Institutional Racism and the Dynamics of Privilege in Public Health

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ABSTRACT

Institutional racism, a pattern of differential access to material resources and power determined by race, advantages one sector of the population while disadvantaging another. Such racism is not only about conspicuous acts of violence but can be carried in the hold of mono-cultural perspectives. Overt state violation of principles contributes to the backdrop against which much less overt yet insidious violations occur. New Zealand health policy is one such mono-cultural domain. It is dominated by western bio-medical discourses that preclude and under-value Māori,[1] the indigenous peoples of this land, in the conceptualisation, structure, content, and processes of health policies, despite *Te Tiriti o Waitangi*[2] guarantees to protect Māori interests.

Since the 1980s, the Department of Health has committed to honouring the *Treaty of Waitangi* as the founding document of Māori-settler relationships and governance arrangements. Subsequent Waitangi Tribunal reports, produced by an independent Commission of Inquiry have documented the often-illegal actions of successive governments advancing the interests of Pākehā[3] at the expense of Māori. Institutional controls have not prevented inequities between Māori and non-Māori across a plethora of social and economic indicators.

Activist scholars work to expose and transform perceived inequities. My research interest lies in how Crown Ministers and officials within the public health sector practice institutional racism and privilege and how it can be transformed. Through dialogue with Māori working within the health sector, fuelled by critical analysis and strategic advice from a research whānau (family) of Māori health leaders and a Pākehā Tiriti worker, and embracing the traditions of feminist and critical race theory I provide evidence of racism that can invoke strong emotional reactions. More disturbing is its normalisation to nigh imperceptibility within ones personal and professional life. The exposure of racism as a socially created phenomenon is a strength of the research presented here.

My action orientation is my ethical response. Honouring *Te Tiriti o Waitangi* is a pathway to transforming racism. Such change is likely to be resisted by the Pākehā majority. This anticipated resistance is not a credible reason to weaken responsibility for such necessary change. Transforming institutional racism needs to be driven by senior managers, professional bodies, unions, and by communities. Policies, practices and leadership that enable institutional racism need to be systematically eliminated from the health sector. Crown officials must be supported to strengthen their professional accountabilities and to embrace

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[1] Māori is the collective term for the indigenous peoples of Aotearoa who more commonly identify as distinct tribal groupings.

[2] *Te Tiriti o Waitangi* in this context refers to the Māori text of the Treaty of Waitangi see a more detailed explanation of the use of this term in chapter three and four.

[3] Pākehā is the term for settlers who came from a variety of cultural backgrounds after Māori settlement of Aotearoa.

ethical bicultural practice. Greater transparency could enable more effective monitoring of Crown behaviour and support transformed practice.

Dedication

To the stroppy Pākehā Tiriti workers of Aotearoa
who daily fight for honourable kāwanatanga and the pursuit of tino rangatiratanga,

moreover, to the generations of women who were denied an education
because they lived in a society where men were valued more than women.

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Glossary

AAP - Affirmative Action Program
CPHAC – Community and Public Health Advisory Committee
CEO – Chief Executive Officer
CERD – Committee on the Elimination of all Forms of Racial Discrimination
CRT – Critical Race Theory
DAP - District Annual Plan
DSP - District Strategic Plan
DHB – District Health Board
DSW – Department of Social Welfare
FFT – Future-Funding Track
ICERD – International Convention on the Elimination of All Forms of Racial Discrimination
HEAT – Health Equity Assessment Tool
HFA – Health Funding Authority
HNA – Health Needs Assessment
HRA – Human Rights Act
HRAA – Human Rights Amendment Act
HRC - Human Rights Commission
MAPO - Māori Co-Purchasing Organisation
MMP – Mixed Member Proportional
MP – Member of Parliament
NACHD - National Advisory Committee on Health and Disability
NHB – National Health Board
NGO – Non-Governmental Organisation
NZHS – New Zealand Health Strategy
NZPHDA – New Zealand Public Health and Disability Act 2000
OECD – Organisation for Economic Co-operation and Trade
OIR – Official Information Request
OPF – Operating Policy Framework
PHO – Primary Healthcare Organisation
PHU – Public Health Unit
PSA – Public Service Association
RHA - Regional Health Authority
SSC – State Services Commission
TPK – Te Puni Kōkiri
TUHA-NZ – Treaty Understanding of Hauora in Aotearoa New Zealand
UN - United Nations
WHO – World Health Organization
WTO - World Trade Organization

CHAPTER ONE: INTRODUCTION

1.0 Introduction

> The Treaty then was not just a political and legal covenant but also a spiritual one... Because of the Treaty, Māori believe right to this day that they are equal partners and yet they know from experience that is not so (Henare, 1987b, p. 7).

The New Zealand government is one of many around the world that have formally committed themselves to eliminate racism and protect and promote the rights of indigenous peoples through adopting international human rights treaties (see United Nations, 1965, 2007). The New Zealand government also has prior commitments and obligations to Māori, dating back to 1840 through *Te Tiriti o Waitangi.* Through this treaty, Māori sovereignty and citizenship rights were confirmed. As outlined in the opening quote by Sir James Henare, this treaty has not manifested in an equal partnership in the governance of this land. The imposition of settler values, the systematic alienation of Māori land and attempts at self-serving assimilation policies of successive governments form the political, legal and spiritual backdrop of this study. My primary focus is however on examining contemporary institutional racism and privileging as allegedly practiced by Crown Ministers and officials in their administration of the public health system within New Zealand.

