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# Briefing on:
# Waitangi Tribunal health kaupapa report – WAI 2575 (stage one)

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Tuesday 16th July 2019 - AUT South Campus

# Waitangi Tribunal

- Set up by the Treaty of Waitangi Act 1975
- A permanent commission of inquiry that makes recommendations on claims brought by Māori relating to Crown actions which **breach the promises made in the Treaty of Waitangi and/or te Tiriti o Waitangi**.

https://www.waitangitribunal.govt.nz/assets/Documents/Publications/Final-PkM-Panui-EP.pdf

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# Waitangi Tribunal Members

- Chair Judge Stephen Clark
- Dr Angela Ballara
- Asso Prof Thomas Roa
- Prof Linda Smith
- Tania Te Rangingangana Simpson

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# Health Kaupapa Claim (WAI 2575)

- 2016
  - many health-related claims had been lodged
  - a full inquiry by the Tribunal was announced
- 2018
  - 205 claims sought to participate
  - both historical and contemporary
- Stage One
  - Oct-Dec 2018
  - Primary health care and systems issues
- Stage two
  - Mid 2019
  - Mental health, disabilities, alcohol, tobacco and substance abuse.
- Stage three
  - Remaining national significant issues and eligible historical issues

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# Stage one report scope

- Systemic issues in primary care
  - Dates from NZPHDA 2000
- Stage one focussed on the Treaty-compliance of
  - The legislative and policy framework;
  - Primary health care funding;
  - Accountability; and
  - The nature of Treaty partnership arrangements in primary care
- The persistence of Māori health inequities was uncontested

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# The (decline of) the three P’s

- Three P’s [participation, protection, partnership] are a reductionist view of the treaty.
- *“Contemporary thinking on Treaty principles has moved on significantly from the ‘three Ps’ approach favoured in the health sector”*. (p. 80)
- *“we found that the Crown’s ‘three Ps’ articulation of Treaty principles is outdated and needs to be reformed”*
- Waitangi Tribunal (p. 163).

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# New Treaty principles

The Tribunal identified the following Treaty principles as particularly applicable to this Inquiry:

- The guarantee of tino rangatiratanga
- the principle of partnership;
  - Good faith, mutual respect, be able to express tino rangatiratanga
- the principle of active protection;
  - Mana motuhake, manage affairs according to own tikanga, also tikanga present in mainstream health services
- the principle of equity; and
  - Specifically target disparities, expected benefits of citizenship
- the principle of options
  - Right to choose social and cultural path, exercise authority

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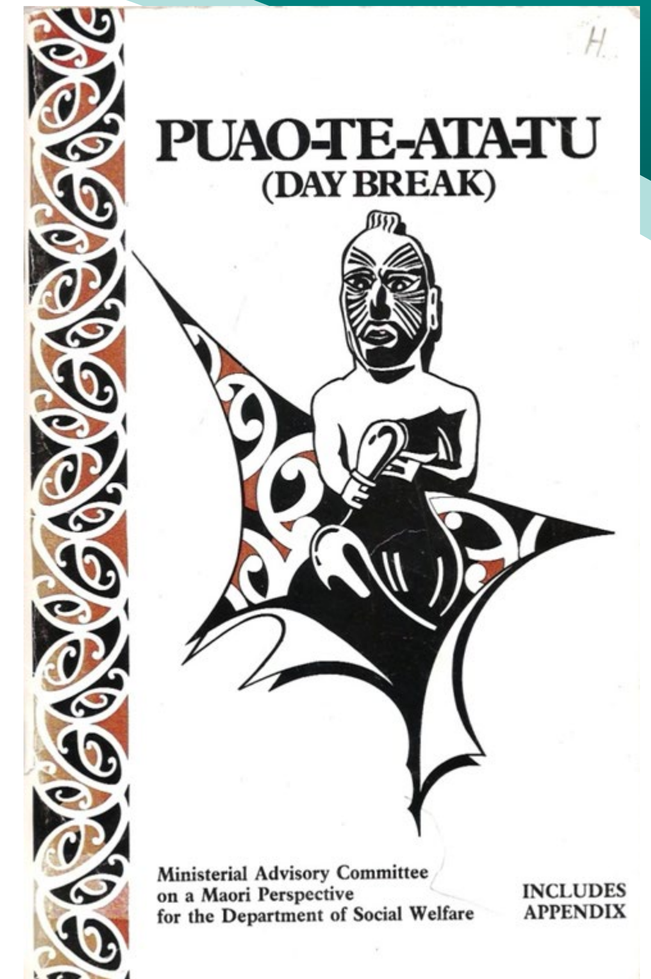
# Institutional racism

