate studies, particularly through the Aniva Nursing Leadership Programme, because we need those qualifications to formalise what we know in terms of our Pacific skills and experience. Without the qualifications and the credentials behind us, we're not going to have a lot of legitimacy within the Westernised model.

It's always been my passion to bring everybody with me on this leadership journey, because I'd like to see more Pacific at my level and above. So I've done a lot of mentoring, outside of work, at home, outside of hours at the expense of spending time with my children. But I think we're seeing the fruit of it: more Pacific nurses with master's degrees, and of course they're paying it forward and are now mentoring.

Having Pacific nurses as part of our workforce and senior roles does help influence better health outcomes, because if you've got them there, then they're the ones that lead by example in terms of cultural competencies, how it's supposed to be for our Pacific patients. But I also look at quality. What does quality health care look like for Pacific when they come in?

It's important to get our Pacific models of care embedded in practice so we can have not only a good understanding of the disease, but understanding of patients' beliefs and values so we can provide better care. Through the PPNA we have support networks such as monthly talanoa sessions to reconnect, and keep each other encouraged throughout the whole year. It brings us a lot closer and a lot tighter together to work towards our common goal of supporting our Pacific communities. ✨

Supporting Pacific GPs

Dr Api Talemaitoga, *chair of the Pacific General Practitioners Network (PGPN)*

The PGPN was formed in 2015 as an informal networking group with the objectives of increased visibility of PGPN representatives at health forums and raised awareness of the PGPN and the work of Pacific GPs. The PGPN supports Pacific GPs in gaining experience and leadership, governance and other training.

The PGPN meets at least three times a year to discuss issues of practice ownership, topical health issues affecting Pacific communities, and provision of collegial support for members that may be struggling with employment and/or training issues. It also provides submissions to government agencies on issues concerning Pacific health and the health of Pacific communities, and supports those involved in research.

The PGPN supported the Pacific Ministry of Health COVID-19 response team in providing first-hand intelligence from what was happening 'on the ground', assisting the messaging with a Pacific and primary care lens (including translation of materials) and also implementing Ministry messages and strategies in a culturally competent way at local practices.

PGPN plans for 2021 also include media training for members and a joint session with Te Ora (Māori GP Faculty) on institutional racism. ✨



Conclusion

Data strongly supports the lack of a representative workforce for Pacific peoples, particularly where the majority of Pacific peoples live. Unanimous support exists for developing and supporting a Pacific health workforce across all roles, and while promising initiatives exist, a unified and widespread approach remains absent. Facilitating and supporting such a unified and comprehensive approach to the building of a representative workforce is a crucial responsibility of government, and indeed a representative workforce within government is a key prerequisite.

Embargoed until 5pm, Monday 5 July 2021

Chapter 4: 2020: The year of COVID-19 | Upoko 4: 2020: Te tau COVID-19

The COVID-19 pandemic has significantly impacted economies and health systems. Aotearoa New Zealand's 'go hard, go early' elimination strategy and response included a focus on equity. It is important that the learnings from this initial response are understood and retained because the pandemic is far from over, and keeping the virus from spreading throughout the country and protecting those who are most at risk of poor outcomes remains a top priority.

An analysis of New Zealand's first wave of COVID-19 showed that although Pacific peoples had a lower risk of contracting the virus compared with NZ Europeans, they were twice as likely to experience a severe outcome (hospitalisation).¹⁴⁸ Pacific peoples during the first wave were also significantly more likely than other groups to have a locally acquired infection (rather than imported or import-related, as had been the case for those of European descent).⁹⁶ This finding, together with a plethora of data from previous infectious disease outbreaks (such as H1N1 in 2009, mumps in 2017 and measles in 2019) suggests that once COVID-19 is circulating in the community, Pacific communities are at very high risk of contracting the virus and subsequently experiencing adverse effects.^{81, 149, 150, 151}

This was borne out in New Zealand's second COVID-19 outbreak and lockdown in August to September 2020, which occurred while borders were closed to prevent import of disease. During this wave, Pacific peoples made up the vast majority (105 of a total 178 (59%)) of confirmed cases (Māori: 22%, European/other: 19%); with incidence rates of 48 per 100,000 for Pacific peoples, 21 per 100,000 for Māori and 3 per 100,000 for European and other New Zealanders.¹⁵² The outbreak was brought under control after a few weeks of intensive case management and contact tracing, although not before further hospitalisations and deaths from the virus. Approximately 10% of Pacific cases were hospitalised during the second outbreak, compared with 4% of New Zealand European cases.

In the United States, Pacific communities have been among the most affected by the pandemic, with reports of Pacific peoples having 9-10 times the hospitalisation rate for COVID-19 as other groups,¹⁵³ but worryingly, COVID-19 rates are not regularly monitored for Pacific peoples as an ethnic group in the United States.¹⁵⁴ These stark inequities demonstrate what could have happened in New Zealand if the virus had not been brought under control.

