



12th May 2019

Re: Submission on the Health Sector Review

To Whom it May Concern,

Thank you for the opportunity to participate in the review of the health sector. This submission is written on behalf of STIR: Stop Institutional Racism. Formed in 2013, STIR is a network of public health professionals and scholars committed to ending institutional racism in the administration of the public health sector. The current core membership includes Professor Tim McCreanor, Dr Maria Baker, Dr Heather Came, Dr Sarah Herbert, Claire Doole, Ngaire Rae, Trevor Simpson, Emma Rawson, Lisa McNab, Lee Tuki, Sue Turner, Grant Berghan, and Miriam Sessa. Collectively we have decades of experience working within the wider public health sector. Further, we are a national network comprising more than 300 STIR Associates working across the public health sector.

Additionally this submission is formally endorsed by Whakawhiti Ora Pai, Whakauae Research for Māori Health Development, Kanohi ki te Kanohi Consultancy, Waka Oranga, Nga Maia Māori Midwives Aotearoa, Kahungunu Health Services: Choices, New Zealand Public Health Association, Digital Indigenous, Te Rau Ora, Manaia Health PHO, Groundwork, Health Promotion Forum of New Zealand and Tāmaki Tiriti Workers. It is also supported by Dr Heather Gifford, Dr Amohia Boulton, Tania Hodges and Associate Professor Jacqui Kidd.

1. What are the most important values for our future public health and disability system?

From the authors' perspectives there are three core values that are integral for the future health and disability system. These are, a commitment to i) honour *te Tiriti o Waitangi* (the Māori text that reaffirmed tino rangatiratanga as opposed to the English version) , ii) embracing anti-racism praxis and iii) the pursuit of health equity. These values must be reflected at all levels of the health system and engage practitioners, managers and policy makers. We must all be held accountable for our professional practice in these key areas.

i) Honour te Tiriti o Waitangi

A genuine commitment to honouring te Tiriti would in the first instance involve meaningful and substantive relationships and engagement among: the Ministry of Health; District Health Boards; and other related Crown entities, and, iwi; hapū; and Māori health providers. Rather than Māori participating as stakeholders, they should be active and leading participants in the design, implementation and administration of the health system. This would entrench the recognition of Māori health leaders, practitioners and academics to be recognised as experts in Māori health.

Research by Came, McCreanor, Haenga-Collins, and Cornes (2019) found Māori and Pacific leaders participating in health advisory groups reported that their knowledge and interests were devalued and they experienced racism and tokenistic engagement. Māori advice should be sought and taken by staff across the health system in a mana-enhancing way that reflects high levels of political and cultural competencies. Simply put Māori knowledge, experience and strategic thinking needs to be trusted.

Given the WAI 1040 finding of the Waitangi Tribunal (2014) that Ngāpuhi (and by extension Māori in general) did not cede sovereignty, the health system must better reflect the changing political realities arising from shifts in demographic structure (Pool & Kukutai, 2018) growing social inequality (OECD, 2014; Skegg, 2019) and ongoing health disparities among Māori in comparison to others. We suggest that the vision of the Working Group on Constitutional Transformation, Matike Mai Aotearoa (2016), provides some leadership here. The modelling of the Working Group calls for 'constitutional transformation' and recognition of indigenous rights to self-determination as per te Tiriti and the Declaration of the Rights of Indigenous Peoples (UN, 2007). It give a strong sense of what is at stake here. In pragmatic terms, it also suggests the use of cultural caucusing in Māori and Pākehā 'houses' moderated by an upper house with equal representation of Māori and Pākehā. Some adaption of such arrangements would help to challenge and displace the entrenched flaws of majoritarian, voting-based systems that marginalise Māori input to decision-making bodies at all levels of the health system.

Further, Māori health providers should be funded to a level where they can deliver holistic services consistent with Māori models of practice and which recognises the complexity of the circumstances of their client base. Analyses of health disparities in Aotearoa show that current funding levels to Māori providers are clearly inadequate to meet cultural health needs as defined by Māori (Mills, Reid, & Vaithianathan, 2012; Ministry of Health, 2017a).

Tikanga Māori should be normalised within the health system, and the entire health system should be configured in a way that reflects Māori culture, theories of health/wellbeing and aspirations. The performance of the health system should be evaluated against holistic Māori measures as well as quality and quantity of life measures. For example, in their critical study of approaches to weight loss, Warbrick, Came, and Dickson (2018) found that initiatives that draw on, or are underpinned by

indigenous knowledge, are more relevant for Indigenous peoples and could lead to better health outcomes.

Moreover, Māori and all people's health and wellbeing is fundamentally linked to the environment. Equity as a position and as an action must also acknowledge the interrelationship of all living things and seek to rebalance all systems. Restoration is not just about remedial application to damaged eco-systems, it is equally about the reinstatement of humans to their rightful place as kaitiaki .

All levels of the health system must recognise culture and wairuatanga as critical dimensions of hauora (Barnes et al., 2017; Marsden, 2003). The health systems needs to identify how to embrace its responsibility to collaborating across Government to ensure all Māori have access to the prerequisites of health and no longer live in circumstances which put the health of whānau at risk (Came, McCreanor, Doole, & Rawson, 2016). In addition, intergenerational trauma and the legacies of colonisation need to be recognised as drivers of health inequities and be central to strengthening the mental health capabilities of the health sector (Chin et al., 2018; Kingi et al., 2017; Pihama et al., 2014).