Institutional racism manifests as :

- *“the outcomes of mono-cultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of ‘the system’ of the power culture”.*

- Ministerial Advisory Committee. (1988). *Puao te ata tu (Day break)*. Wellington, New Zealand: Department of Social Welfare (p19).

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# Racism as determinant of health

- *Q. Would you agree that racism is also a determinant of health ?*
- *A. Yes, I would and this is one that we have learnt a lot more about over recent years and continuing to learn. I think we have now some quite good evidence that racism at a range of levels does determine access to experience of and outcomes in the health care system. (Ashley Bloomfield, p. 151).*

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# Claimant Witness

- *"I think that institutional racism doesn't have to be deliberate. It can be the unintended outcome of well-intentioned people. I am sure that the people that wrote the PHCS weren't trying to write a document that was going to produce institutional racism. But I think what we have is definitely a gap between policy and practice and we've got problematic policy. But I think it's a failure in imagination, it's a failure in monitoring, it's a failure in reporting and it's a failure for consequences for poor performance"*.

- Dr Heather Came-Friar (p.152).

# Health Equity

- *“Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. Health inequities therefore involve more than inequality with respect to health determinants, access to the resources needed to improve and maintain health, or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms”* (World Health Organization, p. 67).

- *“Tino rangatiratanga of hauora Māori is necessary to pursue health equity”* (p. 160).

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Artwork by Robyn Kahukiwa

https://www.pinterest.nz/pin/802555596075449588/?lp=true

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# Legislation and Policy

- Crown/ sector have failed to commit to health equity
- Disestablishment of Te Kete Hauora
- Reductionist effort at Treaty clause in legislation
- Omission of Treaty in lower-level documents

*"We are faced with the prospect of whether an important – and hitherto insufficiently recognised – cause of the inequities suffered by Māori as a population group in the last two decades is the legislative and policy framework of the primary health care system itself" (p.25)*

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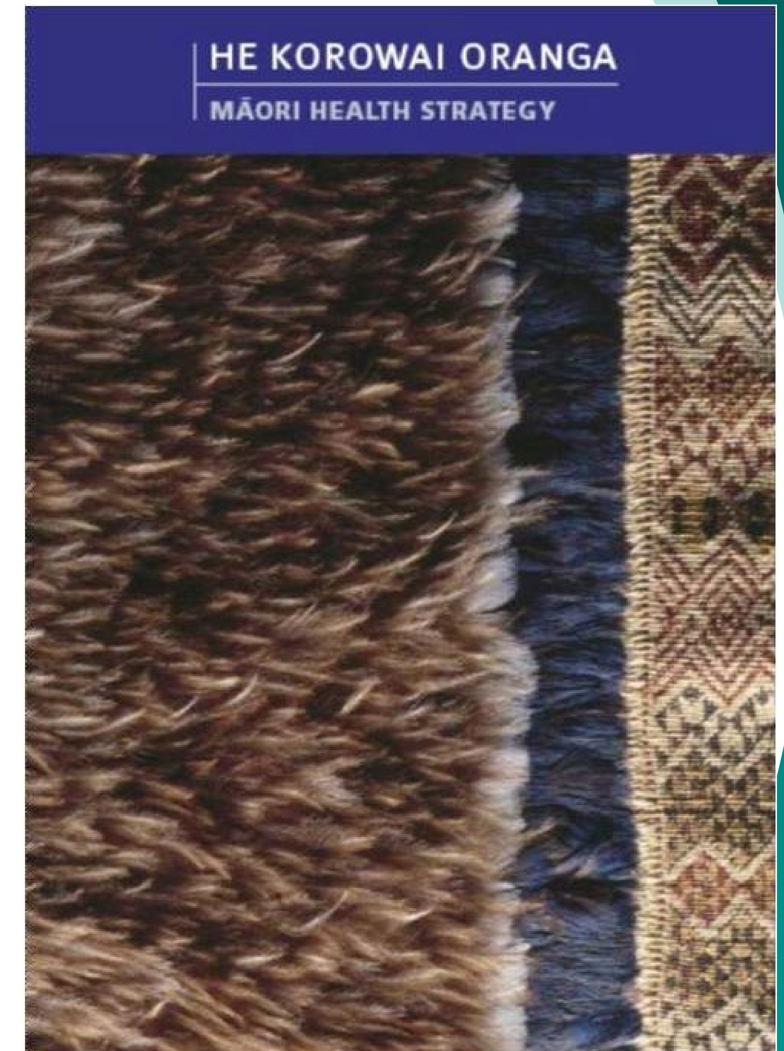
# He Korowai Oranga

