Module two: Te Tiriti o Waitangi, colonisation and racism

Anton Blank

Bias expert

Tēnā koutou. This module is the second of three on bias. It narrows the focus to ethnic bias, and 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. See the Health Quality & Safety Commission website for further information and learning.

Racism is system of belief and practices that society has, and these beliefs and practices ca be seen in systems, institutions and individuals. Societal racism leads to bias against some ethnicities.

In July 2019, the Health Quality & Safety Commission released its latest *A window on the quality of Aotearoa New Zealand's health care*. The report focused specifically 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 at the same time.

Anthony and Tonia Stevens

Kia ora. My name is Anthony Stevens and this is Tonia. He's my eldest son. He has Down syndrome. Tonia is quite an active boy. Being a young teenage boy, he loves basketball, loves his rugby.

What else do you love Tons? Music? Yeah. What sort of music do you like? He loves his hip-hop and his rap.

What else do you like Tons? Kapa haka? Yeah.

In my experience with accessing health care for Tonia, on initial consultations whether it be orthopaedic, ENT services or any other health service, often we find especially with administration staff, they make the assumption that often our whānau don't understand our son's condition. With comments like 'You understand your son has Down syndrome? Do you understand what that entails with that condition?'

Often, that comes across as patronising for us. There's often the assumption made that we're poor, being Māori; socially deprived. There's an undercurrent of racism there. Often, it's body language, you can often tell. Just little remarks. More often than not, the experience has been very cold. Sterile.

In an ideal world I'd just like to be treated in an open, honest way; treated fairly regardless of my colour, race or creed.

Don't make assumptions in regards to what we know about our son's condition. Just be honest and genuine with your engagement rather than seeing us as just another patient on the scene. Even just open up with some pleasantries first perhaps, rather than just seeing the condition that they're dealing with.

'How's his day been? How's his day been at school?'. Just simple things like that, really – taking the time to get to know Tonia aside from just his disability.

Love you dad. Ka pai.

Professor David Tipene-Leach
GP and professor of Māori and indigenous research

There's certainly a difference in the way Māori and Pākehā patients are treated at general practice and at hospital level. I think it needs to be said that it's not likely that doctors know that they're doing this and it's not that they do it on purpose.

But very clearly, in general practice we spend less time with Māori patients, we make a diagnosis less frequently, we give fewer prescriptions and we give fewer referrals to hospital. And, when we go to hospital, we have fewer interventions, we have worse death rates for Māori patients, and Māori patients tend to spend longer in hospital.

I think some of the impacts upon Māori patients is that we don't feel heard. We feel as a patient, as a Māori, that this person is not thinking about me. This person is thinking about somebody else, in somebody else's situation.

The difference between cultural competence and cultural safety is that with competence we often end up 'othering' the other person. We go out and we learn about somebody else's culture, somebody else's way of doing things so that, theoretically we can better understand why they do what they do, and treat accordingly. In fact, it appears we've been doing this, we've certainly been trying to do this in the medical profession for 30 years and it hasn't made a stitch of difference.

What we're now trying to do is to move us from cultural competence to cultural safety. Cultural safety is a concept whereby we tend to think more about the power relationships between the professional and the client or the patient. We like to think about having the professional person thinking about their own culture, their own biases, the way they think about the interaction and how their biases affect the outcomes for the patient.

Dr Matire Harwood
GP and associate professor general practice.

Nō Te Tai Tokerau ahau.
Ko Ngāpuhi te iwi.

Ko Māhurehure rātou ko Ngāti Hine ko Ngāti Rangi ōku hapū, engari e noho ana au ki Tāmaki ki Tonga ināianei.

I am a general practitioner at Papakura Marae Health Clinic. I am also associate professor in general practice at the University of Auckland Medical School and I sit on the Waitematā District Health Board as the appointed member for Māori health.

The process of colonisation, particularly in terms of Māori health, has been both insidious and, I think, explicit. The whole system was set up to disadvantage Māori and advantage non-Māori, particularly Pākehā people. It meant our whole health system, particularly hospitals, have been taken from models set up in the UK where the rooms are very small, and are all about the individual, not about whānau or that collective responsibility.

More explicitly, within the hospital and within our primary care systems too, we're seeing unequal treatment for Māori, so that they are missing out on evidence-based, gold standard treatments. And, as a result, are becoming really unwell, with some people dying as a result.

Institutionalised racism is, I guess, undermining the mana of Te Tiriti of Waitangi in terms of not allowing Māori leadership, whether that's of funding and decision making and contracting, I think that's a major issue. It undermines the whānau voice and how services are determined and implemented.

I think it means, a lot of our district health boards have one or two Māori members on each of them. If we were wanting a true Crown/Treaty partnership we would be looking at having significantly more numbers, given the inequities we have at the moment.

So, it is making sure that the rules, the processes, the policies have Māori leadership in behind them and have an equity lens so we know that we are going to be achieving equitable outcomes.

I think there are a number of simple things that we can do as clinicians to improve the way that we are engaging with Māori – in meaningful ways so that we are improving their wellbeing. One is reflecting on our bias. The implicit bias tests are easily available online now. You can do them online. It's worthwhile doing that and just seeing for yourself whether or not there is some bias in the way you engage with people.

I have a colleague Dr Teah Carlson who has just done her PhD looking at health literacy for heart disease in older Māori. And she ended her talk with this beautiful saying:

> 'As clinicians, 'whakarongo, whakarongo, whakarongo'. You think that means 'listen, listen, listen'. But what I'm saying is listen with your mind, be mindful of how you are at that present time with your patient. Is there baggage that you might be holding? Is it the end of the day? Be mindful of why you might not be in the best place at that time to engage. Whakarongo with your heart, so be loving to people. Always think that they've come to you because they think this is a time to be valued in their lives, so value that person in front of you, show aroha. Whakarongo with your gut, I guess. Trust that gut instinct and that there might be things that they're not able to tell you. In that situation you might want to get another expert in, whether that is kaumātua

support, community health workers, or another Māori clinician to support you and them in their health journey.’

Dr Inia Tomas
Emergency department consultant, Middlemore Hospital

The inequity data is there for everyone to see and it affects Māori throughout their whole life course, from before they’re born to when we die – younger than our non-Māori counterparts.

Anton Blank
Bias expert

Strategies that organisations can implement to address implicit and unconscious bias include:

- providing data about different approaches and outcomes for some groups. For example, prescribing data which shows that Māori are prescribed fewer drugs than other groups
- having a commitment to a racism-free environment, supported by leadership, policies and practices
- actively upholding the Treaty of Waitangi, through employment practices, policies and engagement with iwi and Māori communities
- support staff to learn about te reo and cultural safety
- as an organisation, advocate against racism.

The 2019 amendment to Health Practitioners Competence Assurance Act 2003, requires health practitioners to respond effectively and respectfully to Māori.

Now you have watched this module, we invite you make this just the start of your learning about bias in health care. To find out more, make sure you watch the other two modules in this series of three and see the Health Quality & Safety Commission’s website.

Kia ora tātou.