

TRANSFORMING INSTITUTIONAL RACISM IN HEALTHCARE MANAGEMENT IN AOTEAROA NEW ZEALAND

ABSTRACT

New Zealand has had stark inequalities in health outcomes between Māori and Non-Māori for decades. I argue that, at least in part, embedded institutional racism within the administration of the healthcare system may contribute to these outcomes. Drawing on both qualitative and quantitative evidence from those targeted by racism I provide an overview of how systemic racism manifests in the realms of public health policy making and funding practices. Based on this evidence and informed by previous studies of such racism, within public sector administration, I offer suggestions for Pākehā managers in relation to transforming and preventing institutional racism.

KEYWORDS: healthcare management, healthcare quality, accountability, health policy

“Available health statistics raise serious concerns that Māori are not receiving the standard of health services received by other groups in New Zealand. The Special Rapporteur encourages the Government to continue to work with whānau, iwi and Māori leaders to assess the causes of the discrepancy in health conditions...”(Anaya, 2011, February).

As emphasised by the UN Special Rapporteur, Anaya; something is going wrong in the health sector in Aotearoa which is resulting in poor health outcomes for Māori. Over and above the effects of socio-economic determinants of health, these ethnic disparities in health outcomes are well documented (Ministry of Health and University of Otago, 2006; Robson & Harris, 2007). I suggest a contributing element to these disparities, is institutional racism as enacted by Crown officials and managers in their routine administration of the health system. Informed by counter narratives from senior Māori managers within the sector and a survey of fifty six senior public health managers about their experiences of Crown officials this paper addresses the research questions: How does institutional racism manifest within public health policy making and funding practices and how might

it be transformed? These findings reveal quality assurance failings and a risk management issue for public sector managers but also an opportunity to strengthen efforts to detect and prevent such systemic discrimination.

IMPORTANCE OF TRANSFORMING INSTITUTIONAL RACISM

Evidence is increasingly being compiled to demonstrate the prevalence of racism within Aotearoa¹. This body of research reaffirms the findings of the landmark public sector reports into systemic racism within the public sector from the 1980s (see Berridge et al., 1984; Jackson, 1988; Ministerial Advisory Committee, 1988) and has led the Human Rights Commission (2011) to make addressing structural racism within the public sector a strategic priority. Informed by such studies and the writings of Jones (2001, 2003) I define institutional racism as differential access to material resources and power determined by race, which advantages one sector of the population while disadvantaging another. Institutional racism is thereby enabled through both action and inaction. Within the context of healthcare management I assert that as administrators of the healthcare system managers are responsible for their own professional practice and that of their staff.

Better (2008) contends inequitable access to resources, information and voice are facilitated through patterns of behaviour, procedures, practices and policies as manifest in social institutions. These social institutions are administered by managers who, within the New Zealand public sector, are entrusted to be fair, impartial, responsible and trustworthy in their practice (see State Services Commission, 2007) and to serve the interests of the entire population. Within the context of Aotearoa,

¹Studies have exposed racism within the housing sector (see Housing New Zealand, 2007; Māori Women's Housing Research Project, 1991; Robson & Harris, 2007), the employment sector Alexander, R., Genc, M., & Jaforullah, M. 2003. Maori disadvantage in the labour market. Dunedin, New Zealand: University of Otago, Sutherland, H., & Alexander, R. 2002. The occupational distribution of Maori 1997-2000, *Economic discussion papers*. Dunedin, New Zealand: Department of Economics, University of Otago., the justice system Fergusson, D., Swain-Campbell, N., & Horwood, J. 2003a. Arrests and convictions for cannabis related offences in a New Zealand birth cohort. *Drug and Alcohol Dependency*, 40(1): 56-63, Fergusson, D., Swain-Campbell, N., & Horwood, J. 2003b. Ethnicity and criminal convictions: Results of a 21-year longitudinal study. *Australia and New Zealand Journal of Criminology*, 43(3): 354-367. and the education system Reid, J. 2006. *Barriers to Maori student success at the University of Canterbury*. Unpublished Masters dissertation, Reid, J. 2006. *Barriers to Maori student success at the University of Canterbury*. Unpublished Masters dissertation, Reid, J. 2006. *Barriers to Maori student success at the University of Canterbury*. Unpublished Masters dissertation, Reid, J. 2006. *Barriers to Maori student success at the University of Canterbury*. Unpublished Masters dissertation, Te Puni Kōkiri. 2001. *Follow up review of the Accident Compensation Corporation's service delivery to Māori*. Wellington, New Zealand: Author..