The COVID-19 response for Pacific communities in New Zealand has highlighted the positive results of systematic and robust leadership, resourcing and inter-agency collaboration around a specific issue. It has also highlighted the strengths, resiliencies and innovations within Pacific communities, providers and organisations.

COVID-19 also highlighted the different status of the small but growing Pacific communities in regions outside of the metro Auckland DHBs, and the different effects of measures to control the virus on those communities. As we show in Chapter 1, growth and projected growth of these Pacific populations outside of Auckland are both large. For these populations inequities can be compounded or different in nature. There are unique challenges - for example, isolation, being a minority is made stark or invisible, larger distances to travel for services, lack of familial or community cultural support, and lack of Pacific health providers in their area. Many of these smaller communities of Pacific peoples, such as those in Wairarapa and Whanganui, felt invisible or 'forgotten' in the COVID-19 response and relied on mainstream or Whānau Ora services as stretched Pacific providers dealt with the needs of larger communities. In this way, COVID-19 exposed inequities of a system that is systematically limited in its geographical reach despite clear need.



Leadership of the Pacific COVID-19 Response Team

The Ministry of Health commissioned the Pacific COVID-19 Response Team on 17 March 2020. Multidisciplinary expertise involving technical, clinical, cultural and community leadership and networks were engaged to ensure that at every level of the national response, both known and emerging needs of Pacific communities could be addressed through tailored and evidence-informed strategies and operations.

An integrated approach ensured that critical knowledge, information and key messages could travel immediately in two directions – ‘top-down’ to facilitate the national response and via a ‘bottom-up’ feedback loop that recognised the diverse perspectives of Pacific communities and specific needs for staying safe and well. In an environment that was subject to daily change and where urgent action was needed, the approach was designed to evolve and adapt as the COVID-19 pandemic response progressed.

Five high-level strategies guided the work:

1. **An equity analysis was applied** to the Ministry’s planning and operational activity. This involved experienced programme managers and analysts who were knowledgeable of health systems, policy and communicable diseases management structures and Pacific health.
2. **Capacity of the Pacific health and disability sector was secured** to meet increased demand. Senior Pacific clinicians led engagement with Pacific communities, and Pacific health workforce and provider networks so that real-time information was available to decision-makers. This enabled rapid mobilising of resources and support to informed community providers at the front line (for example, funding for surge capacity, access to personal protective equipment (PPE), and facilitation of linkages to social welfare support services).
3. **Information guidance and support was targeted** to Pacific communities and the Pacific health sector. Pacific communications experts and clinicians supported the tailoring and appropriate translations of national messaging and communications for diverse Pacific communities. Pacific networks enabled the recruitment of language and cultural leadership to respond to media and community requests to ensure consistency of messages that were modified in response to changing alert levels and the emerging response.
4. **Strong links were made to the all-of-government response** to ensure key Pacific health outcomes were embedded in the work of other relevant agencies (eg, the Ministry of Social Development, Ministry for Pacific Peoples, Treasury).
5. **High-quality research and analysis** was made available to guide policy, planning and funding decisions in health as well as other agencies. Epidemiologists and data analysts with knowledge of Pacific health identified, sourced and presented research and analysis that was shared through daily stand-up meetings with diverse Pacific stakeholders from across government and all levels of the health sector.

The Pacific COVID-19 Response Team understood the resources in Pacific communities that could be supported and mobilised, including churches.

We already seemed to be on the right path with preparing our church and congregation for online



Reverend Victor Pouesi, minister of the Congregational Christian Church of Samoa, Māngere East

connections as the Lord guided us. Not knowing that COVID-19 was just around the corner we started our project building a new church in 2017. This gave us the opportunity to upgrade everything, especially the equipment that enabled us to have live streaming and to have much faster connectivity with our people. So for the past three years we have delivered some of our church

activities, like the 13 days of Christmas, a celebration of Christmas, online. This has helped us capture a lot of people’s attention and helped promote the gospel to the wider community. So when COVID-19 happened, our people were already accustomed to tuning in to our live streaming.



Addressing social issues was a key priority.



Debbie Sorensen, chief executive officer, Pasifika Medical Association and Pasifika Futures – the Whānau Ora commissioning agency for Pacific families

Pasifika Futures had 30% of the Pacific population engaged prior to COVID. With COVID, we picked up additional families. And so our overall response was 200,000 Pacific peoples, which is about 60% of our community.

In the families with positive COVID-19 cases or close contacts, 80% of those people had had no engagement with social service support, including Whānau Ora. This was a significant number of Pacific peoples who had previously had no contact with welfare support. So we were looking at a new cohort of Pacific peoples seeking support, who were unfamiliar with the welfare system, unfamiliar in asking for help, and some of whom who had been what we would describe, I think, as the 'hidden poor'. The COVID-19 response really highlighted the starkness of poverty and disparity in our communities.

