# Initial Thoughts:  Building a Social Movement to Transform Institutional Racism in Aotearoa

Dr Heather Came, Claire Doole, Trevor Simpson and Dr Nicole Coupe

*In the 1980s public servants exposed systemic institutional racism within the administration of the public sector through a series of reports; the most well-known of which being Puao te a Ata tu (Ministerial Advisory Committee on a Maori Perspective on Social Welfare, 1988). The health sector had earlier drawn a line in the sand  with  a memo from the then Director-General of Health, Dr. George Salmond (1986) requiring sector engagement with the Treaty of Waitangi. More than twenty years on, the health system continues to produce inequitable health outcomes between Māori  and non-Māori  (Robson & Harris, 2007) in part because of persistent institutional racism within the administration of the health system itself (Came, 2012). Last year the Public Health Association (PHA) (September 2012) passed a remit at the AGM committing us (the public health sector) to take action to address institutional racism within our sector. It is time for courage and to draw a new line in the sand - let's eliminate institutional racism within our sector by 2017. The costs of inaction are high and fundamentally incongruent with the stated values of the public health sector (Public Health Association, 2012).*
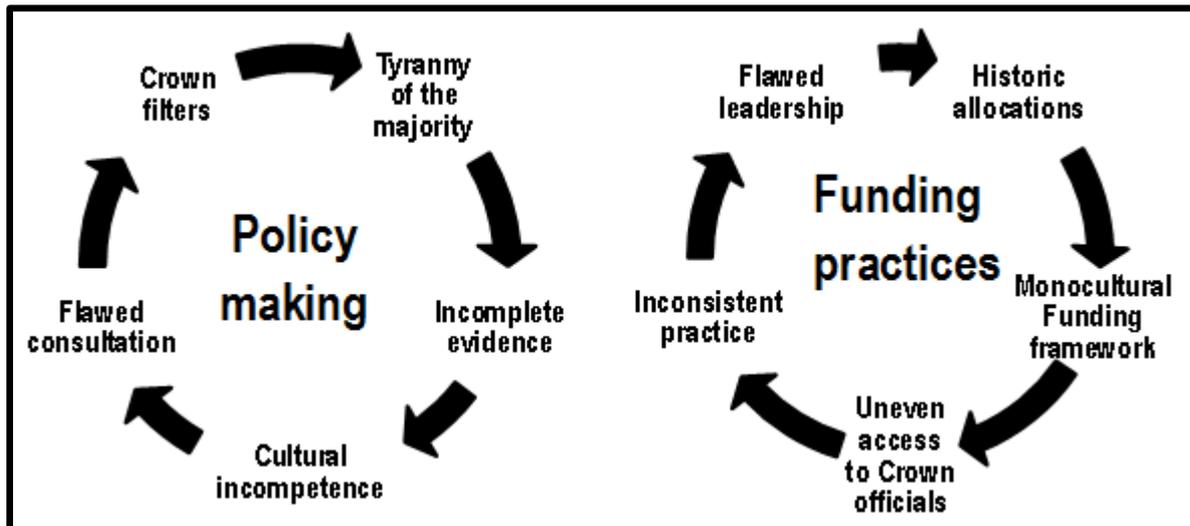
_____

### Background

Institutional racism has been recognised by New Zealands' Ministry of Health since the 1990s. Racism has been passionately debated at public health conferences for decades. These debates have been informed by the work of Camara Jones (2010), Papaarangi Reid and Bridget Robson (2007), Ricci Harris (Harris et al., 2006), Robin Kearns, Helen Moewaka Barnes, and Tim McCreanor (2009).

Institutional racism is a pattern of differential access to material resources and power determined by race, which advantages one sector of the population while disadvantaging another (Jones, 2000). It manifests within policy making, funding practices and  service delivery which disadvantages Māori and other ethnic minorities, contributes to inequitable health outcomes and represents a barrier to aspirations for health equity (Sheridan et al., 2011; Signal, Martin, Cram, & Robson, 2008). Health disparities between Māori  and non-Māori including life expectancy gaps of 7.3 years are well documented (Statistics New Zealand, 2013).

Came's (2012)research, provided clear evidence of how institutional racism manifests within public health policy and funding practices. The research was guided by a predominately Māori research whānau, used activist scholarship to identify ten sites of institutional racism (see figure one). Within policy making racism can be detected in the decision making processes that determine the policy agenda and what evidence is used to inform policy; through deficiencies in cultural competencies and consultation process and the filters that guide Crown sign-off processes. Within funding practices racism manifests in: historical funding allocations that have not been retendered; through the utilisation of mono-cultural funding frameworks, through inconsistencies in Crown practices and health leadership that does not detect or prevent racism.

