**Do Māori lives matter?**

**Accessible transcript**

Audio

Kia ora koutou. Nei rā te mihi atu ki a koutou. Nau mai, haere mai. Welcome along to this presentation. My name is Hector Matthews. I work for the Canterbury District Health Board as the executive director of Māori and Pacific Health. And I'm going to talk to you today about equity, or more specifically, Māori health, equity and inequity, and to shine a light on some of the issues that occur within our New Zealand health system. But before we begin, I'd like to introduce myself in te reo Māori.

**Visual**

**An image of two women standing close together, smiling at the camera, fills the top half of the screen. Overlaid text on the image reads ‘Ō tātou hiranga | What matters to us, Shared decision-making and advance care planning virtual hui, 2–3 December 2020. The bottom half of the screen is white and there is black text on the left-hand side which reads ‘Do Māori Lives Matter?’ Hector Matthews, Executive Director, Māori & Pacific Health, Canterbury District Health Board. In the top right corner is a logo which reads ‘our voice tō tātou reo, advance care planning’. Hector Matthews is shown in a box to the right-hand side. Hector has short dark hair and is wearing glasses and an orange and white checkered shirt. There is a green fern pattern behind him.**

Audio

Kia ora tātou. Ko Whangatauatua te maunga, ko Kārikikura te moana, ko Ngātokukimatawhaorua te waka, ko Ngāti Moroki te hapū, ko Te Rarawa te iwi, ko Korou Kore te marae. Nō reira, tēnā koutou katoa. Kia ora, everyone. I hail from the iwi of Te Rarawa in the far north, and it's my privilege to kōrero to all to you today.

**Visual**

**A white PowerPoint slide appears on screen. On it are the words of Hector’s mihi (introduction) in te reo Māori. In the top right corner is a logo which reads ‘Health Quality & Safety Commission New Zealand Kupu Taurangi Hauora o Aotearoa’. The blue and green company logo comprises of three thin square blocks with white circles of differing sizes within them. In the bottom left corner is a logo which reads ‘our voice tō tātou reo, advance care planning’. Down the left-hand side of the screen runs a light green kowhaiwhai pattern. This layout appears on all of the following slides. Hector is pictured alongside on the right of the screen.**

Audio

Before we get into the presentation proper, just a few little points — a little bit tongue-in-cheek here — but something to remember that we're all adults here. And some of the language that you may hear, you may not understand. It could be in te reo Māori. But many of the things that I'm going to be talking about today can actually be quite confronting. So we have to get comfortable with the discomfort. And if you feel uncomfortable, there's an old Māori whakataukī — tūwhitia te hopo, which means 'banish your fears'. Just set that to one side and get comfortable with that discomfort.

**Visual**

**The next slide appears. A movie classification symbol for mature audiences is shown in the top centre of the screen. It is a yellow circle with a large M inside in bold black text. On the bottom right of the screen is a road sign, it is a red triangle with a bold black exclamation mark inside. Beneath the logo is the word ‘Disclaimer’ in bold black text. The text on the slide reads ‘Language you may not understand may be used at times (te reo Māori). Some may feel confronted and very uncomfortable at times. Strong language and the odd profanity may be used at times. Note: people who swear are more likely to be honest (Journal of Social Psychology and Personality Sciences, Gilad Feldman et al, 2017). Tūwhitia te hopo!’ There is a link at the bottom right of the screen which reads ‘https://www.cam.ac.uk/research/news/frankly-do-we-give-a-damn-study-finds-links-between-swearing-and-honesty’.**

Audio

OK. So let's talk about, firstly, the determinants of health, because in any discussion that one has about inequity, be it inequity of health based on age, disability, ethnicity, whatever it may be, there are a whole range of things that impact on health and our health outcomes that are known as, collectively, the determinants of health — the things that determine our health. And this diagram here is adapted from the Institute of Clinical Systems Improvement in 2014, and the Ministry of Health have used this in their Health and Independence Report. So it's widely accepted in the New Zealand health system about the determinants of health. So we need to understand that there are many, many factors that affect our health, and they are collectively known as the determinants of health, and they can support or be barriers to good health and broader well-being. Key amongst them are socio-economic factors — your education, your income, things like your job. And then there are physical environments — things like the home that you live in, whether it's cold and damp and safe and those sorts of things. And also our health behaviours — whether we drink alcohol, take drugs, whether we have a sensible and nutritious diet, how often we exercise, tobacco use, etc. Those collectively impact significantly on our health. And those are things that for those of us that work in the health system can't directly affect. So it's very, very difficult for us to take responsibility for things that we can't directly impact on. We can influence them. We can promote good health and good diet and good exercise. We just can't directly impact on them. However, another key factor of the determinants of health — about 20 percent of the factors affecting health outcomes are quality to, quality of health care and access to health care. And those are the things that I'd like us to think carefully about now, because those are the things that we can directly impact on. We can impact on the quality of care that we provide for our people and the access to care that people receive. And from the perspective of Māori, we can impact on the quality of care that Māori receive and the access that Māori have to our health system. So that's a really important part of this presentation and understanding equity and how it impacts on us as a population.