One of our advantages is that we are nimble and flexible and able to move funding and resource very quickly directly to families where it's required, and we have long-standing and close relationships with partners. And so I think it's exactly the work that commissioning agencies should be doing and we were pleased to be able to do it. ✨

Innovation among providers flourished, with evidence of holistic and integrated models of care being adequately resourced during this time. Pacific primary care providers worked collaboratively with DHB and public health unit support to tailor contact tracing and testing services for Pacific communities.



Tevita Funaki, chief executive, The Fono

Our pandemic planning started early. We had a pandemic plan, we thought early on about the things that we would need to put in place. So we didn't have any issues with shortages. Two weeks before the first lockdown, we stocked up on PPE for all our services.

Two to three weeks before we hit the pandemic, the demand at our Feleoko Food Hub went up. So we predicted that food security would be an issue. Part of the food security challenge was how we would deliver food and services to meet the needs of our families. We delivered 7,000 food packages during the first lockdown.



We distributed masks in the community – this was instigated by the church community, when there was an early indication that there might be compulsory masking in public transport and so forth. So immediately we connected with the Ministry of Health, the Ministry of Social Development, the Ministry for Pacific Peoples and Pasifika Futures (Pacific Whānau Ora commissioning agency) and said, 'We need to get a supply of masks, similar to food.' We were able to find funds. We got access to just over 250,000 masks, which we distributed, with sanitiser, within a couple of days to over 150 churches and community groups.

We helped with case finding for Pacific for cases and contacts that the system could not trace in the first wave. During the second wave, we said to the Ministry, 'We're not just going to do case finding, we're going to streamline the whole thing.' And part of this streamlining was to identify and find people, give them advice about testing and support and then update their details and connect them to the system. And then we'd do a welfare check. So rather than just saying, 'We're here to find you, you need to contact this line otherwise the police will contact you,' which was scaremongering, we delivered something comprehensive. *

Communication (about COVID-19 and the government's response, including alert levels and the lockdown) was a key component of the response. It was recognised early on that Pacific peoples were less likely to tune in to daily television broadcasts and/or access official websites, and there was concern about misinformation on social media.

Reverend Victor Pouesi, *minister of the Congregational Christian Church of Samoa, Māngere East*

One of the setbacks was so many different mediums of information that really misled so many people, not only from social media, but sometimes the government agencies. They have a different interpretation of the same message and that was sometimes confusing. Maybe that's another area that needed to be improved as well, to make sure that all the government agents have the same message, and how they can relay that to the people.

Our people look up to our leaders, the government and the church, and all those people of influence, because they are the ones that will say something, and then our people will follow. So I think that is something that we need to do well. Like I said, God has set up our community for something like this.

Church people and parishioners want to hear the message from the minister, from their own minister. That's a way of being authentic in the eyes of our people. If the ministers don't say it, then it's not true. It's almost like that.

I encouraged our community to stop looking at social media because that's a different stream of information and could lead to a lot of confusion. I would rather have only one stream of information by experts such as Dr Bloomfield. So our task was to make sure that the right information gets to the people as soon as possible so they are not confused.

That will eliminate any fear or any kind of misunderstanding, because not really knowing what to do creates much more fear than COVID-19 itself. When they settle down and know okay, this is step one, step two, step three, it puts our people at peace: knowing what to do because of the information given to them. So that's exactly what we did. *

Multiple communication channels to address health literacy and linguistic and cultural needs of diverse communities included television, radio, online communications, and working with church ministers to

disseminate key messages.^{156, 157} Innovative communication approaches led by the Ministry for Pacific Peoples included engaging a range of prominent Pacific peoples, including Dame Valerie Adams DNZM, Dave Letele (the 'Brown Buttbean'), Diamond Langi, Faumuina To'aletai, David Tua ONZM, Patrick Tuipulotu and Lesina Nakhid-Schuster.¹⁵⁸

The COVID-19 government website included translations into nine Pacific languages. These were developed alongside videos and daily radio broadcasts on Pacific radio led by Pacific language experts and clinicians engaged to interpret and communicate messages using concepts appropriate for different Pacific ethnic groups.

Debbie Sorensen, *chief executive officer, Pasifika Futures and Pasifika Medical Association*

I think the collective response led by the Ministry, the Pacific response, was fantastic. In particular, I think the communications work was outstanding. Once people understood that English was not the only language that is spoken in New Zealand, it became very helpful. ✨

The flexibility to respond to community concerns contributed to building trust. Local knowledge of community and under-served communities characterised as 'hard to reach' meant access and provision were appropriate.

Reverend Victor Pouesi, *minister of the Congregational Christian Church of Samoa, Māngere East*

I noticed that there were not enough testing stations [in South Auckland] at the time, so I was on my phone and asked one of the Pacific health providers and he managed to coordinate and set up our own station at the church very fast. In just a small time he managed to do that for us.

