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Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand

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ABSTRACT

Māori and Pasifika populations in New Zealand experience poorer health outcomes than other New Zealanders. These inequalities are a deeply entrenched injustice. This qualitative study explores the experiences of six Māori and Pasifika leaders on health policy-making advisory committees. All had extensive experience in the health system. They were recruited, provided semi-structured interviews, the data coded, and a thematic analysis undertaken. Our findings show that inequalities in the health system are reproduced in advisory committees. Participants noted their knowledge and interests were devalued and they experienced racism and tokenistic engagement. Some indicated it took considerable effort to establish credibility, be heard, have impact, and navigate advisory meetings, but even then their inputs were marginalised. Health policy advisory committees need deeper engagement and more genuine recognition of Māori and Pasifika knowledge. Māori and Pasifika leaders have constructive solutions for eliminating health inequities that could benefit all New Zealanders.

Introduction

Aotearoa New Zealand has a long-term population health trajectory that is characterised by deep seated health inequities. Māori (indigenous) and Pasifika (people with genealogical connections to Pacific Island) populations in New Zealand carry the highest burden of disease (Robson and Harris 2007; Marriott and Sim 2014) while the majority, Pākehā (settler peoples) enjoy relatively good health (Moewaka Barnes et al. 2014). Historically these differences arise from colonial policies and practices (Ballara 1986; Walker 1990; Spoonley et al. 2004) that stripped Māori people of their rights, property, infrastructures, institutions and sovereignty (Smith 2012). Likewise, Pasifika peoples have been consistently marginalised by the colonial regime since their arrivals via immigration began in the 1950s (Anae et al. 2015).

In a contemporary context some of these inequities are the result of uneven access to the determinants of health, while others are impacted by lifestyles that reflect the intergenerational impact of colonisation (Theodore et al. 2015). Starfield (2011) argued that some of this inequity is generated through the administration of the health system; through systems, processes and policies. This paper is directed toward illuminating how inequality is played out in health policy development through advisory groups which, ironically, were established to address inequality.

The number of health advisory groups is often fluid changing with each set of health reforms and new governments. Generally there are some high level semi-permanent committees which people are appointed for a set term connected to central government or district health boards (DHB). There are also more short-term committees called together to develop a particular health policy or strategy. Generally there is usually one or sometimes two Māori and/or Pasifika committee members unless it is an ethnic specific advisory board.

Under *te Tiriti o Waitangi*, the founding treaty of the colonial state of Aotearoa New Zealand, Māori were promised the protection of their health as a taonga (treasure) (Buetow and Coster 2001). The United Nations (2007) *Declaration on the Rights of Indigenous People* and the *Convention on the Elimination of All Forms of Racial Discrimination* (UN 1966) also offers protection in relation to the right to health. Similarly, the *New Zealand Public Health and Disability Act 2000* requires the health sector to work towards eliminating health inequities. Reinforcing this a report by Treasury (2004) concluded that Crown Ministers needed to place the highest priority on initiatives most likely to improve outcomes for Māori and Pasifika populations. They maintained particularly in the long-term, policies would be more successful if they were designed, developed and implemented by Māori and Pasifika peoples.

Public policy provides pathways for government to enact and pursue a political agenda via diverse mechanisms for rationalising and distributing public resources. The prioritisation and framing of policy is inherently political, with such arrangements precluding some options while privileging others (Borell et al. 2009). Shore and Wright (1997, p. 8) argued the ' … political nature of policy is disguised by the neutral, legal-rational idioms in which they are portrayed'. Fischer (1995) maintained policy-makers wield considerable power, since they determine whose values and beliefs underpin the work, the solutions generated, and specific goals. In various ways, the use of advisory or reference groups to inform policy development can moderate, or even shape, the form and application of policy. However, as our study will show such influence is far from assured.

