APPENDIX B

Module two: Te Tiriti o Waitangi, colonisation and racism

This module focuses on racial bias, particularly bias against Māori. It is a short overview on these issues. It touches on the role of Te Tiriti o Waitangi as well as colonisation and racism and their impact on Māori health.

People featured in this module are:

- introduction and purpose of module two (Anton Blank)
- *A window on the quality of Aotearoa New Zealand's health care 2019* (Anton Blank)
- Māori consumer story (Tonia and Anthony Stevens)
- access to health services, cultural safety in health care (David Tipene-Leach, GP, professor Māori and indigenous research)
- Te Tiriti o Waitangi, colonisation and racism (Matire Harwood, GP and associate professor general practice)
- Māori health outcomes (Inia Tomas, emergency department consultant)
- identifying and addressing implicit bias, organisations (Anton Blank).

Sir Mason Durie, adapted from his foreword in *A window on the quality of Aotearoa New Zealand's health care 2019*

Good health for everyone demands a society that is fair and just, committed to equal opportunities as well as equal outcomes, and ready to shift the focus if that is needed.

Disparities between Māori and non-Māori have been the subject of numerous reports from the 19th century to the present. For 150 years we have known about the higher rates of Māori illness and the lower rates of Māori survival into old age, and from time to time we have sought to remedy the injustices. Some remedies have led to significant improvements that should be celebrated. The gains include higher life expectancy, lower childhood mortality, near-eradication of 'consumption' and other infectious diseases, and the wider adoption of healthy lifestyles. But those gains, significant as they are, have not eliminated the gap between the health of Māori and the health of other New Zealanders.

Māori are over-represented in almost every type of illness and every known determinant that leads to poor health. It would be misleading to conclude that failures in the health system are the reason for all the disparities. Sub-standard housing, poor education, unemployment, low incomes, cultural alienation, alienation from land and frank discrimination have all contributed to the problem. In that respect, a whole-of-society remedy must be sought. Change is needed in a number of areas. Some are related to the health system, including improved access to services, improved quality of care and sustaining improvements. But, underlying the whole raft of inequities are the questions of indigenous rights, indigenous histories, indigenous realities and indigenous aspirations. Those fundamental questions are as relevant to the justice system or the education system or the national economy or the social sector as they are to the health system. And the common thread is the Treaty of Waitangi – te Kawenata o Waitangi.

The Treaty is a covenant – a Kawenata – that should be recognised 'on the ground' as much as in legislation and lofty strategic ideals. More than simply acknowledging the Treaty as a founding document, the challenge is to implement the promise of the Treaty by tackling inequities through policies, programmes and services that are proudly biased towards Māori. It is not a matter of favouritism, political correctness or deference to Māori; rather, it is a matter of health and wellbeing and the eradication of inequities.

Moreover, Māori understanding of health and wellbeing needs to be given due attention; they are not always the same as the understanding of Asian, Pākehā or European populations, though they do share a common desire – to be well in whatever parameters define wellness.

Te Kawenata o Waitangi should be seen as a 21st century prescription for Māori health. Action is needed on multiple fronts. Within the many parts of the health system, and between the health system and other systems, both locally and nationally, a collective approach and a collective commitment are critical to remedying a situation that has lasted too long.

What is racism?

There are a number of different terms used to talk about racism, including institutionalised racism, structural racism and societal/cultural racism. The different forms of racism are connected, and we therefore have to intervene at multiple levels, because the impact of intervention at only one level will be limited.

In general, racism is a societal system of beliefs and practices that can operate via institutions, organisations and individuals. Racism involves beliefs about the superiority of one's racial cultural heritage over those of other races. Racism can be expressed in different ways, including through biases people may be either unaware or aware of.

We live in a society where persistent messages about racial/ethnic groups are circulating continually. **Societal or cultural racism** influences the way in which our health care institutions are set up and run, and also influences health professionals who are exposed to these beliefs and stereotypes over many years as members of society. This can then impact on how they interact with patients and the judgements they make.

Camara Jones[1] defines **institutionalised racism** as:

> 'differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need…'

Zinzi Bailey[2] defines **structural racism** as:

> 'the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.'