**Figure One: Sites of institutional racism within public health policy making and funding practices.**

*Adapted from Came, H. (2012). Institutional racism and the dynamics of privilege in public health. Unpublished doctorate, Waikato University, Hamilton, New Zealand. Retrieved from http://researchcommons.waikato.ac.nz/handle/10289/6397*

Since April 2012 a group of public health practitioners have been meeting to discuss institutional racism with a view to formally establishing a Special Interest Group under the umbrella of the PHA. Current members include Nicole Coupe (Kereru Research, Evaluation and Development ), Heather Came (Auckland University of Technology), Claire Doole (Auckland University of Technology), Rohan Jaduram (Human Rights Commission), Trevor Simpson (Health Promotion Forum), Tim McCreanor (Te Rōpū Whāriki), Lisa McNab (Navilluso Medical Ltd) and Ngaire Rae (Manaia PHO).  At this time we are based in Kaitaia from the North through to Wellington in the South. Our group proposes to be the backbone of the campaign to end racism with accountabilities to the PHA, the Māori caucus and the currently forming 'governance' whānau. The group will be a co-ordination and communication hub and hope to establish a web presence, regular updates via the PHA e-bulletin for people to follow and contribute to the progress of the mobilisation.

To date the group has drafted a terms of reference and began to passionately debate how we can achieve our bold goal of ending institutional racism by 2017.  We lodged an expression of interest with the Health Research Council for funding to explore

   i)      how to strengthen existing efforts by Crown agencies to reduce, minimise, eliminate institutional racism and
   ii)     how systems theory might be a useful platform for anti-racism interventions but at a first attempt were unsuccessful. We are currently considering other avenues to advance applied research in this area to support change efforts.

We have begun the process of establishing a work plan complete with a program logic model, and are committed to evaluating this work.

The following is our initial thoughts of what needs to be done, and how we can move forward mobilising the public health sector.

**Te Tiriti o Waitangi – Decolonisation**

As identified in the pioneering reports from the 1980s (see Berridge et al., 1984; Herewini, Wilson, & Peri, 1985; Jackson, 1988; Ministerial Advisory Committee on a Maori Perspective on Social Welfare, 1988) institutional racism within a New Zealand context has profound colonial elements. To address institutional racism at a macro level thereby requires reengagement with *Te Tiriti o Waitangi*, the honouring/respecting of Te Tiriti obligations and the normalisation of Te Tiriti-based practice (Health Promotion Forum, 2000). This realignment needs to occur at all levels of the public health sector and ideally will involve ongoing processes of decolonisation.

Decolonisation is both an individual and collective process of analysing the impact of colonisation, mono-culturalism and institutional racism combined with a political commitment to take action to support indigenous sovereignty. Simply put it is about a reconfiguration of the power dynamics imposed through colonisation. Within such processes Nairn (2002, p. 203) argues "…the descendants of the colonisers have different decolonisation tasks than the descendants of the colonised". Huygens (2007) describes decolonisation for some as an active process of reconciliation and ongoing attempts at power-sharing, for others an expression of resistance, or a commitment to healing. It is unclear at this time what this might look like within the context of the public health sector.

Recommendation all public servants go through decolonalisation training

Recommendation all public servants have Tiriti o Waitangi training

***Working with systems theory***

Systems theory is an approach to change Midgley (2006) recommended, when dealing with 'wicked' or complex problems such as addressing institutional racism or child poverty. It is suited for situations when change needs to be sweeping and achieve sustainable transformative impact. Such approaches are familiar to the public health sector via the Ottawa Charter (World Health Organization, 1986, November) which embodies a multi-level systems approach to affect change. Likewise the New Zealand health systems quality assurance strategy (Ministry of Health, 2003) utilises a systems approach to quality improvement.

As part of a system-based approach the coalition leading this work proposes to advocate for anti-racism praxis to be embedded within existing management and quality assurance. At this point we have identified an initial range of remedies to neutralise the sites of racism identified in Came's (2012) research; firstly in relation to policy making (see table one) and secondly in relation to funding practices (see table two)..

**Table One: Recommendations for Anti-Racism Policy Actions**

| Decision making | • Review decision making methods within policy development that ensure indigenous perspectives are considered such as deliberate democracy.<br>• Ensure consistent application of prioritisation tools such as *Health Equity Assessment Tool* (Signal, et al., 2008) and provide relevant training and support<br>• Ensure processes are established to ensure equitable Māori representation within advisory and references groups across District Health Boards and the Ministry of Health. |
|---|---|
| (Mis)use of evidence | • Kaupapa Māori worldviews should often be used to frame policy. |