**Visual**

**The next slide appears and has a heading which reads ‘the determinants of health’. Below the heading is a diagram of a person and alongside it shows how each of the determinants of health impact on the person. Hector highlights the points included on the slide as he talks.**

Audio

So let's firstly begin at understanding what it is I'm talking about when I talk about Māori and the New Zealand Māori population. So, at the 2018 census, there are around 776,000 people that identified with the Māori ethnicity. And that's a significant increase. Year on year, It's more than 5 percent growth in the Māori population from the 2013 census to 2018 census. Approximately 16.5 percent of New Zealanders identify as being Māori, and that's about one in six people. One-third of those are under the age of 15, and the median age is 25 and a half, or 25.4, more correctly, compared with 41.4 for Europeans. So that's a significant difference in the median age. And just to put that in perspective, I'm 55 years old, so I am more than double the median age for Māori. So as a Māori, I'm actually a very old Māori. If I were European, I wouldn't be particularly old, only slightly over the median age. So it's a very, very different-looking population to the general population and, indeed, the European, or Pākehā, population. And we need to understand that when we're looking at health services.

**Visual**

**The next slide appears and has a heading which reads ‘NZ Māori population’. Below the heading is a bullet point list. Beneath that is a diagram of six female figures. Five of the figures are coloured black and one is coloured red. There is a white koru pattern on top of the red figure. Hector highlights the points included on the slide as he talks.**

Audio

So, again, continuing on with the New Zealand Māori population, as I said before, 16 and a half percent of the New Zealand population is Māori. But if you look at this graph here, it represents graphically how very different those age... the ages of that population is. The vast majority of the Māori population are sitting in that under-25 group, and, in fact, a third of them are under the age of 15. And yet, when we look at the European population, it's significantly different, and then you get to the older population group. Once you get over 70, you see almost no Māori are up there. Very, very small proportion of the Māori population are over the age of 70, compared with the non-Māori population. So in the middle, there are similarities in proportions. But at the very young ages and the very old ages, there are significant differences in the structure of the populations. A much lower life expectancy for Māori — less than 6 percent are over the age of 65. And yet, it's three times more in the non-Māori population. And as I've said before, very different age spread in terms of the age— the median age.

**Visual**

**The next slide appears and has a heading which reads ‘NZ Māori population’. Below the heading on the left is a bullet point list. On the right is a horizontal stacked bar chart. Hector highlights the points included on the slide as he talks.**

Audio

So it's really important to understand when we look at our Māori population in New Zealand, they are not the same as the Pākehā population; they are not the same as the European or the general population. The Māori population is different. And if we assume people are the same, we will get it wrong for Māori. And actually, there's lots of data to demonstrate that we have gotten it wrong for Māori all the time because we have assumed Māori are the same as everyone else, and they are not. So let's look at some of that data. What are some of the differences that occur in health outcome or health access for our Māori population?

**Visual**

**The next slide has a heading which reads ‘The Māori population is different’. Beneath the heading are two photos. On the left is a large group of Māori people sitting in front of a whare. On the left is a picture of an artwork of a Māori woman. Beneath the images are the words ‘If we assume people are the same, we’ll get it wrong for Māori’.**

Audio

I put the source of this data here. It's from the Ministry of Health mortality report in 2016. Major causes of death. And what we see here is all cancers, ischaemic heart disease, cerebral vascular diseases, chronic lower respiratory conditions. And in each of those— And all of those are significant killers in New Zealand, and particularly in our health system, there are significant differences. So the mortality rate for the non-Māori population in cancer is about 110 per 100,000 of population, versus 188 for Māori. So by a factor of about 70 percent — two-thirds higher for Māori in all cancers. It's more than double for ischaemic heart disease. It's about 50 higher for cerebrovascular diseases, and almost triple — it's about two and a half times higher — in respiratory— or chronic lower respiratory diseases. What this is showing is that when Māori get unwell, they die at significantly greater rates. And so this highlights the importance of access to health care sooner and in more efficient ways for our Māori population, because there's no good reason why those mortality rates should be so much higher.

**Visual**

**The next slide has a heading which reads ‘Major causes of death 2016’. Beneath the heading is a horizontal bar chart which shows the leading causes of death for Māori and non-Māori in 2016.**

Audio

Let's look a little bit more deeply into some of those. And again, this comes from the Waitangi Tribunal report, the Health Trends Report published in September 2019. And this data here — or these data here — specifically look at cardiovascular disease mortality rates for 35 years and over by gender for Māori and non-Māori. So the blue line is Māori. The grey line there is non-Māori. We have men, or males, on our left and females on our right. And there's a few things that you can see here — that men have had traditionally higher rates of the disease over time, but they are trending downwards. Everybody's rates are trending downwards. But as you can see, in the early parts of this data here, in 1998 through— 1996 through to 1998, the gap between Māori and non-Māori was much, much greater. In fact, the age-standardised mortality rates were twice as high for Māori — more than 700 for men and around 500 for women, for Māori, versus just over 300 for non-Māori men and around 200 for non-Māori women. So the mortality rates were twice as high back in the late '90s. Everybody's rates have dropped over time, but actually those mortality rates still remain around double. So everybody's mortality rate has been dropping. And in fact, after adjusting for age, mortality rates have decreased by 50% between 1996 and 2014. But the Māori rates are twice as high when compared to non-Māori. So we haven't managed to close the gap on cardiovascular disease mortality rates. despite the fact that everybody's rate is dropping, the gap still remains.