Crown officials and managers are also expected to practice in a manner consistent with our founding document, *Te Tiriti o Waitangi*, as affirmed in a plethora of Crown documents and legislation including the New Zealand Public Health and Disability Act 2000.

Discrimination against Māori is in breach of the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) (UN, 1966) and the newly endorsed *International Declaration on the Rights of Indigenous Peoples* (UN, 2007)². Systemic discrimination within health administration also holds the potential to compromise the ‘right to health’ enjoyed by all New Zealanders; as embedded within international human rights instruments such as the *Universal Declaration on Human Rights* (see UN, 1948) and the *International Covenant on Economic, Social and Cultural Rights* (see UN, 1976).

From a management perspective, systemic racism within an organisation can be seen as a failure of both risk management and continuous quality improvement systems; and as both an ineffective and inefficient use of scarce resources. Likewise permitting an environment within which racism occurs is inconsistent with both codes of practice for public servants (State Services Commission, 2007) and codes of ethics for managers affiliated to the New Zealand Institute of Management (2011).

METHODOLOGY AND METHOD

I chose an activist scholarship framework (see Came, 2010; Hale, 2008) to examine how racism manifests within policy making and funding practices and how it might be transformed; influenced by my exposure to feminism (see Jones, 1992; Sudbury & Okazawa-Rey, 2009), Pākehā Tiriti work (see

² The United Nations concluding observations on the New Zealand government’s monitoring return in relation to ICERD, over the last thirty years, have consistently raised concerns about ethnic disparities in key areas of public sector activity CERD. 1974. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1976. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1979. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1981. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1984. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1987. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1990. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 1995. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 2002. Concluding observations of the CERD on New Zealand. Geneva, Switzerland: UN, CERD. 2007. Concluding observations of the CERD on New Zealand Geneva, Switzerland: UN .

Huygens, 2007; Margaret, 2002), kaupapa Māori theory (see Cram, McCreanor, Smith, Nairn, & Johnstone, 2006; Smith, 1999) and critical race theory (see Crenshaw, Gotanda, Peller, & Thomas, 1995). This critical paradigm draws on reflective knowledge about societal structures and power relations and their contribution to oppression and how this might be alleviated. In critical race theory terms, this study deliberately privileges the voices of those targeted by racism, which is juxtaposed against a desktop review of Crown narratives³. It does not purport to represent the complexity of Crown views and experiences and this is a limitation of this study and would be a worthy focus for future research.

At the heart of my research method was the establishment of a research whānau/ reference group composed of local Māori health leadership and a Pākehā crone. My work was grounded through my ongoing engagement and dual accountabilities to my research whānau and Pākehā Tiriti workers active in the struggle to support Māori tino rangatiratanga (sovereignty). Due to the complexity and sensitivities aroused when naming institutional racism I engaged with a variety of ethical frameworks. Specifically I worked with *Te Ara Tika* (Hudson, Milne, Reynolds, Russell, & Smith, 2010), *Ngā Kaiakatanga Hauora mō Aotearoa* (Health Promotion Forum, 1999), Health Research Council guidelines (2008) and the Waikato School of Management guidelines⁴. Critical to my ethical standpoint is my interest in exposing systemic racism embedded within systems, rather than exposing individuals.

My research interest in the first instance emerged from dialogue with Māori while I was employed within a unique Māori co-funding organisation that had a Treaty partnership agreement with two Crown agencies. This study is informed by my reflective research field notes from this co-funding experience and through a review of healthcare, management, historical and social change literature. I undertook a desktop review of Crown documents supplemented through the use of official information requests and dialogue with Crown officials. I engaged in intensive collaborative counter story telling processes with ten senior Māori managers about their experiences of public health policy

³ Albeit informed by dialogue with current and previous Crown officials.