- Tino rangatiratanga equivalent mana motuhake
- Indigenous autonomy; fullest expression of Māori right to exercise authority over their own communities with minimum Crown interference

- Tino rangatiratanga mentioned once in intro not in body of strategy, no explanation of what it is; so strategy doesn't support vision



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# Te Kete Hauora

- Unit focused on Māori health
- Teresa Wall - *their advice not always taken up*
- Disestablished in 2016; functions dispersed through Ministry
- Seen as watering down commitment signal to the sector
- Janice Kuka – *weakened the voice Māori decision-making and advocacy*.
- Tereki Stewart – *created a policy advice vacuum*
- Māori health directorate re-established 2018 (p. 144).

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# Removing Treaty references

- *"When asked in our inquiry about the factors driving the removal of Treaty references, she highlighted the political context of the day, including the 2004 Orewa speech, the seabed and foreshore hikoi, and the government of the day's fear of a backlash from the New Zealand public"*

- Teresa Wall (p. 94).

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# NZ Public Health and Disability Act 2000

- Treaty clause for DHBs
- *"effectively freezes the health sector's purported compliance with the Treaty in time and does not recognise that the Treaty is a living document… Treaty jurisprudence has developed since then".*

- DHB Board representation
- *"The data shows that on only one occasion, in 2001, have all district health boards had two Māori members. At no time have all district health boards complied with the proportionality clause"* (p. 83).

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# Claimant witness

- *"Politics is sort of the art of the do-able and when you're in a difficult negotiation situation as we were and we've got law draftsmen, scribes and given the command and control that was asserted by the 9th floor those days which I don't pursue too much here. But I will say you've got to do the best you can in the worst possible circumstances for your people and so that's the difficulty that Māori MPs in the house [face] as a minority group".*
- John Tamihere (p.76)

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# Consultation over the PHCS

- Sir Edward Taihākurei Durie – "*We did have a bit of a feeling… that co-design means they design and we comment. It's inevitable with Government departments that their people will have a lot of thoughts, they will get excited about their thoughts, and so it comes still back to consultation where they have the initiative and we are commenting on their thoughts*".

- Simon Royal – "*Māori advice, input and structures were not considered. In this way Māori were treated as a marginal part of the health sector, rather than central to government success*" (p.141)

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# Te Puni Kōkiri

- From Section 5 of the Ministry of Māori Development Act 1991 Te Puni Kōkiri (TPK) have a statutory obligation to audit
- Did minor review in 2004; since then inactive
- Lost opportunity for accountability through not implementing the obligation
- TPK shifted focus to monitoring policy development and 'trying to influence'
- "*Wholly inadequate*" Waitangi Tribunal (p. 136).

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# Permissive climate

- Dr Rawiri Jansen - *"If you allow people to develop their own ideas but not strengthen them, repoint them in the right direction and strongly monitor them it won't succeed, you'll get increasing disparity"*.
- Prof Peter Crampton – "… *our system fails in its core function of meeting the basic health needs of those who are most in need*".
- Waitangi Tribunal – *"failing of leadership on the part of the Ministry… equitable Māori health outcomes has not been a high priority*". (p 137).