Came (2014) has identified five forms of racism within health policy making. The first is 'the tyranny of the majority'–how 'democratic' decisions are made and who makes then in relation to setting the policy agenda in Aotearoa. A second strand of racism arises from the privileging of biomedical Western evidence over Indigenous knowledge. Moewaka Barnes (2009) asserts that government institutions (including science as an epistemological practice) are not culturally neutral in their appraisal of evidence in the formation of policy. The third influence is the variable cultural and political values and competencies of government officials writing and reviewing policy. The fourth problem is the consultation process pursued during the development of policy, where the wrong questions are often asked of the wrong people in the wrong timeframes. Finally the fifth form of racism is evident within the organisational sign-off process which is frequently political risk-

averse and works to mask, or eliminate, Māori and Pasifika content. Implicit across these sites is the marginalising of Māori and Pasifika voices through health advisory groups.

The authors for this paper are passionate about health equity and are activist scholars; two have Māori whakapapa (genealogy) and two are Pākehā. This paper addresses a gap in the literature relating to the experiences of Māori and Pasifika leaders within government health policy advisory groups. It seeks to explore to how racism manifests in health advisory groups? Qualitative data was collected through key informant interviews with Māori and Pasifika health leaders who have extensive track records within government policy advisory groups. The study suggests more work needs to be done to make advisory groups less tokenistic and more culturally and politically responsive to Māori and Pasifika participants so that their contributions can be both incorporated into policy in a mana enhancing way.

Method

Participants were secured through purposive sampling within the professional networks of the authors. Key informant interviews were undertaken from November 2016 to February 2017. Six Māori and Pasifika public health leaders, with over a 100 years of collective experience in public health, were interviewed. Their contributions drew on their experience spanned several different governments. Rangi, Samoa and Erina had dual Māori and Pasifika whakapapa (genealogy), Nikora and Leona were Māori, and Masina was Pasifika. There was a mixture of genders involved and participants were in their 40s through to their 60s. Note pseudonyms are used in this paper.

The participants had been in a multiplicity of Ministry of Health and district health board advisory and steering groups. Some had been part of such groups for 20 plus years, others around 10 years. Sometimes they were the only Māori or Pasifika members of the group, other times, 20% of the membership, sometimes 50%. Some participants had been on dedicated Māori or Pasifika policy advisory bodies.

The interviews were conducted either face-to-face or by telephone and were carried out in an hour-long, open-ended format. Participants were asked about their involvement in advisory groups and particularly around issues relating to Māori and Pasifika representation in advisory groups, cultural safety, influence on policy, use of equity tools, evidence and racism.

Audio-recorded data was examined using Braun and Clarke's (2006) steps of inductive thematic analysis as a way of categorising the key patterns in the broader discourse. Two authors independently familiarised themselves with the interviews then generated and populated codes. The codes were used to group data excerpts to common themes and track connections among themes. Discursive analysis of pattern and variation in the thematic data were used to define and name themes and to guide the descriptions that follow.

Ethics approval for the study was obtained from the Auckland University of Technology Ethics Committee (No. 16/377) and funding was obtained through the Auckland University of Technology School of Public Health and Psychosocial Health.

Results

The broad themes from the interviews were (i) navigating the room; (ii) the battle of evidence; (iii) working with government officials; (iv) suspicions of tokenism, and (v) witnessing and experiencing racism.

Navigating the room

All participants acknowledged the strategic importance of advisory group work. However, despite some participants being decades into advisory roles, they recognised such work was frequently difficult and frustrating. When starting out in government advisory groups, some leaders recalled feeling daunted and a little unsafe in being a solitary or minority voice. With experience came more confidence and some informants reported becoming more vocal.

Several of the female leaders used the opportunity of whanaungatanga (actively building relationships) at the beginning of a meeting, to table their cultural, clinical, and professional credentials. They believed this improved their chances of being taken seriously. Masina explains;

> I do speak up about my experience because I don't want them to think I've just been plucked in as a brown girl or woman.

In preparing for meetings, participants would identify who was in the room, and then focus on the material and context, while also attending to the mundane details of negotiating for accurate minutes. Masina explains you are 'always looking for who is the driver here? How can we get shift?' She noted the policy language frequently changes so that sometimes for example, the *Treaty of Waitangi* is a significant consideration in the work, while at other times it is absent or neglected.

The environment in the room was not always experienced as supportive. Several participants noted their contributions were often not recorded in minutes. Masina stated:

> When I say something, I don't know if it's me and the way that I speak or my accent or something. I look around the room and often people … have this kind of stunned mullet look. Like, what is she going on about?