That was so convenient for our older people, because we had been lining up for almost seven hours before we got to the station where we were tested. That really brought a sense of comfort for our people to know that the providers were coming here to the place that our people were used to coming to – now they also have this station here. Thank God for that. But we also thank the Pacific providers as well. They are the hands-on people. They come down to our level, our people, and they really help out in so many ways. ✨

Tevita Funaki, *chief executive, The Fono*

We did the community pop-up stations and the CBACs [community-based assessment centres]. We had to ensure we had enough staff and had an understanding of the best locations to maximise access, and then facilitate this with the DHBs.

We also set up mobile testing clinics. The team went into people's homes and we also did opportunistic testing, and we actually identified a number of positive cases through this. We were able to do this because there was familiarity with families – we'd turn up to the front house and the house at the back happens to be a Samoan family and they're like, 'What are you guys doing, it looks like COVID testing... you might as well test us because we've got symptoms,' and they'd turn out to be a positive case. ✨



In terms of our mobile testing, the DHB said to us, 'You're only going to do swabbing,' but we said, 'No, if we're going to deliver mobile testing, it's going to be a comprehensive clinic. So when we go into homes, we'll do the swabbing, but some of them will need other support, including medical support. We will do a quick welfare check, and we'll connect people with appropriate supports.' Subsequently, this comprehensive mobile clinic service is now the adopted model. ✨

Primary care providers maintained a focus on managing long-term conditions.

Tevita Funaki, chief executive, The Fono

There were also concerns around non-COVID medical issues. We took learnings from other disaster relief operations overseas – for example, when we did measles support in Samoa, we had seen an increase in people not taking medication for diabetes, cardiovascular disease and hypertension.

So, when I asked our clinical governance and clinical leadership teams what's the one thing we need to do, the answer was, 'We need to get our patients with chronic illnesses to keep taking their medicines.'

So we connected with all our pharmacies, identifying individuals with chronic illnesses. And then we said, we'll pick up the medication and deliver it to households. We also put a little hygiene pack when we went into homes.

For some of our elderly who ended up being stuck by themselves, there were issues around social isolation and mental health. So while we delivered medication and hygiene packages, we also dealt with some of their social isolation and connected them with food hubs, and did welfare checks and, where necessary, fast-tracked support from MSD [Ministry of Social Development].

These have been just some of our initiatives during the COVID-19 response. It's been a real journey and I commend my team. ✨

There is emerging evidence that suggests the Pacific response was effective. For example, data during the first wave of COVID-19 showed that, although Pacific peoples had low case numbers, once alert levels escalated, they consistently had the highest rates of testing for COVID-19 – suggesting some success with communication and engagement.¹⁴⁸

The Ministry of Health has commissioned an external evaluation of the Pacific COVID-19 response that will provide more detailed information about some of these activities. This will provide robust evidence about what worked well for Pacific peoples, and what could have been done better. The lessons from the response could be applied to address Pacific health equity more generally, particularly in terms of cross-sectoral and inter-agency collaboration, flexible and rapid deployment of funding and resources, recognition of the need for Pacific leadership and a responsive Pacific workforce, support for Pacific providers that have established relationships with Pacific families and communities, effective and multilevel communication strategies, and holistic models of care (integrating approaches that address health, social and education needs) specifically tailored for individual families and households.

Chapter 5: A transformative approach | Upoko 5: He ara whakahou

While Pacific peoples often face challenging socioeconomic circumstances, the many strengths and resiliencies of the diverse Pacific communities and Pacific health workforce are clear, highlighted particularly during the response to COVID-19.

There are many passionate and dedicated people, groups and organisations working for the betterment of Pacific health in Aotearoa New Zealand. However, interviews reveal these people and organisations often feel they are working against a system that does not acknowledge Pacific values, the challenges and strengths in Pacific communities, nor the context in which Pacific peoples in New Zealand live. The challenge is to change our system, so the experience, expertise and worldviews of Pacific peoples are embraced and learned from, alongside dominant Western worldviews.

Chapters 1 and 2 of this report demonstrate that socioeconomic inequities for Pacific peoples present a major challenge to good health; that the system is fragmented, siloed and urgently needs to be 'joined up'; that current models of care are not working, often hard to access, and urgently need to be revisited; and that there are critical shortages in the Pacific health workforce that urgently need to be addressed.

In addition, the COVID-19 pandemic, like previous outbreaks, demonstrated how susceptible Pacific communities are to the devastating effects of infectious diseases, and the important contribution of the social determinants of health – in particular, housing and employment – to the risks of infection, transmission and adverse health and economic outcomes. COVID-19 brought to light the need for tailored approaches for Pacific peoples, families and communities that are integrated, addressing social and health needs in a holistic way. COVID-19 also emphasised the importance of clear and effective communication, including the need to translate information into the different Pacific languages, and of using multiple forms of media as well as respected people within the community as conduits to disseminate key messages. We saw how a Pacific-specific response to a major health threat, harnessing the combined expertise and wisdom of a small but dedicated sector, can make a difference, and how Pacific providers, authentically engaging and partnering with Pacific communities, can lead the way with innovative models of care for both COVID- and non-COVID-related issues.