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# Independent Practitioner Associations versus Māori providers

http://www.liberaldictionary.com/level-playing-field/

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# (Māori) Health Funding

- In 2017–18 PHOs received **$907 million** in capitation funding. **$167 million** went to Māori patients enrolled in both Māori and non-Māori PHOs.
- The four Māori PHOs received **$28.7 million** &, based on the number of Māori enrolled in those organisations, **$10.17 million** was spent on Māori patients of PHOs. (p57).
- Prof Jackie Cumming - Māori health providers get **1.86%** of Vote Health. Increases in health spending each year are not always matched by increases in spending on Māori health providers. (p.115).

http://www.nemigisi.org/AddFundingSource.asp

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# Inaction in face of need

- In 2007 Deloitte commissioned to investigate additional costs serving Māori communities  compared with other PHOs
- Estimated $21.77 million annually
- Further report developed in 2010 never released (p 109)
- Total missed revenue now $349 million annually (p110).

*"The Crown's failure to amend or replace these funding arrangements for over a decade adequately, in the face of both consistent advice to do so and persisting Māori health inequity, is inconsistent with the duty of good faith, and a breach of the Treaty"* (p.117).

https://www.otago.ac.nz/maori-health-research/people/index.html

# Paucity of data

- *"The paucity of publicly available data limits opportunities to monitor and evaluate the performance of the health sector. Furthermore, in my view if the Crown had a comprehensive commitment to Māori health it would also have a comprehensive range of outcomes and indicators …that it was monitoring. This does not appear to be the case".*

- Dr Suzanne Crengle (p. 130).

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# Deficit orientation

- Dr Bloomfield agreed "*deficit-orientated language commonly used by health professionals contributes to negative stereotypes of Māori*"
- 'Hard to reach' not constructive and diminishes Māori
- Māori described as 'non-compliant'
- Reorientate language – "*…failure of the health sector to deliver health care, rather than failure on the part of Māori*"
- Eru Pōmare Research Centre – "*Māori move from being normal to being 'different' from Pākehā . . . norms'. This thinking normalises the idea that the 'problem' lies with Māori: thus, they 'receive lower levels of health services and poorer quality of service*" (p. 153).

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# Language Matters

- PHCS - No explicit mention equity nor evidence equity analysis
- Statutory obligation to *pursue* not *achieve* objectives
- *Aspirations* are not *actualities* but hopes for the future

- Working together *not* a treaty relationship
- *"In our view, influencing decisions or participating in making them is not the same as making decisions"*
- Waitangi Tribunal (p.80).

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# One size (doesn't) fit all

- *"A 'one size fits all' model tends in practice to suit the needs of the majority, who are rarely the group in most need of help. Even when they can access mainstream aid and services, minority groups such as Māori have often found that what is being provided simply does not work for them or is so alienating that they prefer to disengage".*

- Waitangi Tribunal. *Te Urewera (WAI 894).* Wellington, NZ: Author. *(p.*3776-3777).

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# Crown witness

- *“There was an intention for that [health equity] to occur and we have lots of strategies where intentions are well put and well-articulated, but I think you can demonstrate by the fact that [in]equity is still extant within our Māori populations that intention[s] frequently, here in Aotearoa, [don’t] lead to outcome”*

- Hector Matthews (p68).