If te Tiriti was embraced as the core foundation of health policy there would be a strong emphasis on accountability and transparency to enable Māori to enact their right to monitor the Crown's progress (Reid & Robson, 2007). The Preamble to te Tiriti makes clear the Crown, in proffering the agreement, takes responsibilities for protection of indigenous rights. Honouring te Tiriti necessarily entails accountability. Non-performance in relation to Māori health outcomes is an unacceptable breach of te Tiriti. In the current racial climate, transparency is critical as is a planned response to implementing te Tiriti, ending institutional and other forms of racism and improving Māori health outcomes. All sectors within generic service delivery need to be monitored in relation to Māori health equity, te Tiriti responsiveness, and anti-racism plans (Came & Tudor, 2017).

To support health promotion practitioners and others, STIR (Berghan et al., 2017) has developed an evidence based e-book about te Tiriti application and implementation within the New Zealand health sector. The e-book is based on interviews with senior practitioners proficient in working with te Tiriti o Waitangi and draws on the available literature and the collective expertise of the authors. It provides a clear pathway for te Tiriti application drawing on the Preamble and the Articles of the Māori text of te Tiriti. This type of material and relevant professional training needs to be made available widely within the health sector if we are to successfully strengthen te Tiriti engagement. Other work by Came, McCreanor, Doole, and Simpson (2016) provides practical suggestions about te Tiriti application.

Came, Cornes, and McCreanor (2018) review of ten years of public health policy and how it represented te Tiriti and the Treaty found inconsistencies in policy engagement. Over the 49 policies reviewed only 12 mentioned either te Tiriti or the Treaty. This silence is inconsistent with legislative requirements to engage with our foundational document and particularly a requirement that the Crown protect, but not prescribe, Maori rights. Clearly, further work needs to be done to strengthen alignment of health policy to fulfil the Crown's obligations under te Tiriti to enable Māori to pursue and enact their own sovereign aspirations in relation to health and all other aspects of Māori advancement and development.

ii) Embracing anti-racism praxis

The institutional racism within the New Zealand public sector, as outlined in reports such as *Puao te Ata Tu* (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988) and *He whaipānga hou* (Jackson, 1988), remains widespread across the public sector

(Human Rights Commission, 2011). Eliminating racism needs to be the responsibility of all involved in the administration of the public health system and embedded into individual and team key performance indicators.

There is now overwhelming international and local evidence that racism harms health and is a key modifiable determinant of health inequities (R. Harris et al., 2012; R. Harris et al., 2006; R. B. Harris, Stanley, & Cormack, 2018; Paradies et al., 2015; Priest et al., 2013; Williams & Mohammed, 2013).

Historically, Crown agencies response to this racism in the health sector can be characterised by denial and inaction (Came, McCreanor, Manson, & Nuku, 2019). Likewise, evidence presented by claimants in the recent stage one WAI 2575 health kaupapa hearings, consistently spoke of the lack of political will to address racism and inequities and a gap between policy rhetoric and practice on the ground.

Historically there has been a lack of political will, and therefore a failure to hold agencies to account for achieving improved Māori health outcomes (Royal, 2018, p. 1).

In assessing whether the primary health care framework is prejudicial to achieving equitable Māori health outcomes, counsel note that the PHCS clearly articulates expectations about addressing inequalities. These expectations have not been achieved in the 18 years since its release. This suggests that there is a gap between policy rhetoric and policy practice realities (Te Apatu & Nuku, 2019, p. 25)

Came and Griffith (2017), in their anti-racism framework for allies working in public health, identified several core elements of anti-racism praxis. These include i) engagement in reflexive relational praxis, ii) utilisation of structural power analysis, iii) uptake of socio-political education, iv) engagement with monitoring and evaluation and v) systems change approaches. We advocate that these core elements need to be woven through professional competency documents and tertiary education curricula for all health professionals.

Anti-racism literature strongly supports the idea of addressing institutional racism using a systems change approach (Came, 2012; Griffith et al., 2007). A systems change approach is suited to complex and persistent problems and conveniently dovetails within the existing health sector quality improvement system (Health Quality and Safety Commission, 2018). It involves forming a change management team, undertaking socio-political development and using action research cycles (Reed & Hocking, 2013) to identify and then disrupt sites of racism in a cycle of incremental change and continuous learning. The Health, Quality, and Safety Commission New Zealand is uniquely placed to advance this work.

We also require a national strategy to end racism in Aotearoa as something tailored specifically for the health system. The Committee for the Elimination of all forms of Racial Discrimination (CERD, 2017) recommended New Zealand urgently develop a national action plan to end racism. Came and McCreanor (2015) have argued four pathways to addressing institutional (and everyday) racism that could begin to populate such a plan. These include i) addressing historical racism, ii) enhancing racial climate, iii) transforming public institutions and iv) mobilising civil society.

iii) Pursuit of health equity

From a STIR perspective, central to the pursuit of health equity is honouring te Tiriti o Waitangi and embracing anti-racism practice as outlined above.

We concur with Pickett and Wilkinson (2011) that an unequal society compromises the collective health of our nation. We encourage concerted meaningful efforts to create a more equal Aotearoa. This will involve radical rethinking of social and economic policy. We need to lift people out of poverty and homelessness (Boston & Chapple, 2014; Peters & Christensen, 2016) and structure our tax system so those with the most wealth/income contribute most into the collective pool (OECD, 2014). These interventions need to be targeted to alleviate the pressures on Māori whānau. As of 2013, the average Māori personal income was \$22,500 some \$6000 less than the national equivalent (Statistics New Zealand, 2013). This level of income is not a living wage; that is, it does not cover the real costs of essential family needs as well as energy, health, communication and education costs (Living Wage Aotearoa New Zealand, 2017).

