Preprint version: Came, H., & Kidd, J. (2020). A critical te Tiriti analysis of the New Zealand cancer action plan 2019–2029. *Journal of Cancer Policy*, 26, 100252. https://doi.org/10.1016/j.jcpo.2020.100252

A Critical Tiriti o Waitangi analysis of the New Zealand Cancer Action Plan 2019-2029

Abstract

There are systemic health inequities, including around cancer between Māori (the Indigenous peoples of Aotearoa) and non-Māori. These inequities place a huge social, cultural, spiritual, emotional, and economic burden on Māori as they navigate the intergenerational legacies of colonisation.

The *New Zealand Cancer Action Plan 2019-2029* is one of the first major health policy documents published since the Waitangi Tribunal released the landmark WAI 2575 report. This report found widespread non-compliance of health policy in relation to *te Tiriti o Waitangi*. The New Zealand Ministry of Health have committed to addressing this non-compliance and proactively addressing ethnic health inequities.

This study applies a Critical *te Tiriti* Analysis over the Cancer Plan to review its *te Tiriti* compliance in a new political environment where *te Tiriti* compliance is a priority. The analysis involves a five-phase analysis from i) an initial orientation, ii) a close examination, iii) a determination, followed by iv) suggestions how to strengthen the policy and a v) Māori final word.

We rated the Cancer Plan as *fair* (level 2 of a 4 point scale) on *te Tiriti* compliance which was an improvement over the 2003 Cancer Strategy. Centring mātauranga Māori (Māori knowledge), kaupapa Māori (Māori philosophical approaches) and Māori public health would have strengthened the Plan. Given the consistent failure of the health system to uphold its te Tiriti responsibilities, the absence of detail makes it difficult for the Crown to be held to account.

Indigenous peoples across the world have a right to health. Tools such as Critical te Tiriti Analysis are one way to ensure governments are held to account for their performance.

Keywords: Cancer control, health inequities, Māori, policy analysis, Indigneous

Background

Globally, Indigenous peoples carry the greatest burden of cancer [1]. This is particularly evident in preventable cancers and those which are survivable with early diagnosis such as lung, bowel and breast cancers [2-4]. The failure of the New Zealand health system to prevent cancer amongst Māori and achieve equitable survival rates of those diagnosed is a major driver of ethnic health inequities [3, 5], and life expectancy differentials [6]. As cancer is the leading cause of death in Aotearoa it is critical that we see improved outcomes for Māori across the cancer continuum.

Unique to Aotearoa is *te Tiriti o Waitangi* (*te Tiriti*) a treaty negotiated between the British Crown and Māori in 1840. *Te Tiriti* (the Māori text) affirmed Māori tino rangatiratanga (absolute sovereignty). It also guaranteed Māori equal rights with British subjects, granted limited governance to the British over their own people and offered protection for religious freedoms. There is also the *Treaty of Waitangi* (the English version) a parallel document, within which it is often interpreted that Māori ceded their sovereignty.

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Successive governments have failed to uphold *te Tiriti* [7]. Legislation and health policy usually refers to *the Treaty* (English) rather than *te Tiriti* [8]. Matters are further complicated by the development of a series of reductionist Treaty principles [9]. Under international law *te Tiriti* is the definitive authoritative text.

The Waitangi Tribunal, an independent permanent commission of enquiry charged with investigating breaches of *te Tiriti* and *the Treaty*, is currently examining Crown action and inaction within the health sector. In the Tribunals' [10] stage one report on the health related claims WAI 2575 they found:

> The legislative and policy framework is insufficient in and of itself, and the Crown's renewed, specific commitments to improve Māori health are not enough to negate this insufficiency … We reiterate that the depth of inequity suffered by Māori, and particularly the fact that it has not measurably improved in the two decades since the framework was put in place, mean that the Crown's failures are very serious. (p161).