⁴These requirements are outlined in the Waikato Management School website see <http://wms-soros.mngt.waikato.ac.nz/Research+Website/Research+Ethics/default.htm>

and funding processes; which are referenced within this text. The story tellers, many of whom have worked within and alongside Crown agencies for decades were sourced through my existing networks built up over eighteen years of professional experience within public health. They were all committed to improving the health sector to improve Māori health outcomes. I tested my preliminary findings by conducting a telephone survey of fifty six senior public health managers to bench-mark different groupings of providers' experiences of dealings with Crown officials. The survey cohort included both small and large public health providers, located within both rural and urban settings. Senior managers from Public Health Units (13), Primary Healthcare Organisations and/or Community Health Trusts (10), national and local Non-Governmental Organisations (19) and Māori health providers (14) all participated.

RESULTS

This study identified a range of sites of alleged racism within both policy making and funding practices, which are detailed in the following sub-sections.

Racism within Policy Making

“...policy and policy making are infused with dominant values, Eurocentric ideals, institutionalised biases, and vested interests. So deeply embedded are racialised notions about what is normal, desirable, or acceptable with respect to policy design, underlying assumptions, priorities and agenda, and process that policymakers are rarely aware of the systemic consequences that privilege some, disempower others”(Maaka & Fleras, 2009).

According to O'Sullivan (2007) historically Crown policy platforms have been both contrary to *Te Tiriti o Waitangi* and profoundly racist in their intent and/or outcomes. The Waitangi Tribunal (1986, 1996, 1998, 2011) who have produced extensive independent reports documenting this, continues to work with Māori towards unravelling the consequences of this historic racism. More recent manifestations of Crown racism are more subtle but continue to impact on Māori aspirations in relation to health. Based on the findings of this study figure one depicts how racism seems to

manifests within the policy cycle from conception, through its development. The data pertains broadly to public health policy making across a range of Crown entities.

Insert Figure 1 Here

Firstly within neo-colonial contexts, when indigenous peoples have become a minority, the imposition of Western-based majoritarian decision-making practices becomes a structural barrier for indigenous issues to be prioritised. Indeed O’Sullivan (2003, October) maintains majoritarian democracy in this context become a culturally-specific manifestation of historic racism. Counter storyteller, Berghan (2010 October 18) describes what this means in the context of a senior management team within a Crown agency; “I am the only Māori sitting around the table and there are ten of us. We are sitting up and arguing the prioritisation framework and I am arguing strongly that Māori health should be right up near the top because of poor Māori health outcomes. So we have the debate... you put it on the table, you go hard for it and in the end ...if you don’t have the numbers...” Another counter storyteller (see Māori Provider CEO, 2010 November 1), confirmed this behaviour in relation to health decision making at governance level.

Western bio-medical discourses and epidemiological analysis have formed the basis of government health policy within New Zealand for the last hundred years (Durie, 1994). Engaging in population level analysis ensures the interests of the majority are served. This ‘one size fits all’ approach does not necessarily address the complex health needs of a (minority) indigenous population who have often endured prolonged exposure to the determinants of ill health (Reid & Robson, 2007).

Indigenous tobacco use expert, Bradbrook (2010 October 4) maintains that tobacco control policy for instance, is often based on whatever is “best” global practice of the day regardless of whether such an approach works within an indigenous context. Such approaches dismiss Māori knowledge and evidence in both the structure and content of policy. Indeed a review of the citations across Ministry of Health public health policy identifies that only a handful of Māori academics being cited⁵; with the

⁵These include; Durie, Pere, Ratima, Dyal, Aspin, Reid, Te Rōpū Whāriki, Te Rau Matatini and Te Rōpū Hauora o Eru Pōmare.

bulk of those being to a single (albeit influential) publication. This limitation is compounded when policy is primarily peer reviewed by international reviewers with no transparent external indigenous review process⁶.

Although cultural competency is a requirement for most working within the health sector, as outlined within the Health Practitioners Competence Assurance Act 2003, these requirements do not apply to health policy makers or managers. Many counter storytellers expressed concerns about what they observed as the mono-cultural practice of policy makers, which were condoned by both managers and governance bodies. Kuraia (2010 September 22) maintains health policy typically reflects the dominant racist discourse that “Māori aren’t as good as Pākehā”. This she maintains is reflected in policy decisions around problem definition, sourcing evidence and prioritising actions, thereby institutionalising the racism. This cultural blindness results in policy uncritically perpetuating and universalising western values and solutions.