https://www.sialliance.health.nz/news-/diversity-inclusion-and-the-treaty/

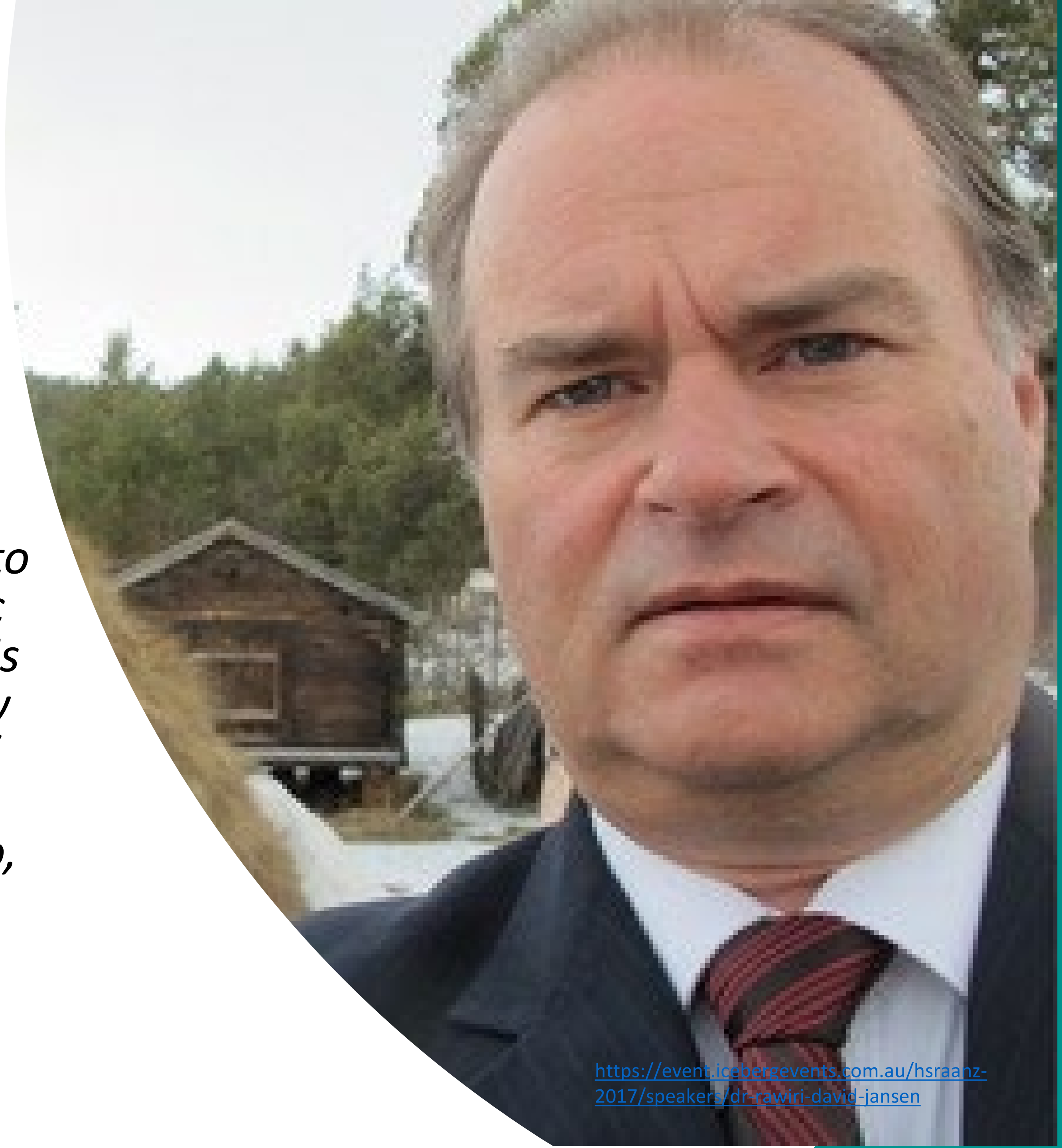
# Failure to monitor

- *"PHOs conduct self-audits of their performance. I would not consider that this activity introduces accountability into the system… According to the chief executives of PHOs who I interviewed, DHBs pass on the primary care funding to PHOs with minimal follow-up regarding how those funds are spent. Some reporting does occur but is generally not scrutinised in a meaningful way".*
- Amy Downes (p. 127).

https://www.fulbright.org.nz/news/from-theory-to-practice-the-promise-of-primary-care-in-new-zealand/

# From Rhetoric to Practice

- *"We often get really inspiring rhetoric from boards and chairs and CEOs and it turns to dust when you get busy trying to run a programme with the bureaucratic tier 3 managers of a programme.  In this respect, explicitly articulating the Treaty and other key concepts at every level of the system would be a positive thing in our view – especially given resistance to, and misunderstandings of, the Treaty, and what it means for this country*".
- Dr Rawiri Jansen (p 95).



https://event.icebergevents.com.au/hsraanz-2017/speakers/dr-rawiri-david-jansen

# Been held to account for performance

- Crown funding agreements - funding can be withheld for poor performance – never been done for Māori health
- Crown has never appointed a monitor to audit DHB poor performance relation Māori health, nor sacked a Board
- No annual plan been rejected in relation to Māori health
- Against Māori advice - DHB Māori health plans mandatory in response to Auditor General's report, revoked 2016
- PHO mandatory Māori health plans revoked 2013