See also:

- Dovidio JF, Gaertner SL, Kawakam K. (2010). Chapter 19: Racism. In: Dovidio JF, Hewston M, Glick P, Esses VM (eds). *The SAGE handbook of prejudice, stereotyping and discrimination*. Sage Publications, 312-327.

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[1] Jones CP. (2000). Levels of racism: a theoretic framework and a gardener's tale. *American Journal of Public Health*, *90*(8), 1212-1215.
[2] Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*. 2017 Apr 8;389(10077):1453-63.

- Williams DR, Lawrence JA & Davis BA. (2019). Racism and health: evidence and needed research. *Annual Review of Public Health,* 40: 14.1-14.21.
- https://e-tangata.co.nz/korero/owen-sinclair-fighting-the-racism-in-our-health-system/.

Window on the quality of Aotearoa New Zealand's health care

In July 2019, the Health Quality & Safety Commission released its latest *Window on the quality of Aotearoa New Zealand's health care*,[3] which focused on Māori health equity.

The report shows a pattern of inequities between Māori and non-Māori over their lifetimes:

- health services are less accessible for Māori
- health services are not providing the same benefits for Māori as for non-Māori
- efforts to improve the quality of health services do not always improve equity for Māori.

The report says that colonisation, failure to meet the requirements of Te Tiriti o Waitangi and institutional racism have established and maintained advantage for most non-Māori and disadvantaged Māori.

A legacy of health inequalities

In their *New Zealand Medical Journal* article[4], Peter Crampton and Bridget Robson say colonialism has left a legacy of health inequalities affecting indigenous peoples in many countries, including New Zealand.

> 'Crown recognition of the impact on the wellbeing of multiple generations of Māori communities has been acknowledged in the apologies that are important components of New Zealand's Treaty of Waitangi settlements.
>
> Increased understanding of historical injustices has contributed to a shift from victim blaming (where the problem lies with Māori) to a focus on how systems create or maintain inequalities.
>
> 'The boundaries between New Zealand's health system and the wider society are porous. It is therefore no surprise that the health system has cast itself as both part of the problem and part of the solution when it comes to systematic health inequalities between Māori and Pākehā.
>
> 'The past two decades have seen major gains in the health system's responsiveness to Māori health needs thanks to the wide acceptance by health professionals and managers that the status quo was not, and continues to be not acceptable.
> For the momentum to be sustained we must keep our focus on doing all we can do to provide services which actually make a difference to health outcomes for Māori.'

[3]Health Quality & Safety Commission. 2019. *A window on the quality of Aotearoa New Zealand's health care 2019*. HQSC: Wellington. Retrieved on 3 October 2019 from https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf

[4]NZMJ 2 May 2014, Vol 127 No 1393; ISSN 1175 8716 Page 7. URL: http://journal.nzma.org.nz/journal/127-1393/6103/

Te Tiriti o Waitangi as a framework to support the health system[5]

A window on the quality of Aotearoa New Zealand's health care 2019 says the Crown and its agencies have obligations to meet Māori rights, including human and indigenous rights, and those specific to Te Tiriti o Waitangi. Te Tiriti o Waitangi is central to the health system, both as a requirement for how it operates and as an improvement tool. Failures to uphold Te Tiriti o Waitangi have contributed to structural inequities, including institutional racism and the continued dominance of Western world views.

Academics who research and write about racism in the Aotearoa New Zealand health system point out that: 'Upholding Te Tiriti o Waitangi should eliminate institutional racism against Māori and contribute to the achievement of health equity'.

The articles of Te Tiriti o Waitangi provide a framework that can support the health system to build and maintain appropriate long-term partnerships with Māori that will help advance Māori health and equity. In Aotearoa New Zealand, we can use Te Tiriti o Waitangi to underpin the sustained, systemic and multileveled approaches needed to improve the health system for Māori.

Alongside the elimination of Māori health inequity, Te Tiriti o Waitangi provides for Māori to determine aspirations and priorities for and to drive Māori health advancement. Quality for Māori must be defined by Māori.

Te Tiriti o Waitangi provides a clear pathway to build the relationships between the Crown and Māori that are required to address institutional racism, advance Māori health and achieve health equity for Māori and non-Māori. The challenge is to implement the promise of Te Tiriti by tackling inequities through policies, programmes and services that work for Māori. By meeting our responsibilities in these areas we prioritise wellbeing, promote Māori capability and advancement and support the future health, education, cultural, social and economic aspirations of whānau.