A recent analysis of the report identified five substantive recommendations for the health sector [11]: the adoption of *te Tiriti* compliant legislation and policy; recognition of extant tino rangatiratanga; strengthening accountability mechanisms; investment in Māori health; and embedding equity and anti-racism within the sector. Since the report's release senior Crown officials from the Ministry of Health have consistently made public statements about their commitment to addressing the recommendations of the report [12].

In preparation for stage two of the WAI 2575 hearings, a retrospective Critical *te Tiriti* Analysis (CTA) of the *New Zealand Cancer Control Strategy* [13] determined the Strategy contained little tangible connection to *te Tiriti* and recommended putting *te Tiriti* and tikanga (Māori protocols) front and centre in future cancer control policy [14]. Likewise, they advocated for strengthened Indigenous content and a stronger orientation to addressing health inequities.

The *New Zealand Cancer Action Plan* (NZCAP) 2019-2029 [15] was developed under what many might consider a progressive coalition government. It was released during a major review of the health sector [16] and after the Waitangi Tribunal [10] released their major report. Due to this timing and the burden of cancer on Māori communities, this action Plan is of enormous strategic importance. This study aims to critically examine the NZCAP for its *te Tiriti* compliance and will review any improvements in policy since 2003.

Method

CTA was developed by Came, O'Sullivan and McCreanor *[17]* based on their experience of giving evidence before the Waitangi Tribunal. As per other CTAs [14, 17, 18] we used a five-phase system. Phase one is an orientation looking at language, epistemology, priorities and engagement with *te Tiriti*. Phase two involves a close examination of the NZCAP against the five elements of *te Tiriti* – preamble, kāwanatanga, tino rangatiratanga, ōritetanga, wairuatanga. This involves examining the content of the policy but also the process of its development to the extent this is visible.

Phase three makes a determination of the policy compliance against a set of *te Tiriti* indicators (see Table 1). They are ranked as poor, fair, good or excellent [19]. Phase four is focussed on ideas to strengthen the reviewed policies while the fifth phase is a final overall Māori assessment.

Table 1: Critical *te Tiriti* Analysis indicators [17]

Preamble	Elements showing that *te Tiriti* is central and Māori are equal or lead parties in the policy processes.
Article 1	Mechanisms to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing, and evaluating the policy.
Article 2	Evidence of Māori values influencing the policy processes.
Article 3	Evidence of Māori exercising their citizenship as Māori in the policy.
Article 4	Acknowledgement of the importance of wairua, rongoā and wellbeing in the policy.

The authors are Māori and non-Māori critical scholars with lived experiences of the impact of cancer. We acknowledge the many lives that are lost prematurely to cancer in this country. We acknowledge the mana (prestige and authority) of those that contributed to, authored and signed off NZCAP. We recognise that our critique is entirely textual; it relates to what ended up on the page not the debate that occurred on the way or good intentions involved.

Results

Phase One: Orientation

The NZCAP affirms the special relationship between the Crown and Māori. Clear statements are made about the Crown's commitment to Māori and that Māori health is the responsibility of all.

> Responding to Māori health aspirations is a *Te Tiriti o Waitangi* obligation and achieving equity in health outcomes for Māori is a core focus of this Plan [15].

The Crown declared it will work in partnership with tangata whenua (Indigenous people of Aotearoa) and "support tangata whenua-led processes, actions and decision-making" (p9).

A section of the Plan is titled the *Treaty of Waitangi.* Subsequently in the text *te Tiriti o Waitangi* is rendered as the *Treaty*. Throughout the remainder of the body of the Plan the term *te Tiriti* is consistently used. Within the NZCAP [15] the authors claim the Ministry of Health and the Cancer Control Agency (CCA) aim to go beyond aligning their work to their *te Tiriti* obligations to "…enabling Māori to flourish and develop and lead their own goals for health and wellbeing". Explicit reference is made to the Ministry of Health's overarching Māori health strategy [20].