Well planned consultation is a powerful tool to test assumptions and produce workable policy solutions. Consultation in some instance is a legislative requirement and often features as a core element within Māori responsiveness frameworks. Many counter storytellers had invested considerable time and resources engaged with Crown consultation processes. A senior Māori executive (2010 November 7) explains a typical encounter: “In most cases there was always a belated approach to Māori and always plausible but downright stupid excuses: of lack of time; not enough time to get a turnaround; the Ministry was putting it upon us; we put in what we thought; we always intended to engage with Māori but didn’t quite get around to it”. When and if consultation happens, counter storytellers reported it occurred late into the process and the input they provided tended not to be visible in the final policy document. In addition tabled questions during consultation often remained unanswered by Crown officials.

⁶The exception being the utilisation of Durie to peer review the *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand/Aotearoa* Ministry of Health. 2002. Building on strengths: A new approach to promoting mental health in New Zealand/Aotearoa. Wellington, New Zealand: Author..

Once drafted policy then progresses through layers of Crown decision-makers towards formal sign-off. For central government health policy this can involve going through the senior management team within Ministry of Health, through Treasury, the Crown law office and through Cabinet. Berghan (2010 November 7) asserts that it is through this process that the Māori specific content, which he maintains is all deemed political sensitive, gets modified to make it acceptable to mainstream. He illustrates this point through the example of his involvement in a Crown reference group the; “...strategy went through seventeen iterations; it started off as a really wonderful product which was crafted by people who knew their stuff ... it had to be approved by non-Māori... most of it got cut out, so we got this... very safe version... But essentially it missed out a whole lot of the key stuff we wanted, which they saw as being problematic... it is the perfect illustration of the stuff that Māori go through which does not have institutional racism written across it but actually when you delve down and look through it all, and across all the hoops, it is a classic example of what goes on”.

Racism within Funding and Planning Practices

Once policy is developed Crown officials then face the challenge of contracting providers to deliver health services. The bulk of public health funding continues to be administered through the Ministry of Health although District Health Boards also undertake some public health contracting. These decisions are made within a context of rationing of health services and concerns from Māori academics such as Robson and Reid (2007) about unmet Māori health needs. Figure two shows how institutional racism and privilege seem to manifest in relation to Crown funding practices.

Insert Figure 2 here

The starting point of this cycle is a set of historical funding allocations which committed the bulk of public health investment into Non-Governmental Organisation and Public Health Units. These allocations principally occurred before Māori providers were developed and have not been reviewed or re-tendered since to confirm they are the most appropriate providers; as would be consistent with Crown procurement policy (The Treasury, 2009). Compounding this situation a senior Crown official

(2011 April 29) confirmed that their Crown agency didn't have the resources to monitor mainstream providers' service delivery to Māori. It was unclear from this study how prevalent this failure to monitor was.

For the last two decades the *Public Health Service Handbook* (Ministry of Health, 2010) has been the foundation document for the purchasing of public health services. As per much public health policy it has a significant (mono-cultural) bio-medical focus and is a cumbersome framework for an integrated Māori public health service. Māori health providers (see Te Tai Tokerau MAPO Trust et al., 2009, May) have over time advocated for the significant reorientation of this document and the inclusion of a kaupapa Māori specification within the collection. This position has been reinforced by utilising the historic example of the 1918 influenza pandemic (Rice, 1988) when generic approaches were used to attempt to reach Māori communities with devastating disparities in mortality.

Relationships can ease or hamper contract negotiation processes and experiences of contract monitoring can enhance or hinder effective service delivery. Through my provider survey, Māori providers consistently reported they had limited access to both DHB and Ministry funders in contrast to the experiences of other types of providers. This limited access is cumulatively reflected in figure three; which demonstrates the inequitable representation of groupings of providers on funder-led steering and advisory groups. Lack of access also suggests less influence.