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# Crown as Sole Auditor

*"It is not solely for the Crown to determine what will be measured and how it will be reported. . . – the Treaty obliges Crown agents to ensure that the health system is accountable to their Treaty partner"* (p. 133)

https://www.cio.com/article/3346025/it-auditor-role-defined.html

https://100maorileaders.com/kerri-nuku

# Ethnic pay inequities

- *"They [nurses] go to work and work an eight-hour day and they go and pack the supermarket shelves at night to make up for their wages that they don't have enough of. With the increasing cost of living they're unable to meet those needs. For nurses that voluntarily now are sleeping in the backs of cars it's because they can't afford the rent; that's a reality"* (Kerri Nuku, p. 150).

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# Māori health plans

- *"…the key point is that appropriate measures for Māori health inequities need to be developed in consultation with the rest of the sector as well as Māori. These measures need to be visible and easily understood both by the sector and the wider public. Further, health entities such as DHBs need to report against these measures"* (p. 126)
- *"…separately publishing measures on Māori health outcomes and then reporting against those measures is an equity enhancing approach"* (p. 129)

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# Tino Rangatiratanga

- *“To the claimants, then, tino rangatiratanga provides for a truly holistic definition of hauora Māori, which encompasses the Māori structures and models which provide for hauora, and the people that those structures and models are for.*
- *We consider that tino rangatiratanga over hauora Māori should be an intrinsic facet of a Treaty-compliant primary health system. Māori-led primary health organisations and providers must have the capacity, and space, to exert their tino rangatiratanga in the primary health care system”*.
- Waitangi Tribunal (p. 158).

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# Partnership

- *"My understanding of the principle of partnership is that there should be a sense of equality in a partnership. It's a two-way relationship and I talked yesterday about the alliancing framework which is characterised by high trust, high shared accountability, so that's how I would think about partnership. It's in a sense a contract between the two parties to behave in a certain way and to work together not just on some aspects of the work but on all aspects of the work".*
- Ministry of Health - Ashley Bloomfield (P. 140).

# Claimant witness

- *“You can print something onto a page, but you’ve got to breathe life into it, and I think that was missing. You breathe life into what you believe tino rangatiratanga looks like . . . but there was no breath of life in that, there was just a lot of words in my view”*

- Taitimu Maipi (p. 82).

# Everyday racism

- *"I'm a 53-year-old Māori male and I have confronted racism my entire life, and it ebbs and flows, and it chops and changes, and once I got a bit more educated and a bit more articulate, some of those racists shut themselves down a wee bit and wouldn't argue with me because I can argue the toss with them, sometimes, some are clever[er] than me and I can't. But, you know, racism in its covert and overt forms exist everywhere and we see examples of that, not just in health, all over New Zealand society".*
- Hector Matthews (p. 154).

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# Māori relationship boards

- Janet McLean described them as a tokenistic arrangement ‘for DHBs to be able to tick a box… ‘do not have the same mana as a statutory board on a DHB’” (p.87)
- Dr Nick Chamberlain, they ‘do not typically have a governance role, a financial delegation, or an effective way to hold DHBs to account” (p. 87)
- Hector Matthews – how does an organisation budget $50K partner with institution with budget $1.4 billion (p. 88).

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# Claimant witness

- *"There was an expectation from BOP DHB that all four PHOs at the time provided representation on various committees. We only had one staff member who could sit on committees … Obviously it was near impossible for us to be represented on the committees given we had limited capacity with only one person. Our ability to fully engage and participate disadvantaged us at times as funding and contracting decisions were often made without us being present"*
- Janice Kuka (p. 89)

# New expectations

- *"The Treaty obligations of DHBs and other Crown agents go beyond becoming more competent and comfortable with mātauranga Māori on an institutional level, as steep a learning curve as that may be for many.* ***Crown agents need to be wholly conversant with the process and manner in which their partner wants, and needs, to engage with them****. They need to have a deeper understanding of the motivations behind their partner's engagement with the Crown"* (p. 92)

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# Cultural Safety

- *“Cultural safety intends to recognise that sociocultural difference manifests, in part, as a power imbalance between different ethnicities. It recognises the dynamics of institutional racism: that tikanga and mātauranga Māori, while centrally important to many Māori, is not recognised as ‘ordinary’ in the nation as a whole, and as a result is not often properly provided for by institutions. In this way, cultural safety recognises that it is not just that services need to be culturally appropriate ; but also, if services are delivered inadequately, then the delivery method of those services can become a negative determinant of health outcomes”*
- (p155-6).