A number of informants noted they 'naturally sought strength and solidarity from other minorities'. Practically this meant Māori and Pasifika members of a committee would co-operate within meetings. Sometimes this collectivism was negotiated prior to meeting, at other times it was more ad hoc. Pasifika leaders were happy to stand in solidarity with Māori, but as Samoa confirmed, they deferred to Māori recognising that Pasifika peoples were not tangata whenua (indigenous to New Zealand).

Some contributors acknowledged that they were sometimes emotionally distressed by the processes and content of meetings. Samoa noted there was lack of respect within some meetings, recalling people talking over her, and arrogance from her peers. At times, Samoa had to resort to putting her hand up and physically standing up to be heard. She had raised concerns about behaviour directly with the chair of a committee. Similarly, after exhausting other means, Nikora made a complaint to highlight disagreement with a process and was prepared to escalate it until heard.

Nikora recognised she felt angry at not being heard. Other participants named these experiences as racism. Nikora encouraged prospective advisory group members to do whatever helps you be 'loud and proud and brown'. Samoa advocated for the 'three c's– courage, credentials and credibility'–as the secret to being heard. She deliberately altered the tone and volume of her voice to be heard more effectively.

Most informants had a clear focus on the kaupapa (mission) of long-term outcomes for Māori and Pasifika communities. In the absence of leadership from government officials, Leona explains

> We don't sit and wait to see when the crumbs will come. You know, we're proactive. We're looking at the ways in which we can do things better … We will go directly to the Minister.

Rangi reported that over time he has grown intolerant of the absence of authentic support for Māori health and that as a result he was prepared to use his seniority in order to be heard. He expected high performance from his colleagues and was 'focussed on achieving better health outcomes for our [Māori] people'. He maintained

> You can say whatever you like in a meeting or discussion but if it's not contributing to better outcomes for Māori people, then you know, it's just a pointless conversation.

The battle of evidence

In terms of evidence Nikora maintained government officials '… drew on everything that was Western, epidemiological, published in great big fat journals that the world thinks are wonderful'. Several informants shared her concern about the strong reliance on evidence from the global North, the assumed 'gold standard' and 'best practice' perceived as originating there. Rangi stressed for Māori these western approaches have consistently delivered inequitable outcomes. He warned that 'until our people value Māori intelligence, nobody else will … which means we'll never have a system that achieves health equity'. He linked the devaluing of Māori knowledge to colonisation.

Participants noted Pākehā seemed to assume they had expert knowledge, which was inherently superior to what they the perceived as anecdotal evidence from Māori. Nikora observed Māori academic contributions were routinely questioned more vigorously in terms of the validity of the research compared with other academic work. Nikora explained how this denial of Māori knowledge played out;

> … they would write a whole lot more based on what the Pākehā (white) researchers were saying. And because they probably were not understanding what Māori were saying, they didn't write it down, so it didn't get heard.

Erina was disappointed at the quality of the Māori and Pasifika evidence used in strategies. She often felt the evidence enabled a deficit discourse against Pasifika and Māori. Erina wanted to see research that showed positive understandings of her people and culture highlighted. She noted policy analysts 'did not know about key studies' such as the Pacific Island Families Study and likewise, they seemed unable to complete a comprehensive literature review inclusive of Māori and Pasifika research.

In a practical sense, this meant Erina did not see herself, her aiga (family), or her people in strategy documents. For example, a committee she was on was reviewing some infographics that depicted a (white heterosexual) nuclear family–mother, father and two children. She explains:

> It was myself actually and one of the Māori people who raised the idea that for Pacific people that can be quite different. You can have ten plus people living in the same household. You could have your parents and your other parents who are [actually] an aunty and uncle … they really struggled with that concept and how to fit it into their [Western] framework.

Several participants observed a reluctance to examine the determinants of health disparities in ways that could strengthen the strategies. Leona explained,

They don't understand where the deficits have come from … where we want to see things at the end and how we want to get there.

Nikora advocated that health policy needs to:

deal with institutional racism, deal with poverty, deal with all those things that are macro economical … those strategies are fluffing around the edges and keeping people in work. Deal with the big stuff. That will make the difference.

Overall there was a view that the knowledge of policy-makers was biased, incomplete and inadequate to inform the development of policy that could eliminate disparities.