Upholding Te Tiriti o Waitangi to eliminate institutional racism

In an article in the *New Zealand Medical Journal* in March 2019,[6] Came et al say that upholding Te Tiriti o Waitangi should eliminate institutional racism against Māori and contribute to the achievement of health equity.

> 'Given the Waitangi Tribunal is investigating health-related breaches of Te Tiriti o Waitangi, we argue institutional racism, a key determinant of health inequalities, needs to be acknowledged and addressed within the health sector. Historically the Crown response can be characterised by denial and inaction.
>
> 'The Crown has the power and resources to take action through mechanisms such as those they are currently applying to child poverty and gender pay inequity. Anti-racism literature recommends planned, systems-based approaches to eradicate the problem. We need the government to uphold our Tiriti responsibilities and we require a plan to end racism in the New Zealand health system.'

They conclude: 'Racism is a breach of the Crown's responsibilities under te Tiriti o Waitangi. Rather than denial and inaction, the health sector needs the Crown to develop a systems

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[5]Health Quality & Safety Commission. 2019. *A window on the quality of Aotearoa New Zealand's health care 2019*. HQSC: Wellington. Retrieved on 3 October 2019 from https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf

[6]*NZMJ* 29 March 2019, Vol 132 No 1492. ISSN 1175-8716 © NZMA. www.nzma.org.nz/journal.

change strategy and plan to eradicate institutional racism. Furthermore, the detection, prevention and eradication of racism should be incorporated into the quality assurance practices of the health system at all levels.'

See also:

- van Ryn M, Burgess D, Dovidio J, Phelan S, et al. (2011). The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Review*, 8(1):199-218.
- Ministry of Health. 2018. *Achieving Equity in Health Outcomes: Highlights of important national and international papers*. Wellington: Ministry of Health.
- Ministry of Health: Achieving equity; https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2018/achieving-equity

Countering implicit bias for organisations

Strategies that organisations can use to address implicit bias include:

- providing data about different approaches and outcomes for some groups. For example, prescribing rates of medications that are higher for non-Māori than Māori
- having a commitment to a racism-free environment, supported by leadership, policies and practices
- actively uphold Te Tiriti o Waitangi, through training, hiring practices and relationships with Māori communities and organisations
- supporting staff to learn te reo Māori and about cultural safety
- as an organisation, advocating against racism
- supporting individuals to recognise and mitigate their bias.

See also:

- Came H, McCreanor T, Manson L, Nuku K. (2019). Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. *The New Zealand Medical Journal (Online)*, *132*(1492), 61-66.
- Jones CP. (2018). Toward the Science and Practice of Anti-Racism: Launching a National Campaign Against Racism. *Ethnicity & Disease*, 28(S1), 231-234.
- *Implicit bias in health care*. Quick Safety article from the Joint Commission. Available at: https://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_23_Apr_2016.pdf
- Institute for Healthcare Improvement website. Filmed interview with Prof. David Williams (Harvard University). *What Is Health Equity, and Why Does It Matter? Parts 3 and 4*. (http://www.ihi.org/education/IHIOpenSchool/resources/Pages/AudioandVideo/David-Williams-Don-Berwick-What-Is-Health-Equity-and-Why-Does-It-Matter.aspx).

Health Practitioners Competence Assurance Act 2003

The 2019 amendment to the *Health Practitioners Competence Assurance Act 2003* requires health practitioners to interact effectively and respectfully with Māori.

Cultural competence and cultural safety

Prof David Tipene-Leach, GP and professor Māori and indigenous research, says the difference between cultural competence and cultural safety is that with competence, we often end up ‘othering’ the other person.

> ‘We go out and learn about someone else’s culture, their way of doing things – so that theoretically we can better understand why they do what they do and treat accordingly.
>
> ‘We have been trying to do this in the medical profession for 30 years and it hasn’t made a stitch of difference.
>
> ‘We are now trying to move from cultural competence to cultural safety. Cultural safety is a concept whereby we think more about the power relationships between the patient or professional and the client or patient. We like the professional person to think about their own culture, their own biases, the way they think about the interaction, and how their biases affect the outcomes for the patient.’