A welcome addition to the NZCAP is the introduction of te Reo Māori (Māori language) co-title *Te Mahere mō te Mate Pukupuku o Aotearoa*. The cover image is a positive depiction of an inter-generational Māori whānau (extended family) gardening together. Major headings throughout the document are translated into Te Reo and the Plan is opened with a mihi (acknowledgement) and a whakataukī (Māori proverb). Efforts to engage with Māori world views are visible across the Plan.

Phase Two: Close examination

Preamble and kāwanatanga

The *NZCAP* emphasises the need for strong leadership (pv), "strong governance, accountability and stewardship" (p11) of cancer services in Aotearoa. It intends to achieve this through the establishment of the CCA and a Cancer Control Agency Advisory Council who are responsible for continuously reviewing and assessing progress (p2).

The Plan explicitly notes the importance of prioritising Māori leadership at all levels (p17). It notes Hei Āhuru Mōwai (the National Māori Cancer Leadership) (p26) will work in partnership with the CCA. It is unclear how this partnership worked throughout the consultation and development phases of the NZCAP, or in the ongoing implementation, monitoring and evaluation of the plan.

Tino Rangatiratanga

Being (person and) whānau-centred is one of the overarching principles of NZCAP. This could align well with collective notions of wellbeing. However the catchcry of the Plan [15] as introduced by the then Minister of Health Hon. David Clarke is "every person, every time". In the standards of care (p55) section and the patient experience section (p56) of the Plan the narrative again reverts to an individual focus. These narratives reinforce the default Western world view of the health system. It is unclear how this enduring ideological tension between Indigenous collective perspectives and other views will be resolved.

The scholarly work of several Māori academics are cited within the Plan (Fiona Cram, Bridget Robson, Donna Cormack) but their ethnic specific scholarly analysis doesn't appear to be incorporated. The importance of growing and investing in kaupapa Māori research capacity is noted, however there is no explicit engagement with issues around Māori data sovereignty. This is no direction around ensuring all cancer research includes ethnic analysis. The importance of the Māori health workforce is emphasised and the need to build that workforce. Mention is also made of the need to strengthen cultural safety and cultural competencies across the entire workforce.

Ōritetanga

The policy authors claim this Plan is equity-led (p26) and they hope to achieve cancer survival equity by 2030. Inequities are described as unfair, unjust and avoidable and equity is one of the four overarching principles. The Plan signals that an equity-first methodology will be used to prioritise allocation of new resources and reallocate existing resources (p29) that will consider *te Tiriti* obligations (p14). The NZCAP [15] states:

> Given that Māori have the poorest overall health status in New Zealand and are significantly disadvantaged in terms of health inequities, it is essential that we ensure the rights and meet the needs of Māori people (p9)… Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes (p10).

In relation to equity for Māori, the Plan acknowledges that some "…areas are currently underserving some populations" (p10). This is framed as there are: "…challenges in accessing cancer services at all levels, particularly for Māori" (p20). This puts responsibility on Māori to access services rather than the system responding to Māori.

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The NZCAP identified the need to address "…all forms of racism" (p13). They propose to do this through a leadership and governance framework and strengthening the workforce (p27). This approach assumes that recruiting more Māori practitioners and strengthening cultural safety will address racism. Anti-racism is not addressed.

Prevention of cancer is identified as a key pathway to equity. The Plan acknowledges that "international best practice" does not always work for Māori (p35). Co-designing smoking cessation services is proposed with young Māori women, based on work already completed by the Ministry. The Plan does not substantially engage with Māori public health traditions or models such as *Te Pae Mahutonga* [21]. The Plan [15] reported that "Current approaches to cancer prevention and management inadequately address the needs of Māori" but the importance and expertise of Māori and iwi providers across the cancer continuum are only nominally acknowledged.