Working with government officials

Erina drew attention to the constant turnover of staff within government agencies, while others observed the high proportion of officials that are new migrants to New Zealand. Rangi reported being in groups with people 'who know absolutely nothing about the topic'. He felt this lack of context and background knowledge was a barrier and disenabling to processes and outcomes.

Rangi further observed that government officials had their own [cultural and political] 'filters and biases that they use to assess and make decisions'. He conceded government officials have to manage 'the politics of a prevailing Minister or Ministers' and that this meant what was developed 'might not be as effective as it could be and can lead to greater inequity'.

Leona maintained some government officials had been subsumed by the 'big bureaucracy of government'. She described them as the 'smiling assassins' to signal their tendency to mimic what they hear. Nikora asserted that often government officials simply didn't understand Māori contributions. Masina echoed these concerns noting

When you do talk, you almost have to, with everything you say, you have to give them a little bit of a picture.

The scarcity of Māori policy-makers was viewed as a problem by several contributors who felt more Māori policy analysts needed to be trained. Rangi highlighted how this was compounded by the wider absence of effective Māori leadership in influential leadership positions within the sector. Leona recognised there were allies within government agencies with good intentions. These allies were sometimes Māori.

Several participants reflected on the importance of who was invited to meetings. Masina noted that if senior government officials were not at the table, it could undermine a process and diminish its mana (prestige). Leona noted:

you know when the Chief Executive Officer is at the table that decisions can be made. You really need the top two or three tiers, not fourth and fifth tier management from Crown [government] agencies.

In a strategic sense Leona noted there is power in the possibilities of the current Waitangi Tribunal settlement and reconciliation process. Through this process iwi (tribes) can take the government to a permanent commission of enquiry to investigate historic and contemporary breaches of te Tiriti. The current health-related claims (Isaac 2016) represent a unique moment to strengthen the position of Māori as Treaty partners rather than end-users of health services.

Suspicions of tokenism

For Samoa, good policy building requires authentic engagement and functional relationships, yet this was not her experience of being involved in advisory groups. Erina was concerned that at times the advisory committee was there to create an impression of inclusivity rather than have substantive input into policy. She explains

> … they just brought it to us and want us to say, yeah that's excellent, do it, kind of thing rather than, yeah, working with us from the start, what are some good ideas.

Erina perceived the engagement of kaumātua as only ceremonial, since after they opened the meeting they then stepped back. A kaumātua is a respected elder with particular cultural expertise. They contribute to important hui (gatherings), sometimes work with organisations and advisory groups. Often they lead tikanga (cultural protocols and customs).

Nikora observed the kaumātua:

> … was always there which was always nice but he was there more just to make the day right [tika], than he was to make sure that there was a stronger Māori voice … It was a bit token … If he is just there to bless the kai [food] I see that as racism.

She welcomed deeper engagement with tikanga and suggested advisory groups could meet at marae (Māori meeting places) and that participants could bring whānau tautoko (family support) to the meetings.

Witnessing and experiencing racism

Most participants disclosed witnessing and experiencing behaviour consistent with racism–that is patterns and practices of disadvantage and or marginalisation. Some informants named it 'covert', 'sophisticated' or 'institutional' racism. Leona observed

> The politeness is very, very overt. Because it's so sophisticated and people get bloody hoodwinked on that, and our own do.

Specific examples shared included a health equity champion that didn't want anything to do with Māori health, and a proposed breast screening programme that was going to target Māori women through a mosque, even though Māori make up a very small percentage of people attending mosques.

Leona raised serious concerns about the credibility of some DHB advisory committees. She has witnessed their failure to follow correct procurement processes and queried whether DHBs, that consistently run at deficit, can credibly oversee contracting and funding processes with others. She shared the example of health funding that had been retendered as a part of a sector-wide review. An analyses of disease burden and ability to access community was carried out and contracts were awarded through a competitive process. Then the DHB's own provider was given additional funding without having to pass through the same scrutiny.