The pursuit of health equity requires BIG picture thinking about social justice and some of that work is beyond the traditional scope of the health sector. We need to embrace health in all policies and utilise whānau ora impact assessments (Ministry of Health, 2007) so we can determine the expected health effects of ALL economic and social policy measures. This aligns with the government's stated intent for a wellbeing budget.

Recent work by Chin et al. (2018) argues that monitoring, evaluation and adequate investment are central to achieving health equity. This means increasing the monitoring of generic health services delivered to Māori and strengthening standards of accountability. We note the problematic removal of the requirement of District Health Boards to produce stand alone Māori health plans as a digression from the pathways to achieving health equity, and in contrast with the need to strengthen accountability mechanisms (Came & Tudor, 2017).

Since the release of the National Advisory Committee on Health and Disability (1998a) landmark report on *The social, cultural and economic determinants of health in New Zealand* health policy has consistently included rhetoric on addressing the determinants of health. STIR argues it is now critical to focus on these drivers of ill health. The health sector needs to determine its contribution to addressing the determinants of ill-health and moving past empty rhetoric. If we are serious about addressing the drivers of inequality, we need to co-ordinate our responses and invest in upstream solutions. We need to prioritise investment in public health which will make cascade savings in clinical treatment costs (Skegg, 2019).

Chin et al. (2018) argued underscoring effective health equity work requires a commitment to authentically share power and foster tino rangatiratanga. Within the health sector we also need to have free, frank and fearless discussions about racism and look beyond the daily challenges of administering a complex system. STIR would like to hear fewer excuses about why the health system is failing Māori and see progress in alleviating health inequities.

2. Think about how the best health and disability system for New Zealand might look in 2030. How would that be different from the system we use today?

The health system would be founded on the relational interdependencies entailed in te Tiriti in which Māori retain and expand upon te tino rangatiratanga in ways that contribute to Māori aims and aspirations, and the state enact changes that decolonise social structures to achieve just and sustainable futures. It would be integrated with the entire economic and social system to eliminate disparities in all domains and assist in creating the conditions, in which all members can reach their potential and contribute to our collective thriving. Public health would be funded to a level where preventable diseases and conditions could be minimised and access to clinical care is free, open and adequately distributed to meet the needs of the population. Following the analyses of Skegg (2019) and others, we would invest in public health to a far greater extent than we currently do so that the public health system can work its prevention, protection and promotion strategy to the point that it relieves the unsustainable pressure, burden and cost of the current system.

3. What changes could make our health and disability system more fair and equal for everyone?

As above.

4. What changes could most improve health for Māori?

The overwhelming theme of the evidence presented in stage one of the WAI 2575 Waitangi Tribunal hearings was the failure of the colonial health system to effectively deliver appropriate health services to Māori. Many described it as a “state of emergency”. There needs to be transformative change of our current health system and the eradication of institutional and other forms of racism throughout.

To improve the health system, we need to see the Ministry of Health, and District Health Boards and their funded providers demonstrate their sustained commitment to realigning policy, practice and investment to uphold te Tiriti o Waitangi. This needs to occur within the context of a wider constitutional transformation aligned to the vision outlined by Matike Mai Aotearoa (Matike Mai Aotearoa, 2016). In addition, there needs to be urgent action to realise and protect the right to health as outlined in Article 23 and Article 24 of the *Declaration on the Rights of Indigenous Peoples* (UN, 2007).

According to Tumu Whakarae (National DHB GM Maori Strategic Reference Group, 2018) any transformed health system needs to be underpinned by kawa oranga. That is, a philosophical orientation that targets optimal tangata whenua wellbeing. The health system needs to be reoriented to achieve pae ora; a holistic concept that encompasses mauri ora (healthy individuals), whānau ora (healthy families) and wai ora (healthy environments). In part, this would manifest as the health system consistently upholding the mana and mauri of whānau.

To enable this vision Tumu Whakarae (National DHB GM Maori Strategic Reference Group, 2018, p. 7) in its submission to the Government inquiry into mental health and addiction has outlined a detailed plan of how this might be achieved. They have identified six priorities

1. Provide and encourage transparent and effective leadership
2. Lead a Māori equity culture in the health system
3. Provide and expect evidence-based approaches
4. Utilise partnering and collective impact approaches
5. Value Māori leadership, intelligence and innovation
6. Advocate for proportionate universalism

Strategies range from the introduction of indigenous best practice contracting, incentivising of high performance and withdrawal of funding for poor delivery to tangata whenua. STIR contends there is a useful strategic direction for Māori health documented in this important submission.

5. What changes could most improve health for Pacific peoples?

iv) Pacific peoples

If the government is truly committed to reducing health inequities, a greater focus must be made to improve the health status of the diverse Pacific communities of Aotearoa. We need to transition from a sustained period of relative inactivity in Pacific health, to one of planned, considered and strategic action.

When decisions are made about health investment, the impact these decisions will have on Pacific health outcomes needs to be consistently considered. If this accountability in relation to Pacific health is not occurring organically, structural mechanisms need to be put in place to ensure the health of Pacific people is considered.