Alongside this equity narrative is a strong parallel claim that the NZCAP is for all New Zealanders (p1). Epidemiological data inconsistently included ethnic analysis. The Plan confirms that proposed screening programmes are assessed by the National Screening Advisory Committee against scientific evidence and an established criterion. It is unclear how Māori are involved as *te Tiriti* partners or how Māori values inform this process.

Wairuatanga

Central to the NZCAP is a mātauranga Māori plan that "...articulates priorities, actions and aspirational and achievable outcomes centred in Māori worldviews" (p28). The authors propose to develop this through co-design with diverse Māori communities. They acknowledge the importance of Māori models of wellbeing (p20) such as whānau ora and kaupapa Māori input across the Plan (p28). Rongoā is included within the Plan and the Ministry of Health [15] state wairuatanga is present in their work.

Significant quantitative data about (mainly Māori) people we have lost prematurely from cancer is presented without acknowledgement of their passing and their significance to whānau, hapū and iwi, indeed all of Aotearoa, at the outset of the Plan. A lived experience of cancer perspective is present in the Plan but it doesn't make explicit the importance of culture to hauora (wellbeing). Explicit reference is made to upholding the *Declaration on the Rights of Indigenous Peoples* [22] and particularly Article 24 which affirms the importance of traditional medicines.

Phase Three: Determination

The CTA determination was undertaken separately by both authors and a consensus determination was negotiated when there were points of difference. If the NZCAP was *te Tiriti* compliant it would be consistently scoring good and excellent ratings against the indicators. For indicators one and two the Plan affirms the relationship with Māori but the structural mechanisms to ensure Māori voice is not visible. Indicator three shows some engagement with Māori values, while indicator four is absent. Indicator five has some visibility but not woven consistently through.

Table 2: Assessment of NZDS against CTA indicators [17].

Indicators	**Poor**	**Fair**	**Good**	**Excellent**

1. Māori equal or lead partners in policy development		✓		
2. Mechanisms to ensure equitable Māori participation/ leadership		✓		
3. Evidence of inclusion of Māori values epistemologies, approaches and authority		✓		
4. Māori exercising their citizenship as Māori	✓			
5. Acknowledging importance wairua and rongoā		✓		

Phase Four: Strengthening practice

The Plan contains starting places for the development of improved practice in the areas of contextualised use of data, clear mechanisms in place for leadership and governance of cancer care, and adequate investment in Māori public health.

Kaupapa Māori epidemiology

Data about Māori health deficits underpin much of the Plan, but the principles of Indigenous data sovereignty [23] remain largely unacknowledged. This is particularly evident from the lack of context around the Māori statistics including how the inequities came into being and what they mean for whānau. The Plan does not attempt to be led by Māori values or health aspirations, but instead adopts a Western focus on individualised reporting of statistics and health equity.

Mātauranga Māori

The use of te reo Māori, the inclusion of Māori health equity as a discrete outcome (p 26) and consideration of Māori-specific features such as wairuatanga and rongoā suggest the involvement of Māori in the development of the Plan. However, no Māori input has been acknowledged, which means that readers cannot identify the whakapapa (genealogy) of the Plan. Māori come across as 'other' in this document, which is particularly problematic given the burden of disease.

Given that Māori cancer inequities have been researched and published for decades [24, 25], the Plan would have better met its obligations to *te Tiriti* to have centred Māori in its conceptualisation, writing and implementation. A lesser alternative to the ideal of a fully Māori-centred document would have been to work with a Māori advisory group that had the right of veto as a mechanism for exercising tino rangatiratanga.

Māori leadership in the cancer research field is well established and senior academics regularly publish kaupapa Māori findings [26-29]. Only a small sample of such papers are cited in the Plan minimising Māori expertise in this area. The call for improved Māori research capacity and capability (p 24) is made without recognising this existing leadership, thus giving the impression of a new field of research being promoted.