**Visual**

**The next slide has a heading which reads ‘Cardiovascular disease mortality rates, 35+ years, by gender, Māori and non-Māori, 1996–98 to 2012–14’. A line graph headed ‘Age-standardised rate (deaths per 100,000)’ is shown on the left hand side. Hector speaks to the text shown on the right hand side of the slide.**

Audio

Now let's look at cancer registration. So these are the cancers that we know about — the people that have turned up to primary care or to the hospital, have been examined, have been tested, and we know they have cancer. 25 years of age and over — Māori and non-Māori. And on the left there are females, and on the right, there are males. It's the age-standardised registrations per 100,000 of population. And what we can see is after we age standardise, there's a slightly higher registration rate of cancer for Māori than non-Māori over time, but it's only slightly. For... females, it's around 400 per 100,000 of population. And for Māori, it's around 500. So it's slightly more, about 20% higher, but not significantly so. And for men, a similar sort of thing — around 400 for non-Māori, and, in fact, just under 500 for Māori. So slight... slightly higher rates of registration for cancer over that period of time from '96 to 2015. However, when we take those same people over the same period of time and look at the mortality rates, what we find is Māori die at a significantly greater rate. There are significantly higher rates of mortality. So these are all the cancers we knew about, which is deeply troubling over such a long period of time, because what it's pointing to is either Māori aren't receiving the same care or the same access to care. So despite the fact that the registration rates are only slightly higher, the mortality rates are significantly higher for cancer.

**Visual**

**The next slide has a heading which reads ‘Cancer mortality rates, 25+ years, Māori and non-Māori, 1996–98 to 2013–15. Two line graphs are shown side-by-side and are headed ‘Age-standardised rate (deaths per 100,000)’.**

Audio

So what this is showing is that our system isn't performing as well for Māori. We've made some gains over recent years, and we saw some of those registration rates dropping. We saw some of those incidents and prevalence rates dropping. But the mortality rate's still remained much, much higher for Māori. There are stark differences in access to health care services for Māori and health outcomes for Māori versus non-Māori. There are these systemic assumptions about equality which exacerbate inequity. And a good example of that currently, for cancer, is our bowel screening programme, which we are currently rolling out. Māori and non-Māori have similar registration rates, so the risk for Māori and non-Māori catching colorectal cancers is pretty similar. However, the mortality rates are much, much higher, and Māori catch the illness, or get colorectal cancers, about a decade sooner, but we don't get access to the services sooner. Our bowel screening programme treats everyone the same, and we screen from the age of 60. And despite the fact that the College of General Practice and the College of Surgeons and the Māori Doctors Association and the Māori general managers from every DHB in the country have written to the Ministry, saying if you treat everyone the same, you will ensure inequities persist. The Ministry has chosen to ignore that. So the systemic assumptions about equality, about treating everyone the same, is actually exacerbating the inequity, because people aren't the same. Māori are a younger population. They have a higher burden of disease, and they tend to get those diseases much sooner, and their mortality rates are higher, and we know this. And despite knowing this, we are still treating everyone the same. So this policy of treating everyone the same actually affords privilege to non-Māori in their access to services and their health outcomes. So it's no surprise that we see unequal outcomes.

**Visual**

**The next slide appears and has a heading which reads ‘The system isn’t performing as well for Māori?’. Below the heading is a bullet point list. Hector highlights the points included on the slide as he talks.**

Audio

So, we're in the middle of a pandemic. The world is in the middle of a pandemic — COVID-19. And I thought it might be prudent to talk about pandemics and COVID-19 and ask the question, because it's directly attributable to inequity — why is equity so important in this pandemic, or, indeed, in any pandemic?

**Visual**

**The next slide has large black text across it which reads ‘Pandemics and COVID-19. Why is equity so important in this pandemic?’**

Audio

So the best... case to look back at for health and equity, and for a pandemic in New Zealand anyway, is the 1918 influenza pandemic. And there've been a few smaller epidemics around the world since then, but that's certainly the largest example and one which we have a lot of data on. So it was an extremely virulent pandemic, that influenza pandemic, with estimates of over 100 million deaths worldwide. So that's significantly greater than what we've seen with COVID at the moment. The New Zealand mortality topped around 8500 people. That's an awful lot of deaths, when you think that we've had 25 deaths for COVID at the moment, and this pandemic has still got a long way to run. 8500 was particularly tragic. And bearing in mind that our population was only 1.15 million. So it was less than a quarter of what we have now and 8500 deaths back at that 1918 influenza pandemic in New Zealand. The national mortality rate was 7.7 per 100,000 people. So almost eight people out of a thousand people died of that flu pandemic in 1918. However, the Māori deaths were believed to be around 2160, a mortality rate of 42.3 per thousand people. So around six times higher. For every non-Māori that died in New Zealand, six Māori died in New Zealand, as a rate per 1000 people. At the time, that was a third— a third of all the Māori population were located in our poorest populations. And it's also generally accepted that the population estimates used for Māori to calculate those mortality rates were based on the 1916 census in New Zealand. And now we know that it was not as sophisticated as the methods we have now and that those mortality rates are likely to be even higher than what's been recorded. So that was a particularly virulent pandemic, and there was significant inequity in infection and mortality for Māori back then. And we knew that coming into this pandemic, and we focused our efforts on equity to ensure that we wouldn't get the same level of inequity for this current COVID pandemic. And we're still working hard on that now.

**Visual**

**The next slide appears and has a heading which reads ‘1918 Influenza pandemic’. Below the heading is a bullet point list. Hector highlights the points included on the slide as he talks.**

So, according to the Ministry of Health, and this was taken at the end of October this year, this shows how, really... how much we've focused on ensuring we have the best possible outcomes, with regard to equity and this COVID-19 pandemic. So, many of the conditions facing Māori in 1918 still persist today in 2020. There's huge variation in socio-economic deprivation, and Māori represent a significant part of our poorest population in New Zealand. There is great variation by ethnicity in access to and quality of care, like there was back in 1918. And the incidence and prevalence of high-risk conditions continue today in 2020. So, looking at the total cases by ethnicity, about 61 percent of our infections were European or other. Māori were around 9 percent. Pasifika were around 10 percent. So that's not too bad for Māori. Māori are 16.5 percent of the population and only 9 percent of the infections. That's pretty inequitable, though, for our Pacific population. They are not 10 percent of the New Zealand population. They're around the 5 percent to 6 percent mark. So there has been great inequity, in terms of infection and total number of cases for Pasifika. But, thankfully, we haven't had that translate into mortality yet for Pasifika.

