

# Unravelling the whāriki of Crown Māori health infrastructure

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## ABSTRACT

New Zealand's central government, and more specifically the Ministry of Health, consistently acknowledges their *special relationship* with Māori and the *strategic importance* of Māori health, and certainly, strengthening Māori health is critical to addressing systemic health inequities. This paper, framed in terms of the Crown principles attributed to the *Treaty of Waitangi*, ie, participation, protection and partnership, examines three structural decisions that threaten to unravel the whāriki (foundational mat) of Crown Māori health policy infrastructure. These include the disestablishment of the Ministry of Health's policy team, Te Kete Hauora, revoking mandatory district health boards' (DHB) Māori health plans and reporting, and downscaling the requirements of DHBs to consult. These actions appear to breach the Articles of te *Tiriti o Waitangi* and may be cited as such in the forthcoming WAI 2575 kaupapa health hearing before the Waitangi Tribunal. The authors call for the Ministry of Health to embrace its Treaty obligations, and to protect and reinstate the whāriki of Māori health infrastructure.

Despite the special relationship between the Crown—including its agencies, such as the Ministry of Health—and Māori in this country, systemic health inequities between indigenous and settler populations persist.<sup>1</sup> Historically, these inequalities may be traced back to the advent of colonisation, land alienation, policies of assimilation, neo-liberalism and legislation such as the *Tohunga Suppression Act 1907*.

In more recent times this has been represented by the omission of any reference to the *Treaty of Waitangi* in the *Health Practitioners Competence Assurance 2003*, an omission that was justified at the time by the Ministry of Health (the Ministry) which claimed that the *New Zealand Public Health & Disability Act 2000* made adequate provision for the Crown's Treaty responsibilities.<sup>2</sup>

Te *Tiriti o Waitangi* was New Zealand's first health policy, which formalised a partnership between hapū (sub tribes) and the Crown, and it articulated the terms and conditions of non-Māori settlement. Te *Tiriti* consists of four articles which acknowledge kāwanatanga (governorship), tino rangatiratanga (Māori sovereignty), ōritetanga (equitable outcomes) and wairuatanga

(spiritual freedom).<sup>3</sup> Influenced by the writings of Durie, we see health as a taonga (treasure), which was guaranteed protection under Article 2.<sup>4</sup>

Influenced by decades of activism by Māori, challenging the Crown to engage with their Treaty responsibilities, the *New Zealand Public Health & Disability Act (NZPHDA) 2000* requires (under part 1(4)) those working in the health sector recognise and respect the principles of the *Treaty of Waitangi*. The principles they are referring to are those identified by the Royal Commission on Social Policy, that is: participation, protection and partnership.<sup>5</sup> Under part 5(3)c of the *NZPHDA* there is a specific requirement for district health boards (DHBs) to reduce health disparities by improving health outcomes for Māori, and part 3 outlines requirements around Māori participation.

These Treaty principles and a commitment to Māori health is reinforced in the policy document *He Korowai Oranga*.<sup>7</sup> Likewise, the current *New Zealand Health Strategy* purports to pursue *equitable outcomes* for all New Zealanders while acknowledging the *special relationship* between the Crown and Māori, and the need to *recognise and respect* Treaty principles.<sup>8</sup>

In terms of Crown Māori health infrastructure, since the Hunn Report,<sup>9</sup> Māori health within central government has been led by an Interdepartmental Committee on Māori Health, later the Standing Committee on Māori Health, then the Ministerial Advisory Committee, which co-existed with the Ministry's internal Māori health unit—Te Kete Hauora (TKH).<sup>10</sup> These structures were complemented with ongoing engagement with Māori communities and later investment in Māori health providers.

The Ministry has pursued the advancement of health equity and, more specifically, Māori health through i) policy advice from TKH within the Ministry, ii) the requirement of DHBs to consult with Māori and iii) the requirement to develop and report on annual Māori health plans and iv) investment in Māori providers.<sup>11,10</sup> These pathways have been the whāriki (foundational mat) of Crown Māori health infrastructure. TKH has been a structural mechanism to ensure Māori voice in health policy. Māori health plans have been a key public accountability measure for tracking performance in relation to Māori health. Structurally, the requirement to consult has enabled some Māori input into DHB planning processes. Māori providers have provided a Māori-led option for contracting clinical and public health services.

In March 2016, Te Kete Hauora, the Māori health business unit within the Ministry, was disestablished.<sup>12</sup> In November 2016, the requirement of DHBs to submit and report on annual Māori health plans was revoked and the requirements for DHBs to consult with Māori were downsized.<sup>13</sup> The authors argue that the whāriki of Crown Māori health infrastructure is being quietly unravelled. Drawing on the Crown's own Treaty principles, this paper explores these potentially far-reaching decisions.

### The disestablishment of Te Kete Hauora—non-participation

The principle of participation highlights the Crown's obligation to ensure Māori participation within the health sector, beyond being an end-user of a service. The Royal Commission on Social Policy interpreted participation as encouraging Māori involvement in the planning and design of health policy, and the delivery of health services. This principle was used to enable

the development of specialist Māori health providers.