Addressing improvement in Pacific health is challenging, but there is a way forward. This way forward involves strong and supported Pacific leadership, effective partnerships with Pacific communities, and systematic, coordinated action within all levels of the health and social sectors and beyond.

Within the health sector, there are a number of key actions that organisations and individual services can take, many of them within existing resources. These actions, presented below as a seven-step framework to improve Pacific health, focus on using data in a meaningful way to inform continuous improvements in service delivery by facilitating access, ensuring continuity of care, promoting high-quality interactions with patients and families, communicating effectively, addressing health and social issues holistically, supporting the Pacific workforce, and engaging authentically with Pacific communities.



A seven-step framework for health sector organisations and services to address Pacific health¹⁸

This framework was developed by Dr Corina Grey, public health physician and Pacific health data and insights lead, Auckland DHB. It is designed to support health sector organisations and services to develop strategies, policies and processes focused on achieving equity and improvement for Pacific peoples.

1. We know our data.
2. We facilitate access, and ensure continuity of care, all along the care pathway.
3. We optimise patient experience through high-quality, respectful interactions.
4. We communicate clearly and effectively using health literacy principles.
5. We ensure our care is holistic, integrated and comprehensive.
6. We support our Pacific workforce.
7. We engage authentically with Pacific communities.



Alongside the work of organisations and health services, government systems and structures can also be improved. At each of the seven steps, we also highlight the role of government and how systems and structures can support and facilitate each step.

Step 1: We know our data

The health sector is awash with information; however, reporting of data by ethnicity, particularly Pacific ethnicity, is often not mandated, and even when it is, much data that is regularly reported is not useful for improvement purposes. There were a number of examples of this in the reporting of data throughout the life course.

In the 'On the life course: maternity and birth' section, we found many regularly reported indicators represent only primiparas (women having their first babies). While this is justified for reasons of comparability of rates of intervention and outcomes between regions, primiparas represent only 15% of Pacific pregnant women, potentially masking important maternal health issues affecting the vast majority of Pacific pregnant women. In the 'On the life course: children' section, we found that the oral health indicators required by community oral health services to be reported to the Ministry of Health each year include enrolment in services and oral health outcomes. However, between these two points on the oral health care pathway, there are many actions within the service that could (and should) be monitored to assess whether best practice is being conducted (such as fluoride application, and other preventive actions) and to evaluate how accessible or effective the service is (such as the location of clinics with the greatest uptake of care).

It is clear from the 'On the life course: youth' and 'Across the life course: disability' sections that there is a scarcity of information on access to and experience of care, making it difficult to know how well current models of care are working for these groups and, just as importantly, if they align with their aspirations and lived experience.

Of concern is the finding in the 'On the life course: adults' section that, even when there is data to show strategies are effective for Pacific peoples (eg, telephone follow-up and community laboratory drop-off options for bowel screening test kits), the information does not necessarily result in resourcing or a change to current models of care. Conversely, the HPV vaccination campaign in 2008/09, as noted in the 'On the life course: youth' section, is an example of a successful use of feedback and data, enabling a Pacific-specific campaign to be launched, based on Pacific values and aspirations.

To facilitate the meaningful use of data, services and organisations could pose the following questions:

- Are we collecting and reporting data by ethnicity?
- What does the data say about Pacific peoples':
 - health outcomes
 - access to care
 - experiences of care
 - quality of care?
- Is this data meaningful?
- Are we interpreting the data appropriately (ie, are we applying a Pacific 'lens' on the data)?
- Can we identify areas of improvement?
- Do these improvements result in lasting change?

In addition, government organisations can ask how their policy, commissioning of services, performance reporting requirements and evaluation approaches support partnerships with Pacific peoples that enable appropriate collection, analysis, interpretation and monitoring of data. Government can look at how Pacific stories and worldviews are communicated in data reporting and at how improvements are facilitated, when they are needed, in partnership with Pacific peoples.

When used effectively, robust data can provide a platform for change and a strong foundation for continuous quality improvement. Systematic research and evaluation of the effectiveness of different interventions and service delivery models are urgently needed in order to build an evidence base of what works for improving Pacific health.

Step 2: We facilitate access, and ensure continuity of care, all along the care pathway

There is a large body of evidence demonstrating that Pacific peoples experience barriers to care all along the health care pathway, from primary to quaternary (ie, advanced, specialised) care.⁹⁴ However, there is limited evidence that interventions to address these barriers have been consistently implemented and maintained throughout the health system. Services must ensure they are located in venues that are accessible to Pacific peoples, operate flexible hours, are welcoming of family members and address barriers such as cost, transport and parking.

Services must also liaise closely with other services and parts of the health system to deliver seamless care, including from the hospital into primary care and back again. This includes strategies such as careful discharge planning and medication reconciliation, particularly for people with multimorbidity and polypharmacy. On discharge from hospital, for example, it is important that patients and their families understand what they need to do in the short, medium and long term, when they need to see their GP and when they need to seek care more urgently.