**Visual**

**The next slide appears and has a heading which reads ‘COVID-19 pandemic’. Below the heading is a horizontal bar chart with the heading ‘Total cases by ethnicity’. Next to the slide is a series of bullet points which Hector speaks to.**

Audio

In terms of testing, one of the ways to try and ensure we don't get inequity in terms of infection, or more particularly in mortality and morbidity, is to ensure that we over-test our most vulnerable populations, and we've certainly done that for Māori. If you look at the testing rate per 100,000, for Māori, it's significantly higher than all other population groups, except Pasifika, and obviously, Pasifika have had a really high infection rate in this pandemic. So their testing rate is also much, much higher. In fact, it's more than double... It's close to double the general population. So that's very, very good. We're over-testing in those vulnerable populations to try and avoid an inequity in terms of mortality. And as you can see, the positivity rate for Pasifika is about the same as everyone else. Māori are much lower. So New Zealand tested at much higher rates for Māori and Pasifika, and this was appropriate, given our history of unequal infection in previous pandemics and the greater risks faced by those populations. So far, the strategy has been successful. But as I'm sure we all know, this pandemic has got a long way to go before it plays out. But so far, our strategy has been good, and we've managed to avoid an inequity in terms of morbidity and mortality.

**Visual**

**The next slide appears and has a heading which reads ‘COVID-19 testing’. Below the heading is a table which shows tests for different ethnic groups by ethnicity. The table shows ethnicity (Māori, Pacific, Asian, Other, Unknown and total), the number of people in each ethnicity that have been tested, the test rate per 1,000 and the positive test results based on ethnicity. Beneath the table are some bullet points which Hector highlights as he speaks.**

Audio

So, one of my favourite poets is Maya Angelou, and I particularly like this quote from her. 'Do the best you can until you know better. 'Then when you know better, do better.' So, i roto i te reo Māori — in te reo Māori — 'Pēnā e mōhio ana tātou ki te ara tika, 'tēnā, me whai!' And the reason I'm saying this here is I presented you with some data earlier about cancer and ischaemic heart disease and so on and looked at mortality rates. So we know lots of stuff about Māori access to health care and the quality of health care that they receive. So what Maya Angelou is charging us with is, well, we must always do the best that we can. However, when we learn new stuff, when we know better, we should look to do better. So let's think about that more carefully. When we know better, do better.

**Visual**

**An image of Maya Angelou fills the next slide Beside the image is a quote which reads ‘Do the best you can until you know better. Then when you know better, do better. Maya Angelou.’ A heading above her reads ‘Pēnā e mōhio ana tātou ki te ara tika, tēnā, me whai.’**

Audio

What do we actually know today in 2020 about Māori health equity? What is it we actually know? Where's our knowledge coming from? What does the evidence tell us? What do we know today?

**Visual**

**The next slide has large black text across it which reads ‘What do we know today about Māori health equity?’**

Audio

Well, we actually know quite a bit. If we look back on some of the publications here, in the year 2000— or 1999 to 2000, the Ministry of Health published a series of three bulletins called Decades of Disparity, and they looked at ethnic and socio-economic inequalities in mortality in New Zealand. And they noted that actually mortality... life expectancy at birth increased. It got worse between Māori and non-Māori during the '80s and '90s. At the beginning of the '80s, the life expectancy gap between Māori and everyone else was six to seven years at the... By the end of 19... of the 1990s, that gap had increased by some two years. So, actually, the gap got worse. Life expectancy gap got worse; inequity got worse over that period of time. Throughout the 1980s and '90s, the mortality rates between low- and high-income groups increased over time, and these inequalities were rooted in historical social processes that entrenched the privileged position of dominant groups. So Māori and non-Māori inequalities in mortality persisted within socio-economic strata. So this was 20 years ago, and the Ministry looked at data for the previous 20 years, and they saw significant inequality, significant inequity between Māori and non-Māori back then.

**Visual**

**The next slide appears and has a heading which reads ‘Decades of disparity 1999–2000’. Beneath the table are some bullet points which Hector touches on as he speaks.**

Audio

The University of Otago has the Wellington School of Medicine, which is part of the University of Otago, and the Wellington School of Medicine has a research centre called the Eru Pōmare Research Centre based in Wellington. And over a long period of time since 1980, they have published a series of documents called Hauora. There have been four of them. Hauora I was published in 1980, and it looked at data from the years 1955 to 1975. Hauora II was published in 1988 and looked at data from 1970 to 1984. Hauora III, published in 1995, looking, again, from 1970 but through to 1991. And Hauora IV, the most recent, was published in 2005, looking at data from 2000 to 2005. And all of those publications looked at various data within the New Zealand health system, and they all showed significant differences between Māori and non-Māori, in terms of their access to services, the quality of care they received, and, more particularly, their health outcomes. So over a period of some 40 years, the University of Otago, through its Wellington School of Medicine, has published, literally, volumes of data demonstrating health inequity that we know about in New Zealand between Māori and non-Māori., And there's a link to Hauora IV there in this slide.