| | |
|---|---|
| | • Encourage policy makers to proactively and consistently prioritise Māori academics citations.<br>• Include socio-political context within policy to demonstrate the impact of the uneven access to the determinants of health.<br>• Best practice research both local and international addresses indigenous knowledge and uses data sets that enable quantitatively valid analysis. |
| **Cultural and political incompetence** | • Prioritise cultural competencies within recruitment of public health policy makers, funders and managers.<br>• Provide training and professional development opportunities for existing public health policy makers, funders and managers.<br>• Provide decolonisation and Te Tiriti o Waitangi training<br>• Embed cultural competency as a performance standard that is monitored within the public sector. |
| **Consultation practices** | • Benchmark best practice consultation practices across central and local government and adopt that within the public health sector.<br>• Actively resource Māori engagement in public health consultation processes.<br>• Crown officials to engage in whakawhanaungatanga processes with Māori health leadership as Te Tiriti partners<br>• Strengthen Ministry of Health and District Health Board consultation processes to ensure meaningful Māori input |
| **Impact of Crown filters** | • Embed the routine use of the *Whānau Ora Impact Assessment* (Ministry of Health, 2007) throughout policy development.<br>• Ensure Māori partners (both internal and external) are involved throughout policy development from conception, development, implementation and evaluation.<br>• Mobilise the political will and legislative requirements within Crown agencies and the sector to urgently address health inequities and honour Te Tiriti obligations. |

**Table Two: Recommendations for Anti-Racism Funding Actions**

| | |
|---|---|
| **Historic public health funding allocations** | • Retender historical public health contracts to enable Māori providers to potentially extend their coverage of services.<br>• Ensure both the Ministry of Health and District Health Boards actively monitor public health service delivery to Māori communities.<br>• Establish mechanisms to ensure prioritisation policies such as the application of the *Health Equity Assessment Tool* are consistently followed. |
| **Mono-cultural funding frameworks** | • Urgently develop a kaupapa Māori public health service specification.<br>• Reframe and reorientate existing service specifications to ensure they:<br>   - *Cite Māori academics and are inclusive of Māori worldviews*<br>   - *Include socio-political context that address the determinants of health*<br>   - *Review international best practice to ensure relevance for Māori communities* |
| **Inconsistent practices** | • Deliberately foster relationships with Māori health providers. |

| of and access to Crown officials | • Establish sector-wide funder-provider communication strategy. |
| | • Establish equitable contract terms and auditing practices that are publically available. |
| | • Ensure monitoring processes, financial reporting and compliance costs are proportional for providers. |
| | • Ensure a consistent level of flexibility is exhibited to providers during contract negotiations. |
| | • Ensure there are equitable opportunities across providers to access discretionary and one-off funding. |
| | • Promote a culture of greater transparency and consistencies around operational practice. |
| | • Publicly report the difference between funding streams to Maori communities, Maori organisations to Non-Maori |
| Leadership | • Consider anti-racism expertise when recruitment public health managers. |
| | • Ensure support and relevant training is available for public health leaders. |
| | • Embed addressing institutional racism within quality improvement planning and make it a key performance indicator for managers. |

### Regional mobilisation: local action

Clearly this body of work cannot be achieved by a handful of people; it requires a groundswell of support from the sector and beyond. The coalition leading this work is currently collecting the names of those interested in getting involved in the campaign and has been pleased by the response and offers to date. We would like to see Public Health Association branches around the country to contribute to the campaign. If we are going to be successful we believe this work needs to utilise our collective networks and resources to influence decisions makers and change agents inside and outside Crown agencies.

To support regional mobilisation work has commenced developing a resource that attempts to clarify institutional racism. It will define institutional racism and outline why it is important, how it operates, how to detect it and how to challenge it. It is hoped that a number of branches will take up the opportunity to host a training session on institutional racism to raise awareness and strengthen anti-racism capacity.

Our vision is the core coalition is the hub and a range of broadly co-ordinated activities are undertaken simultaneously across the country. For the politically inclined a project needs to be developed to gain cross-party political support for a major campaign to eradicate institutional racism across the public sector with a view to the forthcoming general election.

For those with international aspirations others have suggested it is timely that we utilise the reporting mechanisms of the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1966) to expose the racism within our sector. Others are ready to campaign for the upsizing of the Declaration of the Rights of Indigenous Peoples (United Nations, 2007) from a declaration to a convention so state parties are required to report in relation to it.

We have lots of idea, lots of passion and lots of commitment and welcome your contribution to this important work. Feedback is welcome.

**References**

Berridge, D., Cowan, L., Cumberland, T., Davys, A., McDowell, H., Morgan, J., . . . Wallis, P. (1984). *Institutional racism in the Department of Social Welfare*. Auckland, New Zealand: Department of Social Welfare.