Director of the AUT Centre for Pacific Research, El-Shadan Tautoko (*personal correspondence*, 21/5/2019) wants to see greater transparency on investment decisions in health generally and more specifically in Pacific health. He would like to see investment in projects that make a difference for Pacific families. For instance, car parks at Middlemore Hospital would be more useful than high cost/high profile building projects. He observes many small Pacific communities' groups making a difference in their community without government funding; while larger funded groups seem to be producing less results but are skilled at navigating government bureaucracy.

To lift Pacific health status also requires a sustained commitment to improving the socio-economic position of Pacific peoples. Employment and income are critical modifiable determinants of health (National Advisory Committee on Health and Disability, 1998b). Current employment policy has allowed the persistence of sustained ethnic pay disparities which have resulted in 49% of all Pacific people earning below \$20,000 (Statistics New Zealand, 2017).

6. What changes could make sure that disabled people have equal opportunities to achieve their goals and the life they want?

v) Tāngata Whaikaha

STIR welcomes efforts to transform the disability sector, through the Enabling Good Lives (EGL) programme (Office for Disability Issues, 2017), to ensure Tāngata Whaikaha have greater control over their lives through the introduction of budget holding and autonomy to make decisions about its investment. We maintain a commitment to upholding the mana of te Tiriti o Waitangi needs to be central in all efforts to transform the health system. We endorse the concerns of the Iwi Chairs Forum (2018, p. 7) that EGL remains "... centred on the individual and has been designed in accordance with Pākehā/Western models of service design and practice". To preserve the right of Tāngata Whaikaha to self-determination we counsel robust engagement with Māori at all levels of this roll-out to ensure Māori get equitable access to services. Anything less will exacerbate existing inequities.

Approximately 1 in 3 Māori in New Zealand are Tāngata Whaikaha (or Māori with disability). This community are disproportionately represented in negative health and social outcomes (Ministry of Health, 2015). Data are not readily available in relation to health and social outcomes for Tāngata Whaikaha, but it is fair to assume that their experience of health and service delivery are less equitable than for Māori in general. This lack of specific data and analysis compromises the responsiveness of policy and the purchasing of health services for this and other marginalised groups. We urge the commissioning of a comprehensive disability survey every five years with over recruitment of Tāngata Whaikaha to enable the identification of health needs and aspirations to inform policy work in this domain.

Health service priorities for Tāngata Whaikaha include good medical care, accessible transport and housing (Ruth Jones, *personal correspondence* 20/5/2019). Research by Hickey and Wilson (2017) shows there are significant barriers to Tāngata Whaikaha accessing these services. These barriers include institutional racism, lack of connection and engagement, transport, treatment and prescription costs, lack of cultural expertise, physical structure of buildings, childcare issues, and lack of access to tri-lingual (Māori, English, sign) interpreters.

Despite being a signatory to the *International Convention on the Rights of Persons with Disabilities* (UN, 2008) the New Zealand government appears to not have substantially addressed any part of the convention as it relates to indigenous peoples with disabilities. We recommend the New Zealand government develop an implementation plan to fulfil their obligations in relation to *ICRPD*.

In addition, we recommend that Tāngata Whaikaha are consistently represented in all disability sector planning, policy making, service delivery and evaluation. Tāngata Whaikaha themselves need to be empowered to stand for these positions, as well as government and local government providing an inclusive space for them to step into.

7. What existing or previous actions have worked well in New Zealand or overseas? Why did they work, and how might they make things even better in the future?

As above, noting the importance of rebuilding and advancing public health (Skegg, 2019) in order to balance the current dominance of clinical services and secure the prevention/protection/promotion dividend for all our people and society as a whole.

8. What are the most important changes that would make the biggest difference to New Zealanders?

As above.

9. Is there anything else you wish to add?

vi) Strengthening health policy

Health policy is of strategic importance in that it determines where resources are invested and can perpetuate or minimise health inequities. Came, McCreanor, Doole, and Rawson (2016) found in their review of the revised *New Zealand Health Strategy* (Ministry of Health, 2016) that this key strategy relies on ad hoc and piecemeal approaches to addressing health equity. Evidence on achieving health equity suggests that efforts need to be sustained, systematic and multi-levelled in order to be effective.

Racism in health policy compromises the basic human right to health by erecting and neglecting barriers to the equitable, affordable and sustainable access to promoting environments, effective prevention strategies and appropriate clinical services. From a range of sources, including testimony from a group of Māori health leaders with over 180 years' collective experience in the sector, Came (2014) identified five modifiable sites of institutional racism within public health policy making. These sites are: i) majoritarian decision-making practices that marginalise Māori views; ii) the failure to draw on Māori evidence and over-reliance on best practice evidence from the global north (with limited or no indigenous analysis); iii) deficiencies in cultural and political competencies of policy analysts; iv) flawed consultation processes and, v) organisational sign-off processes that dilute and marginalise Māori content. Collectively these findings indicate the systemic failure of quality improvement systems, existing anti-racism initiatives, and health sector leadership to detect and eliminate racism.