**Visual**

**The next slide appears and has a heading which reads ‘Hauora – Māori Standards of Health I-IV 1980–2005’. Beneath the table are some bullet points which Hector touches on as he speaks.**

Audio

In 2006, the New Zealand Family Health Physician published a study which concluded that Māori in New Zealand receive fewer referrals, they receive fewer diagnostic tests, they get less effective treatment plans than non-Māori, are offered treatments at a substantially decreased rate, they're interviewed by their doctors for less time, and they are prescribed fewer secondary services. So this study concluded that Māori encounter a different health system to non-Māori. So when I, as a Māori, enter the health system, I receive a different service, a different quality of service, to my Pākehā wife, for example. It's intriguing that we knew this more than a decade ago — that Māori encounter a different health system to non-Māori.

**Visual**

**The next slide appears and has a heading which reads ‘Health care inequalities NZ’. Beneath the table are some bullet points which Hector touches on as he speaks.**

Audio

In recent years, the Waitangi Tribunal has been hearing evidence. It's heard stage one of the Health Services and Outcomes Inquiry in 2018 and published its report in June 2019. And here are some of its conclusions from stage one of that inquiry. The New Zealand health framework fails to consistently state a commitment to achieving equity of health for Māori. The funding arrangements for primary health disadvantage Māori, both organisations and providers, and the Crown has been aware of these failures for well over a decade but has failed to adequately amend or replace the current funding arrangements. And it goes on. There's a link to that report in the slide. It goes on to discuss a whole range of things. But what I'm highlighting here is there have been failures in our system. There are inequities in our health system. We know about these. We publish these data, and yet, we still fail to respond. And just this year, the New Zealand Health and Disability System Review, and, again, there is a link to the final report from that review, which was only published a few months ago. And some of the conclusions from that Health and Disability System Review — Māori experience of hospital services is characterised by poorer access, poorer outcomes and being exposed to institutional racism. Hospital appointments are less accessible for Māori compared with non-Māori. 16 percent of Māori adults do not attend specialist appointments, and it was compared with 6 percent of non-Māori. And for Māori, deaths preventable by health care are two and a half times as frequent as non-Māori — two and a half times greater chance of dying by something that's preventable in the health care system if you are Māori than if you are non-Māori. So the Māori health outcomes are significantly worse than those of other New Zealanders, and this represents a failure of the health system. And that was published in June of this year.

**Visual**

**The next slide appears and has a heading which reads ‘NZ health and disability system review June 2020’. Beneath the table are some bullet points which Hector touches on as he speaks.**

Audio

So I go back to that question — and again, it touches on what Maya Angelou said — what do we know today about Māori health equity? Because Maya Angelou implored us — do the best that we can until we know better. When we know better, let's do better. So we actually know a great deal about Māori health inequity, and we have known for a very long time. Literally, decades and decades of data tells us how unequal our health system is, how poorly we treat Māori, how poor the access to health services for Māori is, and how different the quality of health care is that Māori receive. So we know about this. There are literally volumes of data published about this. And despite knowing this, we're not doing better. So why aren't we doing better? And I ask this question — do Māori lives really matter? Cause if they mattered, why aren't we doing something about this? Why aren't we doing better? If we know that the funding arrangements are inadequate, why aren't we doing something about it? If we know Māori don't get access to health services, why aren't we changing that to ensure we get better access to health? And I guess this Māori lives matter— 'Do Māori lives really matter?' I'm shamelessly piggybacking on top of the Black Lives Matter movement, because in New Zealand, that's actually what's relevant to us. And often the counter to that, people will say, 'Well, actually, all lives matter.' So let me be really clear. Yes, all lives do matter.

**Visual**

**The next slide has large text across it, over several lines, which reads ‘What do we know today about Māori health equity? We actually know a great deal and we have known for a very long time. So why aren’t we doing better? Do Māori lives really matter?’**

Audio

However, 'all lives matter' is a spurious argument because context matters. And just looking at those graphics that you see in front of you there, not all of those buildings matter. Context matters. The house that's on fire matters the most. Not everyone's lives matter at the beach. If we're at the beach, actually, if someone's drowning in the water, their life matters more than everyone else. The life that matters the most is the one drowning. Now, those are two simple examples around why 'all lives matter' is spurious, cause when we look at the data for health in this country, what we see is Māori are drowning, Māori are on fire. Everyone else isn't. We are experiencing much worse outcomes than everyone else. We have been on fire, and we have been drowning for decades, and everyone has known that we've been on fire and drowning for decades and let us drown and let us burn. So, actually, I ask that question again — do Māori lives matter? Because if, as implored by Maya Angelou, we should be doing the best that we can until we know better, and then when we know better, we should do better, well, actually, we know better now, and we are not doing better. What's wrong with this picture?

**Visual**

**The next slide appears and has a heading which reads ‘Why “all lives matter” is a spurious argument’. Beside the heading are two images. The one at the top is an illustration of several low-rise buildings. Half of the buildings are on fire with flames coming from the windows. The other half are safe and untouched. The second image is an illustration of a young boy who looks as though he is in trouble in the water and may be drowning.**

Audio

The systemic assumptions about equality are exacerbating inequity in this country because we are treating every building the same, despite some being on fire and some not, because we are treating every person the same, despite some drowning and some not. What's happening is Māori are drowning, Māori are catching fire, and we are missing out on the fruit. And, actually, something needs to be done about this in our health system. This fixation that we have with treating everyone the same, and I'll return to the National Bowel Screening Programme. Treating everyone the same and screening from the age of 60, despite the fact that we know the majority of Māori colorectal cancers occur before the age of 60 will ensure unequal outcomes for Māori. We know that now. We knew it before the bowel screening programme was rolled out. The College of General Practice has written to the Ministry of Health, as has the College of Surgeons and the national Māori general managers and the Māori Doctors Association have all written to the Ministry of Health, saying, 'You should not be treating Māori the same. The data tells you that they are different. They get the illness sooner, and they die sooner.' And despite this, we're still treating everyone the same. My plea is to have an equity approach and treat people differently, based on the data we receive. And I think the key issue to understand around this is when you have an equity approach, nobody loses. But at the moment, our equality approach affords privilege to non-Māori, in terms of access to services and their health outcomes. So it's no accident that Pākehā receive better access to health care and better health outcomes than Māori, because the system is set up to ensure that. And as uncomfortable as that sounds, we need to understand that this is a reality in the New Zealand health system.