Came, H. (2012). *Institutional racism and the dynamics of privilege in public health.* Unpublished doctorate, Waikato University, Hamilton, New Zealand. Retrieved from http://researchcommons.waikato.ac.nz/handle/10289/6397

Harris, R., Tobias, M., Jeffreys, M., Waldergrave, K., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine, 63*(6), 1428-1441. doi: 10.1016/j.socscimed.2006.04.009

Health Promotion Forum. (2000). TUHA-NZ: Treaty Understanding of Hauora in Aotearoa New Zealand. Auckland, New Zealand: Author.

Herewini, M., Wilson, R., & Peri, M. (1985). Maori Advisory Unit Report. Auckland, New Zealand: Department of Social Welfare.

Huygens, I. (2007). *Process of Pakeha change in response to the Treaty of Waitangi.* Doctoral dissertation, Waikato University, Hamilton, New Zealand. Retrieved from http://researchcommons.waikato.ac.nz/bitstream/10289/2589/1/thesis.pdf.txt

Jackson, M. (1988). *The Māori and the criminal justice system: He whaipānga hou: A new perspective*. Wellington, New Zealand: Department of Justice.

Jones, C. (2000). Levels of racism: A theoretical framework and a gardener's tale. *American Journal of Public Health, 90*(8), 1212-1215. doi: 10.2105/AJPH.90.8.1212

Jones, C. (2010). *Achieving health equity*. Paper presented at the Annual Public Health Association Conference: Tomorrow for Tomorrows People, Turangawaewae, New Zealand.

Kearns, R., Moewaka Barnes, H., & McCreanor, T. (2009). Placing racism in public health: A perspective from Aotearoa/New Zealand. *GeoJournal, 74*(123-129). doi: 10.1007/s10708-009-9261-1

Midgley, G. (2006). Systemic intervention for public health. *American Journal of Public Health, 96*(3), 466-472. doi: 10.2105/AJPH.2005.067660

Ministerial Advisory Committee on a Maori Perspective on Social Welfare. (1988). *Puao te ata tu (Day break)*. Wellington, New Zealand: Department of Social Welfare.

Ministry of Health. (2003). *Improving quality: A systems approach for the New Zealand health and disability sector*. Wellington, New Zealand: Author.

Ministry of Health. (2007). Whānau ora health impact assessment. Wellington, New Zealand: Author.

Nairn, M. (2002). *Programme on racism collected newsletters 1985-2002*. Auckland, New Zealand: Treaty Conference Publications Group.

Public Health Association. (2012). *Te ture whakaruruhau: Code of ethical principles for public health in Aotearoa New Zealand*. Wellington, New Zealand: Author.

Public Health Association. (September 2012). *Minutes of Annual General Meeting*. Author. Wellington, New Zealand.

Reid, P., & Robson, B. (2007). Understanding health inequities. In H. R. Robson B (Ed.), *Hauora Maori standards of health IV* (pp. 3-11). Wellington, New Zealand: Te Rōpū Rangahau Hauora A Eru Pomare.

Robson, B., & Harris, R. (2007). *Hauora: Maori standards of health 4. A study of the years 2000-2005*. Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare.

Salmond, G. (1986). Circular memorandum No.1986/70. Wellington, New Zealand: Department of Health.

Sheridan, N., Kenealy, T., Connolly, M., Mahony, F., Barber, A., Boyd, M. A., . . . Moffitt, A. (2011). Health equity in the New Zealand health system: A national survey. *International Journal for Equity in Health, 10*(1).

Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *Health equity assessment tool: A users guide*. Wellington, New Zealand: Ministry of Health.

Statistics New Zealand. (2013). New Zealand period life tables: 2010-12. Wellington, New Zealand: Author.

United Nations. (1966). International Convention on the Elimination of all Forms of Racial Discrimination Retrieved from http://www2.ohchr.org/english/law/cerd.htm

United Nations. (2007). *Declaration on the rights of indigenous peoples*. New York, NY: Author.

World Health Organization. (1986, November). Ottawa charter for health promotion *Proceedings of the 1st international conference on health promotion* Ottawa, Canada: World Health Organization.

Dr Heather Came is a seventh generation Pākehā New Zealander and a recent graduate at Waikato Management School where her research focused on institutional racism. She currently teaches health promotion, evaluation and community development at Auckland University of Technology.

Claire Doole Claire Doole is a senior lecturer at AUT University and an experienced nurse and community activist. She has learned more from her clients than she ever imagined. Claire is the tau iwi partner teaching Māori health and te Tiriti o Waitangi in practice in the undergraduate nursing programme.

Trevor Simpson (Tuhoe/ Ngati Awa) is Deputy Executive Director for the Health Promotion Forum of New Zealand. He also holds the portfolio for Māori Health Promotion Development.

Dr Nicole Coupe (Kai Tahu, Te Atiawa) is a kaupapa Māori epidemiologist working in Mental Health and Addictions.