We recommend that structural mechanisms be implemented to ensure significant Māori input into: i) setting health policy agendas; ii) making health investment decisions; and iii) representation on senior management teams. We support the establishment of mandatory review processes that ensure Māori evidence and cultural frameworks are cited and explicitly drawn on to inform all health and social policy. We counsel the strengthening of consultation processes and advisory group

processes to ensure meaningful Māori participation and partnership particularly in areas of high health inequity (Came, McCreanor, Haenga-Collins, et al., 2019).

vii) Strengthening public health contracting

Both generic providers (public health units, primary health organisations, and non-governmental organisations) and Māori health providers are contracted by the government to deliver public health services. The rhetoric of the New Zealand government procurement policy (Controller and Auditor-General, 2008) and health policy (Ministry of Health, 2016) establishes a funding environment where all providers are theoretically treated equitably. However, in reality this is not the case. A nationwide survey of public health providers by Came, Doole, McKenna and McCreanor (2017) identified a pattern of inconsistencies in Crown treatment of providers consistent with definitions of institutional racism. Quantitative data showed Māori providers were found to have: i) shorter contract timeframes; ii) higher perceived compliance costs; iii) more intense monitoring; and were iv) audited more frequently. Qualitative data showed more intense and difficult interactions between many Māori providers and their funders.

We recommend that senior managers within the public sector have key performance indicators in their employment contracts to ensure they take responsibility to identify, prevent and remove institutional racism within their domains. Across the health sector, the Health, Quality and Safety Commission needs to ensure quality improvement systems are strengthened to detect, prevent and minimise institutional racism. Specifically, funders need to develop transparent criteria for the allocation of discretionary and/or one-off public health funding and publish it on-line and consistently follow it (Came et al., 2017). The application of prioritisation guidelines should be mandatory for investment and disinvestment decisions and Crown Officials should have access to funding and resources and the relevant training to apply these guidelines. There needs to be a consistent approach to the allocation of costs of living and/or Forecast Funding Track across all health providers.

viii) Māori health workforce

Russell, Smiler and Stacey (2013) make a compelling argument that matching the demographics of the workforce to the demographics of the population, improves health outcomes and access to services for Māori. Curtis, Wikaire, Stokes, and Reid (2012) concur that a matched workforce can enable access to culturally appropriate health services for all health consumers and this is a critical step in addressing health inequities.

Currently, Māori form 15% of the population (Statistics New Zealand, 2016) and Māori nurses make up only 7% of the nursing workforce (Nursing Council of New Zealand, 2015). Health Workforce New Zealand (Ministry of Health, 2017b) have predicted that, to match the nursing workforce to the ageing population by 2028, will require an additional 10,209 Māori nurses. There are longstanding issues around the recruitment of Māori students into nursing programmes, retention of students within, and the successful completion of such programmes (Foxall, 2013). Māori new graduates are also consistently reporting difficulties in securing professional roles. Meantime, senior Māori staff report issues around progression, promotion and accessing workforce development opportunities.

The Ministry of Health (2008) has identified a number of upstream and downstream determinants of Māori participation in the health workforce. These include healthy work environments, affordability of tertiary education, and institutional racism. Research (Navigate, 2002) commissioned by the Ministry around the retention of Māori staff within their own organisation identified staff felt culturally compromised at work, and they recommended actions be taken to normalise being “Māori” within the Ministry (Navigate, 2002).

We recommend that an overarching Māori health workforce strategy be developed for the regulated and unregulated health workforce, utilising a systems approach, looking at the determinants of Māori participation in the health workforce, and including institutional racism. To inform this work we urge the Ministry of Health to establish a single repository for Māori health workforce data to enable tracking of progress towards targets.

ix) Tauīwi health workforce

In light of enduring systemic health inequities, the authors believe that the tertiary education sector, health industry employers and professional bodies need to take action to strengthen the political and cultural competencies of those working within all levels of the health sector (Came & da Silva, 2011). The suite of existing tertiary programmes appears to be failing to provide those in the health sector with the necessary cultural and political competencies to address health inequities.

Tiriti education in the health sector needs to be repositioned from a one-off training to an ongoing professional development requirement so currency can be maintained and strengthened. Explicitly drawing on te Tiriti o Waitangi, Came and Tudor (2016) identify four elements to strengthen professional practice and diminish racism. These include practitioners learning i) the history of the whenua on which they practice, ii) nurturing good cultural manners, iii) actively supporting the continuation and restoration of indigenous authority and control, iii) prioritising work that advances indigenous aspirations.

Heke, Wilson and Came (2018) working with the Knowledge-Action-Integration cultural responsiveness practice framework, found that cultural competencies in the regulated workforce show a lack of consistency and clarity across competencies. They called for the development of a core cultural competency across the health workforce. As well as reviewing cultural competencies we believe core competencies need to be developed around i) proficiency in applying te Tiriti o Waitangi in everyday and strategic practice, and ii) engagement in anti-racism praxis. These competencies should apply to individuals, teams and/or organisations.

This strengthening needs to occur immediately for current students and be rolled out for the existing health workforce. We need transformative educational programmes that require reflection on power, white privilege and racism. Structural analysis (Came, Warbrick, Doole, Hotere-Barnes, & Sessa, 2019) and reflective practice (Margaret & Came, In press) needs to be part of a more radical core curriculum for all health practitioners.

x) Pay equity for Māori Providers

Māori whānau often have complex health needs and experience considerable socio-economic disadvantage. Successful relationships and outcomes require tailored interventions from health practitioners skilled in both western medicine and te Ao Māori. Māori nurses are critical to successful Māori outcomes for whānau, hapū and iwi and are named as key stakeholders in much contemporary health policy (Ministry of Health, 2016).