Insert Figure 3 here

Inconsistencies in practice were also present across a range of Crown funding activities (Came, 2011). Māori providers reported shorter contract timeframes than other providers⁷ and proportionally higher compliance costs⁸ in their dealings with the Crown. Although none of the participating Māori providers had been performance managed by funders they collectively reported higher levels of

⁷ 64% of Māori providers had one year contracts in contrast to less than 25% for other groupings of public health providers. Likewise 28% of Māori providers had three year contracts compared to over 60% of NGO and PHU providers.

⁸ 64% of Māori providers reported burdensome compliance costs in contrast to under 30% of other groups of public health providers.

external auditing⁹ than other providers. Māori providers were less likely to gain access to annual cost of living adjustments¹⁰ on their contracts and reported less access to discretionary and one-off funding¹¹ than other providers. This pattern of differential treatment was also consistently raised through counter narratives and I suggest it is a strong indication of the presence of institutional racism.

I maintain these practice inconsistencies and uneven treatment of Māori health providers through historic and contemporary funding processes seems to represent a systemic failure of quality assurances processes, risk management systems and human resource practices. I posit that those managers administering the health sector should detect and address patterns of bias. Ultimately this failure of leadership is a collective one of public sector management.

DISCUSSION

“I refuse to accept the idea that man is mere flotsam and jetsam in the river of life, unable to influence the unfolding events which surround him. I refuse to accept the view that mankind is so tragically bound to the starless midnight of racism and war that the bright daybreak of peace and brotherhood can never become a reality”(King, 2002).

Good intentions do not prevent institutional racism; rather I maintain it requires personal and professional courage. Doing something risks not being effective but doing nothing inevitably perpetuates and supports a system that continues to disadvantage Māori. We all have different resources at our disposal but, I suggest Pākehā managers can act within their individual spheres of influence to transform racism.

At a structural level I suggest the most effective way to address institutional racism against indigenous peoples within a colonial context is to enter into a process of decolonisation with the clear purpose of

⁹ 60% of both Māori and PHU providers reported been audited 2-5 times in the last five years. Additionally 13% of Māori providers reported been audited more than five times in the last five years.

¹⁰ Over 70% of Māori and NGO providers reported never or occasionally accessing cost of living adjustments; compared to 53% of PHUs reporting always accessing it.

¹¹ Only Māori and NGO providers reported never or rarely accessing discretionary funding. PHO and PHUs accessed this funding either occasionally or often.

restoring indigenous sovereignty (Jackson, 1989). Within Aotearoa we have Te Tiriti as an imperative to sanction this transition. Examples such as the transition in South Africa from their racist apartheid regime are powerful reminders that anything is possible (Tutu, 1994). Central to such a transformation is historical redress and resource redistribution to minimise the structural advantages gained by white people through historical racism. Treaty settlements have been central to such processes in Aotearoa (Love, 2001).

The sites of racism presented within this paper are conveniently also sites for anti-racism interventions and there are practical things that can be done to minimise, reduce and eliminate racism that can be actioned immediately. Within the context of policy making, consideration needs to be given to what decision-making and prioritisation process are utilised and how Māori are involved in those processes without being structurally disadvantaged by majoritarian decision-making. Prioritisation processes need to be consistently and robustly applied. Māori world views need to be embedded within the structure of policy and must address the needs of the entire population. I suggest this policy must also be tailored to meet the needs of Māori.

Those recruited to develop policy must be culturally competent and those already engaged within the system need access to relevant training to secure these essential competencies. The sourcing of cultural competency standards for Crown officials as applicable for health professionals could go some way to enabling this. Whanaungatanga (relationship building) is critical to any successful consultation process with Māori (Ministerial Advisory Committee, 1988). Successful consultation requires engagement with Māori leadership and consideration should be given to resource Māori for fulfilling this valuable role for Crown agencies. Policy sign-off processes need to engage Māori throughout to address the dilution of Māori content within policy. Existing tools such as the *Whānau Ora Impact Assessment Tool* (Ministry of Health, 2007), when consistently applied, could serve to prevent the development of mono-cultural policy.

Within the context of funding practices Crown officials need to be even-handed in their relationships with providers and in the distribution of information and resources. A strengthened and transparent

communication strategy with the public health sector would go some way to achieving this. Greater care needs to be taken in selecting representatives for funder led steering and advisory groups so groups of providers have even representation. The *Public Health Service Handbook* (Ministry of Health, 2010) needs to be revised in consultation with Māori providers before it is transferred to the National Service Framework Library to broaden out its focus. Historic public health funding allocations should be reviewed and retendered in line with Crown procurement practices.