**Visual**

**The next slide appears and has a heading which reads ‘Equality vs equity’. Beneath the heading are two images, both show three illustrated figures reaching for apples hanging from a tree. The illustration on the left is titled ‘equality’ and shows each figure standing on a box of the same size. The figures are all different heights. The illustration on the right is titled ‘equity’ and has the figures standing on boxes of different heights. The shortest person has the biggest box and the tallest person has the smallest box, so that they are all able to reach the apples. Beside the images are two bullet points which Hector speaks to.**

Audio

So, I have a video here, which I want you all to listen to, by an English gentleman called Paul Scanlon. And just have a listen, and we'll talk about this shortly.

**Visual**

**The next slide appears and there is an image of a gentleman named Paul Scanlon in the middle of the screen. He has white hair, a white beard and black-rimmed sunglasses. He is sitting outside wearing a blue jacket. A heading above him reads ‘I interrupted a racist joke’.**

Audio

(Paul Scanlon:) Some time ago, I was speaking at a corporate event in America. I was the guest speaker that night at dinner. I was at a table full of white people and a guy, one of the bosses who’d invited me actually, started to tell a joke that I knew straight away was going to be racial and black people were going to be the butt of the joke. In those split seconds, in the early sentences of the joke, I had a decision to make. Do I say something or stay quiet? No one else was saying anything though I’m sure they felt uncomfortable. So I spoke up and I said “I don’t think this joke is one I want to hear, I don’t like the way it’s going, I think it’s going to be at the expense of black people. I’m not comfortable with that, would you mind not telling it, or I could leave the table”. It was very uncomfortable. I remember he didn’t tell the joke, but it was uncomfortable the rest of the night. Later in my room I journaled what I felt about what was going on. I thought two things were at play. One was what I would call white solidarity. The other is what I would call white social capital. White solidarity is an unspoken code that we have as white people, that means we would never embarrass each other by creating a racial discomfort for each other by interrupting a racist joke or pointing out a act of prejudice or discrimination. We kind of keep quiet because it’s a social code that we have that we would remain in solidarity with each other, which protects our whiteness. Our white advantage our white privilege that was at play at the table that night that allowed him to do what he’d obviously done many times. White social capital is what you get if you stay quiet. You get included, you are one of the boys, you are an insider, you are good to be around, you’re a team player, you’re fun. Which may give you opportunities of inclusion as well in a corporate setting, a business setting, a social setting. It is an accruing of white capital by going along with it. What I want to say to my white friends listening to this is that our silence at those times is not benign, it is malignant because we become complicit in the continuation of the racist joke telling. It gets told again and again because when we heard it, we didn’t say anything and as socially awkward as it is and knowing you’ll be penalised if you say something, I’m appealing to us because millions of us every day have this opportunity to say something. To speak up, to stand up for people of colour and black people. And you will be excluded, and you will lose social capital but you will be a champion of a cause that you wish someone had been for you at times in your life. And I think many of us feel we can’t do anything at the large government level, we can’t protest on the streets, we don’t feel comfortable with this or that. Can you say something today? Wherever you are in your life, can you speak up, because our silence is not benign. It is continuing the problem. We can all play a part like this every single day. Let’s speak up. Let’s play our part is what I’m appealing for. Love you guys, thank you.

**Visual**

**The slide disappears and is replaced by a video of Paul Scanlon, with a black background on either side. The video begins playing, Paul talks directly to the camera.**

Audio

So Paul Scanlon touched on this idea that if we sit back and allow things to continue, actually, we are supporting the status quo, and supporting the status quo actually allows inequity to continue. If you sit back, you get social capital. However, it persists the unequal outcomes and the inequitable outcomes that, in this case in New Zealand, Māori receive. And there's a little quote here by Nobel Prize winner Elie Wiesel — And it goes, really, to the heart of things. I've told you a whole lot of data here. If we turn a blind eye, if we walk past it, it will persist. The evidence for Māori inequity is long-standing. It's robust, it's persistent, it's pervasive, and it's compelling. If we are ambivalent, ambivalence is not benign. If you just let it slide, it will get worse, and we are seeing that today. It's quite disturbing the amount of times that we see data that we know will lead to unequal outcomes, will lead to inequity, and people sit there in silence. So ambivalence is not benign. In matters of justice, one cannot sit by and allow the status quo to continue. And that's really what Paul Scanlon was touching on there when he interrupted the racist joke. Yes, it's uncomfortable. However, it's necessary if you want to make change, because it's often those casual things that allow the system to continue, and that's what we see in the New Zealand health system. Indifference to an issue supports inequity. Inaction does not follow the evidence that we see published time and again in New Zealand. The existing system perpetuates what we know to be wrong in our system. Complicity with the status quo is malignant. So, we do know better. We've seen the data. It's published time and time again. We do know better. So why aren't we doing better?