Significant pay disparities, of up to 25% (Human Rights Commission, 2011) exist for kaimahi (workers) who work in Māori and iwi providers in contrast with those performing comparable duties in other parts of the health sector. These pay disparities were acknowledged by the former Minister of Health (Coleman, 2016) and occur even in cases where staff have the same qualifications, and occur despite the International Labour Organisation *169 article 20, section 2* which states that ‘Governments shall do everything possible to prevent any discrimination between workers and (b) equal remuneration for work of equal value’.

Pay disparities are the consequence of how the government currently funds healthcare. There seems to be a gap between Māori perceptions of cultural and health need versus the “standard” western

notions of health need which leads to a funding gap. Contracts awarded to Māori providers do not allow for pay equity nor recognition of the dual competencies of Māori practitioners and the complexities of working with complicated intergenerational health and social dynamics.

For some years, through correspondence with the Ministry of Health, select committees, and successive Ministers of Health, Te Rūnanga and the NZNO have lobbied for structural discrimination, as manifested in pay disparities, to be urgently addressed. They have also raised this issue at the United Nations multiple times, yet there remains no movement on the longstanding pay parity campaign *Te Rau Kōkiri*. Each year this issue remains unresolved. Māori nurses and their whānau continue to receive less income than the families of nurses working within DHBs and other parts of the health sector. Entrenched pay inequities are now affecting the retention and recruitment of nurses into Māori health. Māori nurses are vital for the future health and wellbeing of whānau, hapū and iwi and, given demographic prediction, the New Zealand population as a whole.

We recommend that the Ministry of Health and DHBs take urgent action and leadership to reconfigure contracting and funding processes to ensure pay parity for those working in Māori and iwi health providers. This will involve a review of “standard” caseloads in the context of Māori providers so salary formuli can accommodate both cultural and clinical effectiveness of engagement with Māori whānau. Double the competencies shouldn't result in 25% less pay on the ground.

Heather Came, Sarah Herbert, Claire Doole, Tim McCreanor

For STIR: Stop Institutional Racism and endorsing organisations.

References

- Barnes, H. M., Gunn, T. R., Barnes, A. M., Muriwai, E., Wetherell, M., & McCreanor, T. (2017). Feeling and spirit: developing an indigenous wairua approach to research. *Qualitative Research*, 17(3), 313.
- Berghan, G., Came, H., Doole, C., Coupe, N., Fay, J., McCreanor, T., & Simpson, T. (2017). *Te Tiriti-based practice in health promotion*. Auckland, New Zealand: STIR: Stop Institutional Racism.
- Boston, J., & Chapple, S. (2014). *Child poverty in New Zealand*. Wellington: Bridget Williams Books.
- Came, H. (2012). *Institutional racism and the dynamics of privilege in public health*. (Unpublished doctorate), Waikato University, Hamilton, New Zealand.
- Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science and Medicine*, 106(0), 214-220. doi:10.1016/j.socscimed.2014.01.055
- Came, H., Cornes, R., & McCreanor, T. (2018). Treaty of Waitangi in New Zealand public health policy 2006-2016 *New Zealand Medical Journal*, 131(1469), 32-27.
- Came, H., & da Silva, S. (2011). Building political competencies for the transformation of racism in Aotearoa. *Kotuitui*, 6(1-2), 113-123. doi:10.1080/1177083X.2011.615332
- Came, H., Doole, C., McKenna, B., & McCreanor, T. (2017). Institutional racism in public health contracting: Findings of a nationwide survey from New Zealand. *Social Science and Medicine*. doi:10.1016/j.socscimed.2017.06.002
- Came, H., & Griffith, D. (2017). Tackling racism as a “wicked” public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine*. doi:10.1016/j.socscimed.2017.03.028
- Came, H., & McCreanor, T. (2015). Pathways to transform institutional (and everyday) racism in New Zealand. *Sites: Journal of Social Anthropology and Cultural Studies*, 12(2), 24-48. doi:10.11157/sites-vol12iss2id290
- Came, H., McCreanor, T., Doole, C., & Rawson, E. (2016). The New Zealand health strategy: Whither health equity? *New Zealand Medical Journal*, 129(1447), 72-77.