There is growing evidence that empowering and supporting people with chronic conditions to self-manage in the community can reduce hospitalisations and adverse outcomes.^{160, 161, 162} In New Zealand, an example of one such intervention focused on achieving equity in outcomes is the Mana Tū programme, which is a Whānau Ora approach to type 2 diabetes.¹⁶³ However, the funding for self-management interventions for Pacific peoples with chronic conditions has been ad hoc and inconsistent, making it difficult for primary care providers to dedicate the time and resource needed to establish and maintain, and build the necessary evidence base for, such programmes. In addition, despite the higher burden of chronic diseases among Pacific peoples compared with other groups, there is limited evidence of the specific development and tailoring of chronic disease services for Pacific individuals, families and communities.

To ensure services are facilitating access and continuity of care, the following questions could be posed:

- What feedback and evidence do we have regarding accessibility of our services? How are we addressing this?
- How are we facilitating seamless care before, during and after our encounters with patients and families?
- How are we empowering and supporting patients and families to manage their own health and wellbeing in the community?



Evidence shows that better experience of care results in better health care outcomes.¹⁶⁴ In order to improve Pacific experience, our systems must have the ability to understand the voices, messages and worldviews of Pacific peoples. We need to understand why and how barriers are experienced and how these can be removed. Government organisations can commission, require and support efforts to amplify Pacific voices, through Pacific-specific patient experience surveys, and supporting engagement and partnerships with Pacific consumers and their families that enable their experience of barriers to be shared and better understood. If Pacific experience is not amplified and understood, it cannot help to improve the system.

Step 3: We optimise patient experience through high-quality, respectful interactions

As well as the national adult inpatient experience and primary care patient experience surveys,¹⁶⁵ many DHBs and primary and community care providers conduct their own forms of patient feedback-gathering, including positive feedback and complaints. However, it is unclear whether there is a systematic approach to obtaining the feedback of high-priority groups (including Pacific peoples), acting on this feedback and letting patients and their families know how their feedback changed the service or practice.

There is evidence that negative experiences in the health care system can affect patient experience, quality of health care and subsequent outcomes for Pacific peoples.^{122, 166, 167} Negative experiences with providers can also make people reluctant to seek care in the future, and often arise because of a failure to acknowledge Pacific values or a mismatch in expectations between providers and patients and their families.

Cultural safety is a concept that has been around for several decades in nursing and midwifery education,^{168, 169} but there is great variability in awareness of it among the health workforce. Unlike cultural competency, which focuses on cultural awareness and differences between groups, cultural safety has a focus on the delivery of quality care through changes in thinking about power relationships and patients' rights. A definition of cultural safety has recently been recommended in New Zealand,¹⁷⁰ which requires health care professionals and associated health care organisations to:

- examine themselves and the potential impact of their own culture on clinical interactions and health care service delivery
- acknowledge and address their own biases, attitudes, assumptions, structures and characteristics that may affect the quality of care provided
- engage in ongoing self-reflection and self-awareness, and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity
- influence health care to reduce bias and achieve equity within the workforce and working environment.

To address equity of quality of care and of outcomes, it is important that Pacific values are acknowledged and enabled, including the central place of family, collectivism and communitarianism, spirituality, reciprocity and respect across our system.¹⁷¹ This could occur through policies, commissioning and services that do not limit numbers of family members, that provide space for prayer and spiritual expression, and allow time for meaningful and trusting relationships between providers and patients and their families to develop. At all levels of our system, we also need actively to combat the effects of racism and stigma, view patients and families as partners in care, and emphasise strengths and resiliencies, rather than focusing on limitations and deficits.

The learnings from, and models of care provided by, many Pacific providers (an example of which was provided by the Fono in Chapter 4), which take a social determinants approach, acknowledge Pacific values and recognise the importance of effective communication, could be expanded, while simultaneously building an evidence base for progress in Pacific health.

The following questions may help government agencies and organisations, as well as services, develop ways to optimise patient/family/provider interactions and quality of care:

- What feedback and evidence do we have about patient experiences within our services? How have we acted upon this information? How have we provided feedback on subsequent changes to our services?
- How do our policies and processes acknowledge and align with Pacific values?
- How are we ensuring our workforce is operating in a culturally safe way?

Step 4: We communicate clearly and effectively using health literacy principles

The importance of good communication with Pacific patients and their families cannot be over-emphasised, yet formal training in this area is lacking. Good communication was a recurring theme throughout our interviews with Pacific health experts. In addition, there is evidence that poor communication and miscommunication within the health system is contributing to inequities in access and outcomes for Pacific peoples, from child health¹²² to infectious diseases, heart disease,^{167,173} and palliative care.¹³⁹

Pacific families have reported feeling they lacked information from health care providers, leading to difficulties negotiating processes within the hospital system, such as knowing the support services available, their eligibility for these services and what to expect at various stages of care. The use of medical jargon can alienate families and information in the form of written resources, most often only available in English, can be confusing, long and unappealing.