TKH was established in 1993 as a business unit and later a directorate within the Ministry of Health to provide specialist policy advice on and to address inequalities and inequities in Māori health status.<sup>14</sup> Subsequently, it has been an important structural mechanism for Māori participation in health policy and decision-making. TKH has been a unique Māori voice within the Ministry, providing Māori health expertise and cultural input.

At an operational level, a report commissioned by the Ministry, the Navigate report,<sup>15</sup> noted that “the knowledge of experienced Māori staff is critical to the work of the Ministry in achieving its [Treaty] commitments” (p. 2). This report confirmed that most Māori staff felt culturally compromised within the Ministry. Māori staff reported a lack of support and understanding about Māori ways of working and for uniquely Māori issues. Navigate reported Māori staff were concerned at “the entrenchment of negative views of Māori in the fundamental conceptualisation underlying policies and procedures” (p. 8).

At a macro-level, Deputy Director General Māori Health—Ria Earp, former head of TKH credited the team with encouraging acceptance of the importance of Māori health and reducing inequities within the health sector.<sup>16</sup> Earp explained:

*“[TKH] have been building the evidence that Māori need more effective, culturally appropriate services. Māori worked hard over many years to convince government of the necessity for specific, Māori-run social services that would incorporate Māori cultural approaches and would be based on the three key Treaty of Waitangi principles of partnership, participation and protection (p.21).”*

Wenn concurred and described TKH as integral to the Ministry in its capacity to develop new policy, analyse proposals and ensure its advice was acted on appropriately.<sup>17</sup> She maintained that TKH “addressed Māori concerns at a macro-level, and with which Māori were comfortable” (p. 61).

Teresa Wall, another former head of the TKH, asserted that “all the work of the Ministry should be aimed at this one goal of

improving Māori health”<sup>18</sup> (p. 11). She also noted that TKH had picked up a monitoring role to assess whether this goal was being achieved and they were actively providing advice about how to strengthen Māori health outcomes.

On 1 March 2016, the Ministry disestablished TKH.<sup>12</sup> Under the new structure there is a solitary Chief Advisor Māori Health who contributes as their capacity and political access permits. Little information is publicly available in relation to this major restructuring. From the new Ministry organisational chart, those TKH staff that remained were dispersed across the Ministry.

The disestablishment of TKH has parallels beyond the health sector. Writing about tertiary education, Potter and Cooper<sup>19</sup> identified a pattern of what they termed ‘white-streaming’, ie, the generalising of designated Māori positions. Their study, commissioned by the Tertiary Education Union, revealed a widespread pattern of disinvestment in Māori designated roles in favour of generalised roles across teaching, student and staff support, and research positions. Staff reported their distress in the changes: many had resigned or wanted to, and reported lower job satisfaction and the loss of collegiality. There was often no rationale given for the restructuring, but it seems to be diluting concentrations of Māori intelligence and downsizing commitment to positive Māori outcomes.

### Revoking district health board Māori health plans—unprotective

Kingi described the principle of protection as the Crown’s duty actively to eliminate health inequities at all levels.<sup>20</sup> He argued this principle requires positive interventions to improve Māori health outcomes. Traditionally this principle has been addressed through targeted approaches, for instance, in public health, health promotion and primary health.

Māori health plans have been widely used within the health sector as a mechanism for prioritising protecting and monitoring Māori health outcomes. Through these plans, organisations can declare their intentions, commitments and progress towards improving Māori health against defined measures and indicators. The monitoring of

these are a powerful public accountability measure. Likewise, by releasing information publicly, organisations can learn from each other about critical success factors or ineffective approaches.

For some years, the Ministry has held a mandatory requirement for DHBs to produce stand-alone Māori health plans.<sup>13</sup> These plans were to detail DHBs’ commitment to the Ministry’s priority areas such as immunisation, mental health, rheumatic fever and oral health. In developing these plans, DHBs had the opportunity to engage with local stakeholders, including Māori health providers and iwi, to align planning to reflect Māori aspirations.

For the 2017/18 DHB annual planning process, the requirement for developing a Māori health plan was revoked by the Ministry without consultation.<sup>21</sup> Several DHBs raised concerns about the loss of accountability, the increased risk of poorer Māori health outcomes and the lack of clarity around evaluation.<sup>22</sup> One noted the changes would undermine Trendly<sup>beta</sup>, an innovative web-based resource that enabled Māori and others to monitor and bench-mark DHB performance in relation to Māori health.<sup>23</sup>

The Ministry’s response to the DHBs was that the Māori health indicators could be incorporated within the annual plan, though detail around specific action should not be included.<sup>22</sup> Furthermore, it confirmed that, where measures could be disaggregated by ethnicity, there would be no differential targets; however, such disaggregation itself undermines the ability of DHBs to address inequity. Nevertheless, regardless of Ministry requirements, a number of DHBs may continue to develop Māori health plans because they feel it is the tika (correct) thing to do in order to maintain their relationships with Māori (DHB colleague, personal communication, 20 December 2016).