- Came, H., McCreanor, T., Doole, C., & Simpson, T. (2016). Realising the rhetoric: refreshing public health providers' efforts to honour Te Tiriti o Waitangi in New Zealand. *Ethnicity & Health*, 22(2), 1-14. doi:10.1080/13557858.2016.1196651
- Came, H., McCreanor, T., Haenga-Collins, M., & Cornes, R. (2019). Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand. *Kotuitui: New Zealand Journal of Social Sciences*, 1-10. doi:10.1080/1177083X.2018.1561477
- Came, H., McCreanor, T., Manson, L., & Nuku, K. (2019). Upholding Te Tiriti: Ending institutional racism and Crown inaction on health equity. *New Zealand Medical Journal*, 132(1492), 62-66.
- Came, H., & Tudor, K. (2016). Bicultural praxis: the relevance of Te Tiriti o Waitangi to health promotion internationally. *International Journal of Health Promotion and Education*, 1-9. doi:10.1080/14635240.2016.1156009
- Came, H., & Tudor, K. (2017). Unravelling the Whāriki of Crown Māori health infrastructure. *New Zealand Medical Journal*, 130(1458), 42.
- Came, H., Warbrick, I., Doole, C., Hotere-Barnes, A., & Sessa, M. (2019). He hokinga ki te mauri: strengthening te Tiriti o Waitangi public health education in tertiary education settings. *Teaching in Higher Education*, 1-16. doi:10.1080/13562517.2019.1613357
- CERD. (2017). *Concluding observations of the CERD on the New Zealand government (CERD/C/NZL/CO/21-22)*. Geneva, Switzerland: United Nations.
- Chin, M. H., King, P. T., Jones, R. G., Jones, B., Ameratunga, S. N., Muramatsu, N., & Derrett, S. (2018). Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy*. doi:10.1016/j.healthpol.2018.05.001
- Coleman, J. (2016, 11 Feb). [Maori clinical workforce].
- Controller and Auditor-General. (2008). *Procurement guidance for public entities*. Wellington, New Zealand: Author.
- Curtis, E., Wikaire, E., Stokes, K., & Reid, P. (2012). Addressing indigenous health workforce inequities: A literature review exploring 'best' practice for recruitment into tertiary health programmes. *International Journal of Health Equity*, 11(13). doi:10.1186/1475-9276-11-13
- Foxall, D. (2013). Barriers in education of indigenous nursing students: A literature review. *Nursing Praxis in New Zealand*, 29(3), 33-39.
- Griffith, D., Mason, M., Yonas, M., Eng, E., Jefferies, V., Pliheik, S., & Parks, B. (2007). Dismantling institutional racism: Theory and action. *American Journal of Community Psychology*, 39, 381-392. doi:10.1007/s10464-007-9117-0
- Harris, R., Cormack, D., Tobias, M., Yeh, L.-C., Talamaivao, N., Minister, J., & Timutimu, R. (2012). The pervasive effects of racism: Experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science and Medicine*, 74(3), 408-415. doi:10.1016/j.socscimed.2011.11.004.
- Harris, R., Tobias, M., Jeffreys, M., Kiri, W., Karlsen, S., & Nazroo, J. (2006). Racism and health: The relationship between experience of racial discrimination and health in New Zealand. *Social Science and Medicine*, 63(6), 1428-1441. doi:10.1016/j.socscimed.2006.04.009
- Harris, R. B., Stanley, J., & Cormack, D. M. (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. *PLOS One*, 13(5). doi:10.1371/journal.pone.0196476
- Health Quality and Safety Commission. (2018). *A window on the quality of New Zealand's health care*. Wellington, NZ: Author.
- Heke, D., Wilson, D., & Came, H. (2018). Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand. *International Journal for Quality in Health Care*, mzy227-mzy227. doi:10.1093/intqhc/mzy227
- Hickey, & Wilson. (2017). Whānau hauā: Reframing disability from an Indigenous perspective. *Mai Journal*, 6(1), 82-94. doi:10.20507/MAIJournal.2017.6.1.7

- Human Rights Commission. (2011). *A fair go for all? Structural discrimination and systemic barriers to ethnic equality*. Wellington, New Zealand: Author.
- Iwi Chairs Forum. (2018). *Report of the independent monitoring mechanism regarding the implementation of the UN Declaration on the Rights of Indigenous Peoples in Aotearoa New Zealand*. Geneva, Switzerland: Expert Mechanism on the Rights of Indigenous Peoples, Human Rights Council.
- Jackson, M. (1988). *He whaipānga hou: The Māori and the criminal justice system [Part 1]*. Wellington, New Zealand: Department of Justice.
- Kingi, T. K. R., Durie, M., Elder, H., Tapsell, R., Lawrence, M., & Bennett, S. (2017). *Maea Te Toi Ora: Maori Health Transformations*. Wellington, Aotearoa New Zealand: Huia Publishers.
- Living Wage Aotearoa New Zealand. (2017). 2017 living wage rate: \$20.20. Retrieved from https://d3n8a8pro7vhmx.cloudfront.net/nzlivingwage/pages/263/attachments/original/1487586293/The_Living_Wage_Rate_Announcement_2017_alternativev2.pdf?1487586293
- Margaret, J., & Came, H. (In press). Organizing—What Do White People Need to Know to Be Effective Antiracism Allies Within Public Health? . In C. Ford, D. Griffith, Bruce M, & K. Gilbert (Eds.), *State of the Evidence & Tools for the Public Health Professional*. United States: APHA Press.
- Marsden, M. (2003). Kaitiakitanga: A definitive introduction to the holistic worldview of the Māori *The woven universe: Selected writings of Rev. Māori Marsden* (pp. 54-72). Masterton, New Zealand: The estate of Rev. Māori Marsden.
- Matike Mai Aotearoa. (2016). *He whakaaro here whakaumu mō Aotearoa*. New Zealand: Author.
- Mills, C., Reid, P., & Vaithianathan, R. (2012). The cost of child health inequalities in Aotearoa New Zealand: A preliminary scoping study. *BMC Public Health*, 12(384). doi:10.1186/1471-2458-12-384
- Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare. (1988). *Puao te ata tu (Day break)*. Wellington, New Zealand: Department of Social Welfare.
- Ministry of Health. (2007). *Whānau ora health impact assessment*. Wellington, New Zealand: Author.
- Ministry of Health. (2008). *He tipu harakeke : recruitment of Māori in the health and disability workforce*. Wellington, New Zealand: Ministry of Health.
- Ministry of Health. (2015). *Tatau kahukura: Māori health chart book* (3rd ed.). Wellington, New Zealand: Author.
- Ministry of Health. (2016). *New Zealand health strategy: Future directions*. Wellington, New Zealand: Author.
- Ministry of Health. (2017a). *Funding to Māori Health Providers by the Ministry of Health and District Health Boards, 2011/12 to 2015/16*. Wellington, New Zealand: Author.
- Ministry of Health. (2017b). *Health workforce New Zealand annual report to the Minister of Health 1 July 2015 to 30 June 2016*. Wellington, New Zealand: Author.
- National Advisory Committee on Health and Disability. (1998a). *The social, cultural and economic determinants of health in New Zealand: Action to improve health*. Retrieved from Wellington, New Zealand:
- National Advisory Committee on Health and Disability. (1998b). *The social, cultural and economic determinants of health in New Zealand: Actions to improve health*. Wellington, New Zealand: Author.
- National DHB GM Maori Strategic Reference Group. (2018). *Tumu Whakarae submission to the Government inquiry into mental health and addiction*. Auckland, New Zealand: Tumu Whakarae.
- Navigate. (2002). *Retention of Maori staff within the Ministry of Health*. Wellington, New Zealand: Ministry of Health.
- Nursing Council of New Zealand. (2015). *The New Zealand nursing workforce: A profile of nurse practitioners, registered nurses and enrolled nurses 2014-2015*. Wellington, New Zealand: Author.