Māori public health

Public health is the sector that has the most potential for cancer prevention and early detection through planned and opportunistic screening, meeting psychosocial needs and supporting cancer and post-cancer care [27, 30]. The Plan includes a call for kaupapa Māori focused, community-level cancer prevention and management programmes (p 61). However, this area of the Plan is significantly under-developed.

The lack of engagement with the current level of mātauranga Māori about what works is a critical failing in the Plan. Instead of building on Indigenous knowledges, it presents the ‘problem’ of cancer inequities as though it is a fresh field of endeavour. As described above, whakapapa is a vital part of mātauranga Māori, which means that overlooking or ignoring existing Māori initiatives sends a message about their irrelevance to this Plan.

Rhetoric versus detail
The Plan does not appear to be Māori-led or demonstrate the power sharing you would expect given the Waitangi Tribunals’ WAI 2575 health report [10] or their WAI 1040 report [31] that ruled Māori never ceded sovereignty. Given the historic consistency of the Crown’s poor performance in relation to Māori health, without detail of what they are going to do differently, the NZCAP risks remaining rhetoric or even worse propaganda. Detail is required to develop accountability mechanisms for Crown actions and inactions in relation to *te Tiriti* compliance.

Conclusion

Phase Five: Māori final word

The whakatauākī (proverb) on page iv illustrates the key intent of this Plan. Tā Hēmi Hēnare is quoted as saying “*Kua tawhiti kē tō hāerenga mai kia kore e hāere tonu, he nui rawa āu mahi kia kore ai e mahi tonu*: you have come too far not to go further, you have done too much not to do more”. However, when taken within the context of the NZCAP, it appears to signal that cancer care in Aotearoa is on the right track and that we must push ahead with current efforts to see results. The history of *te Tiriti* health breaches, inequitable cancer treatment access and high morbidity and mortality all point to the need for a radical revision of cancer care.

We applaud the increased use of te reo Māori and some Māori health concepts in the Plan, but suggest that the effect will be inadequate unless mātauranga Māori, Māori models of health, and evidence of Māori success and achievement in the cancer care sector are centred. It is disheartening to read a new document that ‘intends’ to create a space for a Māori-focused plan at some point in the future. The view from the outside of the Plan is of a missed opportunity to transform cancer care.

While global efforts to address Indigenous health inequities may find some utility in the NZCAP in its current form, we propose that the development of such plans would be significantly strengthened by being led and shaped by Indigenous peoples and their unique approaches to wellbeing.

This Critical *te Tiriti* Analysis has demonstrated that, while the language and intent of the NZCAP is appreciably improved on the previous document, there is still a significant gap between the current document and one that would meet Crown obligations to *te Tiriti*.

Policy Summary

The burden of disease carried by Indigenous people’s globally is unacceptable. This paper utilises critical te Tiriti analysis to determine to what extent the New Zealand government has upheld its responsibilities to Māori within the recently released Cancer Control Plan. This form of analysis can be modified and used by other constituents to monitor the performance of their government policy makers. CTA involves a robust critique of the public policy being reviewed and offering suggestions how to strengthen the next reiteration of policy.

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Glossary

Māori	The Indigenous peoples of Aotearoa.
Te Tiriti o Waitangi	The Indigenous text of a treaty negotiated between Māori and the British in 1840.
Mātauranga Māori	Māori knowledge.
Kaupapa Māori	Māori philosophical approaches.
Aotearoa	Māori name for New Zealand.
Tino rangatiratanga	Absolute sovereignty.
Tikanga	Māori protocols.
Kāwanatanga	Governance.
Ōritetanga	Equity.
Wairuatanga	Spirituality.
Rongoā	Māori medicine.
Mana	Prestige and authority.
Tangata whenua	Indigenous people of the land Aotearoa.
Whānau	Extended family.
Mihi	Acknowledgement.
Whakataukī	Māori proverb.
Hauora	Wellbeing.
Whakapapa	Genealogy.