**Visual**

**The next slide appears and has a heading which reads ‘Ambivalence is not benign’. There is a list of bullet points down the left hand side which Hector speaks to. There is an image on the right hand side of Elie Wiesel, who sits with his palms facing together, hands in front of his face and his thumbs beneath his chin. Beside his image is a quote ‘We must always take sides. Neutrality helps the oppressor, never the victim. Silence encourages the tormentor, never the tormented.’**

Audio

Quality, fairness, bias and inequity — I fully appreciate that questioning the fairness of our health system is an uncomfortable undertaking. The principle of care based on need is a core value for most health professionals, particularly in the context of life-threatening disease. None of us wants to believe that our health system or those of us working in it might discriminate on the basis of ethnicity. Yet, an honest look at the evidence makes it difficult to avoid this assessment. Māori encounter a different health system. We know that. We've known it for many years. We know it now. So the challenge for us is to actually stand up and challenge that and force the system to change. We have a wonderful health system in New Zealand, but it's imperfect, and we know about many of the imperfections. We have to have the courage to face those, to confront those imperfections and change them, just like Kate Sheppard did back in the latter part of the 19th century. She challenged the status quo, and she got universal suffrage vote for women. And yet, more than 125 years later, we are still struggling to find true equality for our wāhine. But we're a lot better off now than we were 125-odd years ago. But we need to challenge the system. It's a wonderful system. It's a very good system, but it's imperfect, and it is full of inequity and privilege for those who have power and privilege.

**Visual**

**The next slide appears and has a heading which reads ‘Quality, fairness, bias, inequity’. There is a list of bullet points down the left hand side which Hector speaks to.**

Audio

So, not to leave you all depressed about that. What are some of the things that you can do immediately? Well, firstly, stop normalising Māori inequity. Every day, we see data which says Māori have worse outcomes of this, worse incidents, worse prevalence, much fewer access to services, and so on, and so forth. Let's just stop normalising Māori inequity. We know that it's there, so let's act to change that. Stop blaming Māori for colonisation, deprivation and poor health. It's not someone's fault, and in particular, it's not Māori. It's not the fault of Māori. It is what it is, so let's work to change that. Let's all take responsibility for the things that we are able to control and influence. And in many cases, that's how people access our services and the quality of care that they receive. So if we know, for example, that Māori receive fewer prescriptions, and we do know that, because Pharmac has published data on that, then let's see prescribers in this country examine themselves around that and ensure that there is no difference, or indeed, if there needs to be greater access for services, that that changes. Know what your service should expect to see by ethnicity. If our population of Māori in New Zealand is 16.5 percent, then I would expect to see that across the country, in terms of presentations. In some populations, though, it's much, much higher. Our proportion of young people is much, much higher, so we should see that, in terms of access to services. And if we don't see that, we should seek advice and make changes to our service to ensure that we see the appropriate presentations and access to services. Let's not perpetuate the practice of treating people equally if the data, if the evidence shows that this will exacerbate Māori inequity and will afford privilege to non-Māori. So be courageous and challenge the way we shape our system, monitor performance towards equity and make us all responsible for achieving equity. Don't just look at the Māori in our system and say you should improve equality, cause 99 percent of all the data and resources of all the money and services goes to non-Māori. So shine a spotlight on the non-Māori part of the system and make them responsible for improving equity. And a nice, simple piece of advice — I know it's hard to do, but intervene sooner and more often with Māori. You want to change inequity, think about how you can intervene sooner and more often with our Māori population, whatever service that may be.

**Visual**

**The next slide appears and has a heading which reads ‘Things we can do immediately’. There is a list of bullet points down the left hand side which Hector speaks to.**

Audio

What other things can we do, can I do? There's no single solution to this. I certainly appreciate that. One of the things you can do is assume that you'll probably get it wrong for Māori. And the reason I say this is if you walk into any situation, into a service or a planning meeting or whatever it may be, immediately assuming that you'll probably get it wrong for Māori, you will stop, you will pause, and you will think in different ways. And this will drive you to reflect and engage in different ways to ensure that you have Māori voices around the table and do better for Māori. Don't be complicit. Speak up when you see, hear or experience bias. Another simple piece of advice is say 'kia ora' at every opportunity. I love what Air New Zealand has done over the last decade to transform themselves, and I appreciate that it's been pretty tough in a pandemic environment where people are flying less. But look what they've done for the use of te reo Māori on our national carrier. Why can't we do that in our national health system? Say 'kia ora' all the time. And the reason that's important is because 'kia ora' belongs to us here in Aotearoa. You won't hear it in any other place in the world, unless people are doing it because they're Kiwis living overseas. It belongs to us. But when you look at the history of colonisation in New Zealand and the native schools which prevented te reo Māori from being used as a language of instruction within our schools, you'll appreciate that our country tried to stop te reo Māori being spoken. Now, we've changed it in the last decade or so, but we need to change that even more. And saying 'kia ora', using te reo Māori more often, sends a really powerful message to Māori that the system sees you, it hears you, it understands you, and it welcomes you. And we haven't always been that way in our health system. Use te reo Māori at every opportunity, not just 'kia ora'. If you know words in te reo Māori, if you know things like 'kei te pai', 'kei te pēhea koe', kōrero mahi, hui, use those words as often as possible. Use them in your emails. Use them on your telephone. Try more and more to use te reo Māori, cause every time you do it, you give permission to others to use it, you make it more acceptable, and you send that message to Māori that we see you, we hear you, we're doing our best to understand you, and we welcome you. And pronounce it correctly. And if you don't know how to pronounce it, learn, and when you know better, do better. Use Hauora Māori services when you can. Don't rely on them. We need everyone to be more culturally competent and more culturally responsive. But when you're not sure, seek advice from Hauora Māori services. They will help you out. When you know you're saying something wrong, do better, and that applies to our place names, someone's surname, whatever it may be. When you know better, do better. Support your Māori staff and whānau in your team and in your service. Help them grow and develop our own Māori workforce to do better. If we want to change inequity, we have to do stuff. We have to be active about improving access to and quality of health care. We can't just say it. We actually have to do stuff.