- OECD. (2014). Inequality hurts economic growth, finds OECD research. Retrieved from <http://www.oecd.org/newsroom/inequality-hurts-economic-growth.htm>
- Office for Disability Issues. (2017). Enabling good lives. Retrieved from <https://www.odi.govt.nz/nz-disability-strategy/other-initiatives/enabling-good-lives/>
- Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., & Pieterse, A. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PLOS One*, *10*(9), e0138511. doi:10.1371/journal.pone.0138511
- Peters, E. J., & Christensen, J. (Eds.). (2016). *Indigenous Homelessness : Perspectives From Canada, Australia, and New Zealand*. Winnipeg, Manitoba: University of Manitoba Press.
- Pickett, K., & Wilkinson, R. (2011). *The spirit level: Why greater equality makes societies stronger*. USA: Bloomsbury.
- Pihama, L., Reynolds, P., Smith, C., Reid, J., Smith, L. T., & Te Nana, R. (2014). Positioning historical trauma theory within Aotearoa New Zealand. *AlterNative: An International Journal of Indigenous Peoples*, *10*(3), 248-262.
- Pool, I., & Kukutai, T. (2018). Taupori Māori - Māori population change - Decades of despair, 1840-1900. Retrieved from Te Ara the Encyclopaedia of New Zealand website: <http://www.teara.govt.nz/en/taupori-maori-maori-population-change/2>
- Priest, N., Paradies, Y., Trenerry, B., Truong, M., Karlsen, S., & Kelly, Y. (2013). A systematic review of studies examining the relationship between reported racism and health and wellbeing for children and young people. *Social Science & Medicine*, *95*, 115-127. doi:10.1016/j.socscimed.2012.11.031
- Reed, K., & Hocking, C. (2013). Re-visioning practice through action research. *Australian Occupational Therapy Journal*, *60*(3), 181-188. doi:10.1111/1440-1630.12033
- Reid, P., & Robson, B. (2007). Understanding health inequities. In H. R. Robson B (Ed.), *Hauora Māori standards of health IV: A study of the years 2000-2005* (pp. 3-11). Wellington, New Zealand: Te Rōpū Rangahau Hauora a Eru Pōmare.
- Royal, S. (2018). Summary of Simon Royal's evidence (#A23 & #A70). Wellington, New Zealand: Waitangi Tribunal.
- Russell, L., Smiler, K., & Stace, H. (2013). *Improving Māori health and reducing inequalities between Māori and non-Māori: Has the primary health care strategy worked for Māori? An evaluation of the period 2003-2010*. Wellington, New Zealand: Health Research Council, Ministry of Health.
- Skegg, D. (2019). *The health of the people*. Wellington, NZ: Bridget Williams Books.
- Statistics New Zealand. (2013). 2013 census quickstats about Māori. Retrieved from <http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-about-maori-english/education.aspx>
- Statistics New Zealand. (2016). Māori population. Retrieved from <http://www.stats.govt.nz/browse-for-stats/people-and-communities/maori/maori-population-article-2015>
- Statistics New Zealand. (2017). Selected ethnic groups (total responses) by total personal income (grouped), for the census usually resident population count aged 15 years and over. Retrieved from <http://nzdotstat.stats.govt.nz/wbos>
- Te Apatu, H., & Nuku, K. (2019). *Closing statements WAI 2575 and WAI 2713*. Wellington, New Zealand: Waitangi Tribunal.
- UN. (2007). *Declaration on the Rights of Indigenous Peoples*. New York, NY: Author.
- UN. (2008). *International Convention on the Rights of Persons with Disabilities*. Geneva, Switzerland: Author.
- Waitangi Tribunal. (2014). *He Whakaputanga me te Tiriti - The Declaration and the Treaty [WAI 1040]*. Wellington, New Zealand: Author.
- Warbrick, I., Came, H., & Dickson, A. (2018). The shame of fat shaming in public health: moving past racism to embrace indigenous solutions. *Public Health*. doi:10.1016/j.puhe.2018.08.013

Williams, D., & Mohammed, S. (2013). Racism and health 1: Pathways and scientific evidence. *American Behavioral Scientist*, 57(8), 1152-1173. doi:10.1177/002764213487340