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# Surviving Māori PHOs

- There were 14 Māori PHOs; now only …

Ngā Mataapuna Oranga
National Hauora Coalition
Ngāti Porou Hauora Charitable Trust
Ora Toa PHO

- *“The cumulative effect of these[Treaty] breaches partly explains why only four Māori primary health organisations remain”*.
- Inadequate support from Crown
- Waitangi Tribunal (p. 117).

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# Where do whānau, hapū, iwi, Māori providers fit into this structure?

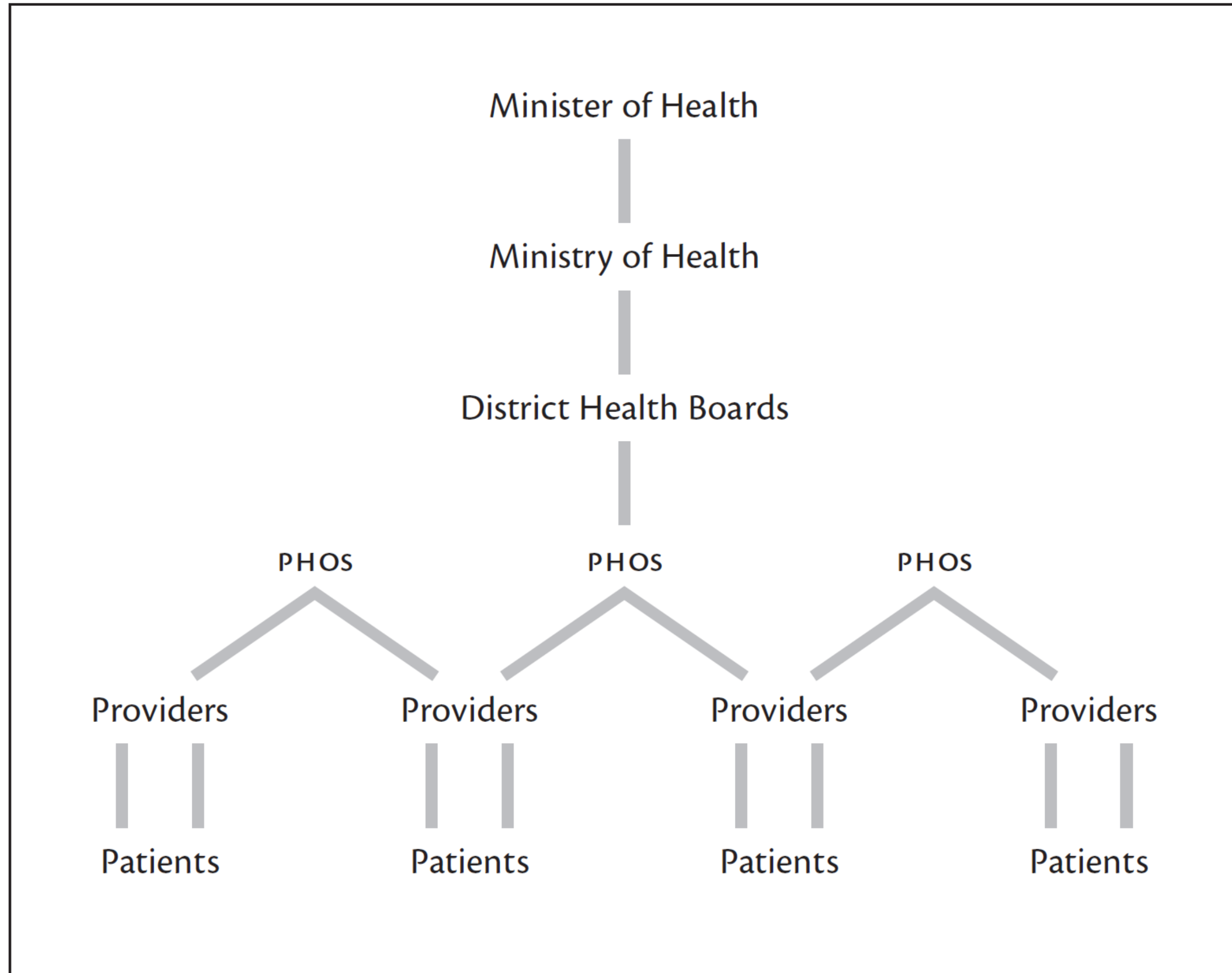

Figure 1: A basic outline of the devolved layers of the primary health care system

- (p41)

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# Māori within Crown agencies

- *"It would be fair to say that Māori inequalities has [sic] been normalised in DHBs … it was very clear that they didn't want to have a conversation about institutionalised racism, it was never explicitly said but you could read the body language, you could understand when a conversation was not ready to be heard, it became a struggle because often part of the challenge of many Māori working in a DHB in the Ministry is having to frame the conversations in a way that are palatable so that they can be heard, so that they can be [understood], that wears you down. It wears you down".*
- Janet McLean (p. 147)

https://www.nzherald.co.nz/bay-of-plenty-times/news/article.cfm?c_id=1503343&objectid=11464007

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# Crown's serious failure

- *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 on their own… 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*".
- (p. 161).

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# Crown’s overall failure

- *“The Crown’s failure to abide by its Treaty obligations and ensure that its agents and the health sector as a whole are doing the same has contributed to the dire state of Māori health outcomes. It cannot continue to evade its obligations... the health inequities experienced by Māori compel an urgent, and thorough, intervention”*.(p. 163).
- *“We recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes since the commencement of the NZPHDA 2000”* (p. 170).

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# Co-governance