**Visual**

**The next slide appears and has a heading which reads ‘What can we/I do?’. There is a list of bullet points down the left hand side which Hector speaks to.**

Audio

Which leads me to a well-known whakataukī — a well-known proverb in Māori. All of this data isn't to beat people up. All of this information isn't to beat people up. It's to challenge us all. He manako te kōura i kore ai — wishing for crayfish won't bring it. You can't be just sitting around, waiting for the crayfish to occur. If you want crayfish, you actually have to get off your backside, get into the water and find those crayfish. If you want equity, you can't keep doing the same thing. We actually have to get off our backsides, look at the data, challenge ourselves, be confronted by what we see and make changes in order to get better health outcomes. And if that means testing more Māori, getting more Māori in, ensuring that we have te reo Māori all over the place, ringing our Māori patients and whānau. Whatever that may be, we need to do things differently in order to get better health outcomes for Māori, because the system hasn't worked so far. It perpetuates inequity. So why am I saying this? There's another old Māori saying which I think many of you have probably heard before.

**Visual**

**The next slides appears and has an illustration in the middle of the page of a young Māori male floating in water on an inflatable ring. Beneath him are two kōura on the sea bed. Text at the top of the illustration reads ‘He manako te kōura I kore ai’. At the bottom it reads ‘Wishing for crayfish won’t bring it.**

Audio

Hutia te rito o te harakeke — if you rip out the centre of the flax — kei hea te komako e kō — where, then, will the bellbird fly? Kī mai ki ahau — you say to me — he aha te mea nui o te ao — what is the most important thing in this world? Māku e kī atu — and I will say to you — he tāngata, he tāngata, he tāngata. So, the most important thing in the world — he aha te mea nui o te ao? He tāngata, he tāngata, he tāngata. What's the most important thing in the world? It is people. It is people. It is people. And if we see, in Aotearoa, in New Zealand, a group of people who are suffering, who have suffered with health inequity for decade after decade after decade, and we know this and we fail to act, then we are complicit in that inequity. Now that we know, we have to make changes to improve that, because if we truly mean that people are the most important thing in the world, then we have to act for our most vulnerable, those who have the worst health outcomes. And in line with that particular whakataukī — that saying — he aha te mea nui o te ao?

**Visual**

**The next slides appears and has a whakatauki written in large black text centred in the screen. Hector reads it out and provides a translation.**

Audio

Here's a little video from Te Kura Kaupapa Māori o te Whānau Tahi, the kura kaupapa Māori that my children went to, and now that my mokopuna goes to. Have a listen to this. (GUITAR MUSIC PLAYS) - ALL: ♪ Hutia ♪ te rito ♪ o te harakeke, ♪ kei hea ♪ te kōmako ♪ e kō? ♪ Kī mai ♪ ki ahau, ♪ he aha ♪ te mea ♪ nui, ♪ te mea nui ♪ o te, te ao? ♪ Māku ♪ e kī atu ♪ ki a koe — ♪ he tāngata, ♪ he tāngata. ♪ Hutia ♪ te rito ♪ o te harakeke, ♪ kei hea ♪ te kōmako ♪ e kō? ♪ Kī mai ♪ ki ahau, ♪ he aha ♪ te mea ♪ nui, ♪ te mea nui ♪ o te, te ao? ♪ Māku ♪ e kī atu ♪ ki a koe — ♪ he tāngata, ♪ he tāngata. ♪ Māku ♪ e kī atu ♪ ki a koe — ♪ he tāngata, ♪ he tāngata. ♪ (ALL PERFORM HAKA) (MAN CALLS IN TE REO MĀORI) (ALL PERFORM HAKA)

**Visual**

**The next slides appears and a video is shown in the middle. It is a group of young Māori students singing. Hector plays the video and it zooms in on a young girl in the centre of the group.**

Audio

Kia ora koutou. Thank you for listening to my presentation. And as a call to action, my plea to everyone listening and watching today is to think carefully about what it is that you and your team and your services can do in terms of changing these unequal inputs and unequal outcomes that Māori experience. So how can you engage better with Māori patients, whānau and communities? Get those voices around the table. Seek their views around what is needed and what they can do to support you to deliver better services. In terms of advanced care planning, what is it that we can do collectively, but individually as well, to ensure that more Māori know about this, get engaged in this and spread throughout their community and their whānau and their hapū and their iwi so that they have greater opportunities to engage with this particular kaupapa and get better access to that service to enjoy the same privileges of outcome that others in our community experience. So, think about it. There isn't a single answer to this. There isn't a golden bullet to it. But what you what you must ensure is that more Māori voices are heard and we engage better, and when you think you don't know, you probably don't. So send those pointers out into the community. Ask your Māori colleagues. Go into your Māori community. Engage better with Māori, whānau and communities, and they will have the answers for you. And like I said before, assume you'll get it wrong for Māori, because you probably will, and that will make you think in different ways. So, kia ora tātou. Nei rā te mihi anō ki a koutou. Tēnā koutou huri noa, tēnā noa tātou katoa.

**Visual**

**The video disappears and Hector appears full screen.**