### Downscaling consultation in DHB annual plans—the lack of partnership

DHB annual planning processes are of strategic importance as they determine where the bulk of Vote Health is invested. These plans are expected to be aligned to detailed Ministry guidelines;<sup>21, 24</sup> DHBs need to undertake consultation, the plans are

reviewed by the Minister of Health and, if they are satisfied, funding released.

The 2017/18 guidelines are highly prescriptive and include a strict word count in a new streamlined process,<sup>25</sup> and the previous requirement to consult<sup>21</sup> has been dropped from the new guidelines. However, we anticipate that, again, some DHBs will formulate a Māori health plan and engage with their partners.

Well-planned consultation can build on knowledge and experience, test assumptions and produce workable solutions. Both the Ministry and DHBs have statutory obligations to consult with Māori through the *New Zealand Public Health & Disability Act 2000*. The Ministry has published consultation guidelines, which emphasise the special relation between Māori and the Crown and the importance of the Treaty principles, and confirm that implicit in the Treaty principles is the requirement to consult on matters that affect Māori.<sup>26</sup>

Kingi<sup>27</sup> argued that the principle of partnership refers to the obligation of the Crown to include Māori in the design of legislation, policies and strategies. This principle is a response to concerns that for instance, generic planning and interventions do not address the specific cultural, social and economic determinants of Māori health, ie, their ill-health. Cultural knowledge and expertise are therefore important in the development of health policy where Māori are part of the target population.<sup>28</sup>

Came reported senior Māori leaders' many concerns about Crown consultation processes.<sup>29</sup> These included tight (and therefore disrespectful) timeframes, the (biased) framing of questions, the restriction of who was included in the consultation process (which, by definition, undermines the principle of partnership), how consultation was conducted (ie, along lines decided by Pākehā, and not observing Māori tikanga (customs and correct protocols)) and, critically, what happened to the contributions afterwards. Decades into their careers, some leaders reported that Crown officials were just not listening, and they noted that recommendations from key health hui from the 1980s and 1990s still remain unaddressed.

A recent report by the Controller and Auditor-General revealed a plethora of problems with existing DHB reporting on

Māori health,<sup>30</sup> in which context, we suggest that the removal of requirements to report on this aspect of our nation's health only supports a lack of accountability, and ultimately greater inequity.

## Implications for practice

The three decisions made by the Ministry of Health and as outlined in this paper contradict the recommendation of Cram's study of health equity—and inequity—commissioned by the Ministry of Health.<sup>31</sup> The study, which drew on nearly 50 key stakeholders from across the health sector as well as international literature on indigenous and minority health, recommended that organisations make explicit organisational commitments to Māori health. Cram proposed setting targets, monitoring progress and collaboration, and advocated for the normalisation of equity analysis through the use of tools and frameworks such as the *Health Equity Assessment Tool*.<sup>6</sup> Echoing Cram's analysis, we suggest that the decisions reviewed in this paper set back progress towards health equity, especially in the context of *te Tiriti o Waitangi*, as the revoking of the requirements under scrutiny suggest either that health equity has been achieved—which it has not; or that the requirements are not important—which they are. Moreover, such deregulation, in our view, also represents another breach of *te Tiriti o Waitangi*.

*Te Tiriti o Waitangi* is the founding document of the colonial state of New Zealand and should be considered during the development of all social and economic policy. Through the WAI 2575 kaupapa claim,<sup>32</sup> the Waitangi Tribunal has identified approximately 100 health-related deeds of claim since 1840 related to Crown Ministers' and/or Crown Officials' breaches of *te Tiriti*. The three decisions outlined in this paper appear to be further breaches of *te Tiriti*, specifically in reducing the participation of Māori stakeholders in matters that concern their health; in being less protective of Māori health; and in discouraging the participation of Māori for Māori health.

However, while it is tempting to reiterate the importance of the principles of participation protection and partnership,



these principles are part of the problem in that they were defined by Crown agencies without their Treaty partner. Over the years, various politicians and academics have named or claimed as many as 54 principles of the Treaty.<sup>33</sup> Like others, the authors recognise the Māori text of *te Tiriti o Waitangi* as the founding document of the colonial state of New Zealand, a recognition that is in line with the principle of *contra proferentum*, whereby the indigenous language version of a treaty takes preference over any version written in the language of the coloniser(s).

The Ministry of Health seems to be stepping away from their obligations in

relation to Māori health. Te Kete Hauora, mandatory Māori health plans and reporting, consultation with Māori have all been key elements in the whāriki of Crown Māori health infrastructure in this country.<sup>10</sup>

<sup>34</sup> The health sector needs structures, leadership and support to address the complex challenges of health inequities. Structural mechanisms to ensure Māori input at all levels of decision-making, and accountability mechanisms such as planning and reporting to monitor progress towards health equity are basic Treaty responsiveness measures. To address health inequities, we need Māori-led solutions and a health bureaucracy responsive to its Treaty obligations.

#### Competing interests:

Dr Came is co-chair of STIR: Stop Institutional Racism—this is a nationwide network of activist scholars and public health practitioners committed to eliminating institutional racism in the health sector.

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