Discussion

We found very little literature on the use or effectiveness of indigenous or minority representation on policy development advisory committees in the international setting. It is

not clear whether such mechanisms are used elsewhere although there is some evidence of efforts to consult in relation to age and gender. It appears that Aotearoa presents an unusual degree of interest and commitment to such approaches but even here there is little in the way of academic study of the implications of this orientation. The authors maintain Māori involvement is critical for the government to fulfil their te Tiriti o Waitangi obligations and prudent with Pasifika to strengthen the cultural relevance of policy.

Māori and Pasifika health leaders involved in such work interviewed for this study reported variable success navigating Crown government advisory groups and influencing health policy and funding decisions. Accounts of processes and activities of advisory groups suggest that as a setting they can be uncomfortable and emotionally distressing. To be effective and to be heard in such groups required participants to be forthright, resourceful and tenacious. There may be merit in a dual approach having ethnic specific advisory groups, as well as integrated advisory groups representing all stakeholders. We found racism was often normalised within policy processes. Further, government Crown officials, as hosts of advisory groups, could take greater responsibility to embrace more culturally inclusive processes–from how meetings are chaired through to what gets recorded. The onus should not fall exclusively on Māori and Pasifika leaders to prepare for these cultural exchanges.

The unrealised opportunity of developing and improving health policy through the advisory group process could be part of a deeper, and ongoing, strategic engagement between Māori and Pasifika communities and the government. The contributions of kaumātua through appropriate application of tikanga can be positive, but some of the participants experienced it as tokenistic and a barrier to authentic and respectful sharing of their expertise and mātauranga (knowledge). Establishing trust, which is critical to constructive engagement, requires mutual respect and is enriched by a shared vision. Māori as Treaty partners should be able to expect high levels of cultural competencies from government officials and staff recruitment should target these competencies, or existing staff supported to develop them.

The leaders reported Māori and Pasifika knowledge and expertise was frequently ignored, debated, contested or perceived as unworthy or invalid. It is unclear whether this blockage arises from unconscious bias (Blank et al. 2016), and the extent to which it is a reflection of inter-personal, societal or institutional racism (Moewaka Barnes et al. 2013). What is clear is this neglect of grounded knowledge is in direct contrast to the rhetoric of government policy documents that affirm the importance of Māori and Pasifika led-solutions and expertise.

This study highlights the determination and commitment of Māori and Pasifika leaders to remain focused on health outcomes and strategically engaged with the government. Yet more work needs to be done before Māori and Pasifika realities are no longer marginal in the context of health policy. Western paradigms continue to prevail. Many participants shared their dissatisfaction with the policy documents they had contributed to. Too often agreements reached in the working groups change. The post-committee (political) organisational sign-off, can shift the framing and orientation of policy and undermine gains negotiated.

As well as cultural competencies, government officials and agencies need to be equipped with Treaty and intercultural competencies that facilitate partnership approaches rather than conventional stakeholder relations. This requires power to be shared (Ramsden 2002) in terms of decision-making, prioritisation, framing and shaping of meaning (Lukes 2005).

It would be useful for government officials to engage in the rich literatures of cultural safety, cultural competencies and anti-racism praxis so that they are prepared for this.

When committees and advisory groups engage with Māori and Pasifika leaders there is a responsibility to act on the advice provided. These leaders are a valuable resource whose time and skills could be used elsewhere to support their communities. The leaders interviewed had mana and agency; they were knowledgeable experts in their field, with clinical, cultural and community expertise. Inviting these leaders to engage in policy making is a good first step, however the opportunity to include this expertise to address Treaty obligations and inequalities was clearly missed.

Conclusion

Māori and Pasifika leaders are committed to contributing and developing health policy that works for Māori and Pasifika communities. Yet, the leaders had mixed experiences on advisory groups and observed a systemic undervaluing of Māori and Pasifika intelligence. They sought authentic relationships and respectful (rigorous) academic exchange in a context where Māori and Pasifika experiences were not marginalised by western mono-cultural norms. From this study it seems more could be done by government officials and agencies to ensure Māori and Pasifika leaders are respected so that they can fully engage in government advisory groups. Participants in advisory groups should not be witnessing or experiencing racism or unconscious bias from colleagues. To address health inequities it is critical that health policy incorporates solutions from Māori and Pasifika leaders, in order to deliver health outcomes for these communities that at this time carry the predominate burden of disease. Cultural and political competencies of government officials and those leaders that sit on health advisory groups need to be strengthened.

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