Communication is a particular challenge for families where English is a second language, and there is more for government agencies to do to ensure an appropriate response to this challenge. Despite hospitals clearly stating that all patients have a right to access translation services, families reported that offers of an interpreter were rarely made and never in urgent or emergency situations.⁹⁴ Despite years of well-documented concerns about the limited use of interpreters and translators in the health care system,¹⁷⁴ there is still no systematic approach or consistent guidance on this important issue, and there continues to be a lack of monitoring of interpreter use. The right to effective communication, including the right to a competent interpreter, is one of the 10 specific rights codified under the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.¹²³

Much has been made of the importance of health literacy, which is defined as the capacity to obtain, process and understand basic health information and services in order to make informed health decisions.¹⁷⁵ The Ministry of Health has published a useful health literacy framework for health services, which recognises the important role of the health system in reducing demands on people, and builds the health literacy skills of the workforce and individuals and families who use its services. A health-literate system provides high-quality services that are easy to access and navigate, and gives clear and relevant health messages so people can manage their own health effectively, keep well and live well.¹⁷⁵

In addition, mass communication approaches with Pacific communities, as we saw during the COVID-19 response, can be highly effective when Pacific-led, aligned with the values and contexts of Pacific peoples' lives, carefully considers the appropriate messages and messengers, and are available in the different Pacific languages.

To effectively address communication with Pacific peoples, government agencies, organisations and services should ask:

- Are we systematically asking all patients what is their preferred language and whether they require an interpreter? Are we providing interpretation and translation services in a timely fashion?
- What are we doing to reduce the health literacy demands on our patients?
- What are we doing to build the health literacy skills of our workforce? And our patients and families?
- How are we obtaining feedback to ensure our health messages are clear and relevant?



Maryann Heather, GP, South Seas Healthcare

I've been working in general practice in South Auckland for the last 13 years. You look at all our patients that we have, our diabetics, our asthmatics, our COPDs [chronic obstructive pulmonary disease patients], the skin infections, the scabies, the non-communicable diseases, and things haven't really changed. A lot of money has been put into things but the stats and the numbers come back and we haven't really shifted. Things have not gotten better for us in terms of Pacific health, and for our community.

Our model of care isn't working. We need the right model of care that is developed by Pacific for Pacific. We've got programmes and we've got KPIs [key performance indicators] but they come from the Ministry, from our PHO, from the DHB. And it's a set of numbers, stats that they need to meet to make it look good. I mean, that probably sounds harsh, but in reality, that's what I see. I see the things that we try to implement, that people are dictating that we should do, we should stick to the programme and recommendations for our people, it just doesn't work.

The other thing is having the right staff that can look after our Pacific people to deal with language barriers, and health literacy and the barriers to accessing good health care. The people that are making policies need to listen to the people that are actually dealing with community and dealing with the patients and dealing with these families because there are so many other issues involved in looking after them and getting on top of their health.

We need to look at another way. ✨

Step 5: We ensure our care is holistic, integrated and comprehensive

It is clear that current mainstream models of care, which are often siloed and highly fragmented, are not working for Pacific patients and their families. There is an urgent need to 'join up' services that address the often-complex needs of families and are tailored to their specific circumstances, rather than applying a 'one-size-fits-all' approach.

COVID-19 highlighted the close and dynamic interaction between health, social circumstances and economic impacts, and resourcing was made available to support Pacific providers to deliver models of care that addressed these factors holistically. We must build on and strengthen these models of care by facilitating rapid access to social, financial and housing supports within the health system, recognising that good health cannot be achieved without addressing the context within which Pacific peoples live.

We must also adapt services to address the growing rates of long-term conditions and multimorbidity, particularly among Pacific patients. Requiring patients to attend multiple appointments for different conditions on different days is inefficient and taxing for patients and families. Patients must be viewed holistically, not as individual conditions or body systems. 'Specialty' services within health must be coordinated so that multiple conditions can be addressed at the same appointment, or at the very least at the same location on the same day. This approach would also deal with issues around polypharmacy and the risks associated with multiple drug interactions. Ideally, this coordinated approach should be taken so appointments are well coordinated for people within the same family or household.

Useful questions for government agencies, organisations and services to ask include the following:

- How do our services address the social and economic challenges of our patients and families? How do we facilitate pathways into social and housing services and income support?
- How do our models of care respond to people with multimorbidity, reducing fragmentation, duplication and the stresses of accessing health care?
- How do our models of care acknowledge the importance of family, in terms of other family members who require health care as well as family members being carers and supporters?

Dr Siro Fuata'i, GP, Baderdrive Doctors

At general practice level, you need a whole wraparound service to support family. Our standard consultation time is a 10-15-minute consultation per patient, almost without consideration of the family being involved.

We need a different team approach, managing the family and involving the family in looking after their family member. We need to see at least one or two family carers in support when patients come to the clinic. If patients can't speak or understand English then you need somebody who can speak the language, spend time going over issues, and have staff who are able to connect with them and make sure that if you put a plan in place they can be supported with that plan.