In relation to the mechanics of contracting, providers should have access to equitable contract terms and monitoring, auditing and compliance costs should be proportional to contract size. Providers should be able to expect a consistent approach to contract negotiations across providers and in terms of financial reporting requirements, access to cost of living adjustments and to discretionary funding. Greater transparency around all of these requirements and functions could support efforts to prevent and transform racism within these practices as modelled within the English response to the Lawrence Inquiry (Macpherson, 1999) into racism within the police force.

CONCLUSION

The public health system in Aotearoa is currently failing Māori (Robson & Harris, 2007). A range of ethical and pragmatic issues arise for public sector management who are charged with administering the system. The current empirical study isolated a range of sites where racism can be identified across Crown policy making and funding practices. The health sector needs to prioritise developing inclusive policy that normalises Māori world views and addresses the complex health needs of Māori. Likewise Crown operational protocols and practices need to be strengthened, applied consistently and monitoring effectively through robust quality assurance processes and motivated line management. Crown agencies should be able to detect and address systemic racism through their routine administration of the public service; they are after all entrusted and resourced to do this important work on behalf of all New Zealanders. Senior management teams need to be held accountable for rectifying this situation. However the responsibility for transforming and preventing such racism is a shared one; of both an engaged civil society, and vigilant leadership from public sector management.

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Figure 1: Racism within the Policy Cycle.

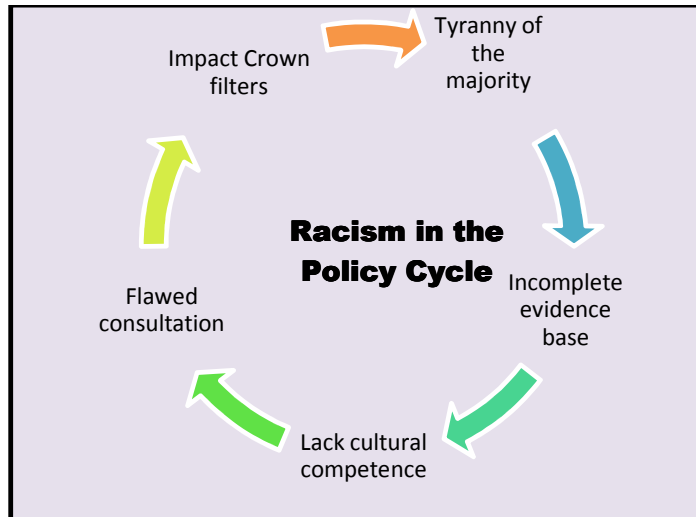


Figure 2: Racism in Funding Practices

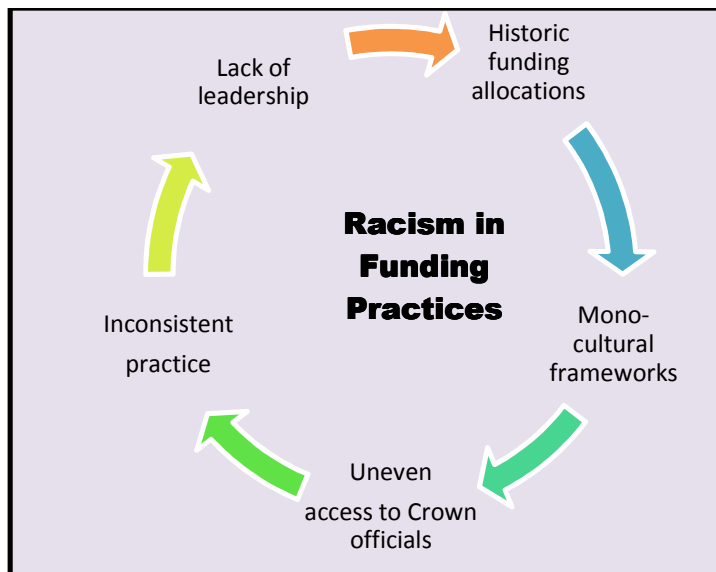


Figure 3: Representation on DHB and Ministry Steering and Advisory Groups