- *"The Tribunal has made clear in its previous reports that co-governance, particularly in social service design and delivery, is an essential part not only of upholding the Treaty relationship, but also essential to the improvement of Māori socio-economic status*". (p. 165).

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# Summary

- The persistence of Māori health inequities was uncontested
- Crown/ sector have failed to commit to health equity
- Disestablishment Te  Kete Hauora
- Reductionist effort at Treaty clause in legislation
- Omission of Treaty in lower-level documents
- Consistent underfunding of Māori health
- Lack of Māori health data for monitoring and accountability
- Crown aware of failures and failed to adequately remedy
- Lack of Treaty-consistent Māori control and/or partnership in decision-making in relation health design and delivery
- Does not recognise tino rangatiratanga or mana motuhake

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# Recommendations

- Amend Treaty and equity clauses in NZPHDA 2000
- Investigate a standalone Māori Primary Care Authority by 2020
- Review primary health funding including compensation for underfunding
- Review and strengthen accountability mechanisms & monitoring
- Co-design Māori primary care research agenda
- Reinstate Māori health plans and Treaty clauses in contracts
- Redesign partnership mechanisms at all levels

*"Finally, we recommend that the Crown acknowledge the overall failure of the legislative and policy framework of the NZ primary health care system to improve Māori health outcomes since the commencement of the NZPHDA 2000" (p xvi)*

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Photo: Denis Came-Friar

# Māori in the health workforce

- nurses (7.4 % in 2018) ;
- midwives (9.4 % in 2016) ;
- oral health (4.2 %in 2017) ;
- physiotherapists (4.9 % in 2018) ;
- psychologists (5.3 % in 2018) ;
- radiology (5.4 % in 2010) ;
- Dietitians (3.6 % in 2010)
- laboratory scientists (1.7 % in 2010) ;
- laboratory technicians (4.7 % in 2010) ;
- pharmacists (2.5 % in 2018) ;
- optometrists (1.8 % in 2010) ;
- dispensing opticians (1.9 % in 2010) ;
- podiatrists (6.9 % in 2010) ;
- osteopaths (7 % in 2010) ; and
- chiropractors (12 % in 2010)

- (p.142).

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