Then we need to try to move them to the next level where they can manage the majority of what we expect them to do with just some input. Many nurses, health care assistants, visiting nurses, for example, can do the majority of the roles that the GP does without support from the GP.

There can be five government agencies managing one family, and the family completely confused about a whole lot of things because agencies don't talk to each other. Having a coordinated approach would be more productive than everybody sounding helpful, but not really being helpful.

I sometimes wonder why we don't re-allocate a lot of the resources to managing Pacific families. It's about managing the whole thing, and having a whole team around to support the family through that. So the big thing is resourcing. There is appetite for a reorientation of the service with increased funding for wraparound services.

Services for Pacific health tend to be resourced in a piecemeal approach, which means providers are in effect trying to compete for those little pops of funding. We need to be able to say, we're going to manage this in this broad approach that will cover a whole lot of things, that involves a whole lot of people in a whole lot of organisations in a comprehensive approach to health care for Pacific peoples. ✨

Step 6: We support our Pacific workforce

A strong, supported and resilient Pacific workforce is a foundational requirement for Pacific health equity. As noted in Chapter 3, Pacific peoples are significantly under-represented in almost all parts of the health workforce – including doctors, nurses, midwives, allied health workers, dentists and dental health workers, data analysts, policy advisors, planners, funders, managers and senior officials. Every expert interviewed emphasised the importance of having a workforce representative of and responsive to the needs of Pacific peoples and families.

We are currently far behind where we should be – and a systematic programme including strategies across the entire pipeline (from school to training to recruitment and retention to leadership-building) is urgently needed to redress this. We need deep commitment to building Pacific workforce capacity and capability across the entire health system, and this will require a considered, intentional and systematic approach. This must include systems-level expectations that enable organisations and services to:

- develop plans on the active recruitment and retention of Pacific staff, as well as measuring and monitoring the effectiveness of these plans (see To'a Fereti's comment in the 'Pacific nursing support and development' section in Chapter 3)
- recognise and reward the added value that Pacific staff bring, including lived experience, knowledge of Pacific values and worldviews, Pacific language speaking skills, a Pacific lens on data, policies, processes and models of care, and close connections with Pacific communities and other networks



- actively plan how to build Pacific capacity and capability within their workforce, including opportunities to upskill and develop career pathways for Pacific staff (see Hamish Crooks' comment in the 'Upskilling the unregulated workforce' section in Chapter 3)
- ensure services are not only culturally safe for consumers, but also that the workplace is culturally safe for staff, acknowledging that Pacific staff are most often a minority in the workplace and are therefore more likely to be affected by unconscious bias and/or have multiple competing demands due to their cultural expertise
- develop leadership training and leadership opportunities for Pacific staff.

It is also important to recognise that working in Pacific health can be stressful, due to the often-complex health and social needs experienced by Pacific peoples and families, and Pacific staff must be well supported themselves to prevent burnout.

Step 7: We engage authentically with Pacific communities

Finally, to make significant and lasting gains in Pacific health equity, we must engage authentically with Pacific communities and consumers, working to understand their aspirations, needs, issues, challenges and priorities. As has been shown throughout this report, there are many strengths and resiliencies in Pacific communities, who often hold the solutions and just need support from the health sector to implement them. The close working relationships between Pacific providers and churches during the COVID-19 response is a salient example. It is crucial that we build on the learnings and successes of this engagement and, in true Pacific style, make the most of the opportunities created by a pandemic that has resulted in so much upheaval and chaos throughout the world.

Conclusions | Ngā kōrero whakamutunga

In conclusion, and in brief, *Bula Sautu* shows us some of the worst inequities in our health care system, but also profiles providers, communities and individuals responding creatively, brilliantly and vibrantly within the constraints imposed upon them. *Bula Sautu* shows how our mainstream health system is designed neither for nor with Pacific peoples and is failing to meet Pacific needs. It reveals our systems of data and analysis systematically occlude, miss and misunderstand Pacific peoples and their complexity so that we at present cannot fully even understand the complete nature of these inequities.

These inequities of quality of care and outcome represent a systemic failure of New Zealand citizen and human rights, and a national shame.

In response to these findings, we propose a three-pronged way ahead: at a macro, system level the board of the Commission proposes in the preface to this report four areas for system-level change, and proposed early steps, and at a meso level, in Chapter 5, we propose a seven-step framework for health sector organisations and services to address Pacific health and develop strategies, policies and processes focused on achieving equity and improvement for Pacific peoples. At a micro level, the Commission has convened a Pacific consumer group to respond to the findings of *Bula Sautu* with an appropriate diversity of Pacific consumer voices, and will convene a Pacific consumer steering group to plan the Commission's ongoing response.

The inequities demonstrated in this report demand Pacific voices and Pacific issues be a vital part of the health reforms conversation.



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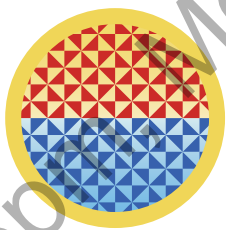
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