The existence of institutional racism within and outside the public sector in Aotearoa (see Berridge et al., 1984; Jackson, 1988; Ministerial Advisory Committee, 1988), the United Kingdom (see Blofeld, Sallah, Sashidharan, Stone, & Struthers, 2003; Macpherson, 1999) and the United States (see Kerner Commission, 1968) has been acknowledged in a variety of ways for decades, resulting in a flurry of remedial actions. As scholarship on racism has developed, there has been increasing recognition that when one group of people are experiencing discrimination, another is being privileged, creating a double burden (see Jones, 2003; McIntosh, 1988, July/August; Paradies, 2006). My interest from an activist scholarship tradition lies in understanding and revealing this pattern of behaviour with a view to mobilising action to transform such systemic racism.

In this opening chapter, I introduce my research questions, my personal and professional background, the local and international significance of this topic and my thesis structure.

1.1 Statement of Research Question

This study records my efforts, shaped by input from others, to understand the dynamics of institutional racism and privilege in the context of the Crown's administration of the public sector on behalf of all New Zealanders.

Specifically within this research, I examine:

- To what extent and how is institutional racism and Pākehā privilege manifested within public health policy and funding practices?
- What are the emerging directions to dismantling and preventing institutional racism within public health policy and funding arising from this research?

This study specifically examines racism targeting Māori despite the Crown's commitments under *Te Tiriti o Waitangi* to protect the interests of Māori.[4] As a piece of activist scholarship, this study is predominately a deficit analysis. In undertaking this analysis, I acknowledge that much admirable work has been done and is currently being done by both Māori and non-Māori within and outside of the public sector to minimise and prevent systemic racism. I suggest that this body of work is not yet complete.

1.2 Personal Background

The anti-racism activists whom I affiliate have an ethic of being reflective about our own stories and often trace these stories back over generations to establish our involvement/collusion/resistance to colonisation and our orientation to Māori. In this section, I provide such a telling of my story and path to activism.

My ancestors (see Figure 1) are buried in the Port Albert, Matakana, Leigh, Waipu and Wellsford cemeteries in Aotearoa and before that in Australian, Canadian, English, Scottish, Irish, French and Sri Lankan soil. They migrated to Aotearoa from the 1830s through to the 1880s and largely remain on land originally inhabited by Ngāti Wai and Ngāti Whātua o Kaipara. The signing of *Te Tiriti o Waitangi* in 1840 established the terms and conditions of that settlement in Aotearoa. As a Pākehā New Zealander, Te Tiriti also grants me both rights and responsibilities as a citizen of this country.

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[4] In taking this focus I recognise that other groupings of people also experience systemic discrimination but their experiences are not the focus of this study.
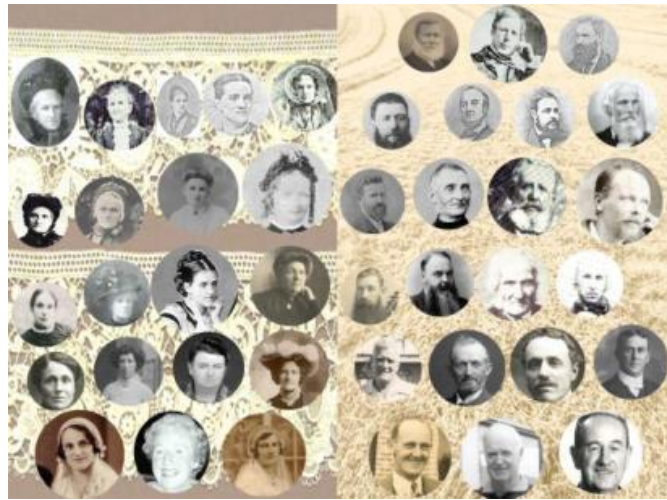
Figure 1: **My Ancestors**
These images are of my parents, grandparents and their parents and so on, representing the Smith, Leng, Dunning and Came branches of my family back to the oldest family photo of Mary McLennan (Nee Hoe).

Growing up as a member of the 'dominant' Pākehā cultural group I concur with Haggie (2002), former National Co-ordinator of Project Waitangi, that I am used to dealing with ethnocentric institutions that are designed to meet my needs. Through participating in the Pākehā dominated education system I was taught what Ramsden (1994, p. 2), Māori health advocate, describes as a "sanitised version" of New Zealand history, where the English colonisers saw it as their responsibilities to civilise and modernise this country. I learnt from newspapers and listening to adults around me that Māori were more likely to be unemployed, fail to achieve success within the education system, be sent to prison and be less healthy than non-Māori. I was taught to value the notion that everyone should have a 'fair' chance to succeed, as we were all New Zealanders together.

I also learnt about 'fairness' from playing social and competitive sport with my family, being the third of four children, where elaborate sharing and negotiation was required on a daily basis and through spending ten years attending an interdenominational Sunday School (taught by an assortment of my aunties). There I learnt Christian teachings of 'being good to your neighbours' and 'love one another as I [Jesus] have loved you'. Injustice was something that happened in third world countries, particularly in Africa, where there were corrupt regimes, war and natural disasters that meant we [Pākehā] needed to sponsor 'needy' and starving children.

My first attempts at activism occurred while I was still a teenager. They were both modest and unsuccessful. I loved history and at secondary school had the unusual experience, at that time, of being taught about *Te Tiriti o Waitangi* and New Zealand colonial history. When I moved to the city to go to university I was exposed to a diverse collection of new people and experiences. I met stroppy feminists, articulate political Māori, vegetarians, gay men, lesbians, and people involved in solidarity actions of assorted kinds. Within quite a short period, I

started the long journey of learning Te Reo Māori (Māori language) and in doing so became a minority for the first time in my life. I began to learn about my own, up until then invisible to me, culture. After university hostel food, inspired by my sister, I became a vegetarian and surprised myself by working out that I was neither heterosexual nor lesbian rather bisexual. Becoming a feminist to me seemed an inevitable rite of passage for any sensible young woman. Activism and the pursuit of social justice endure as key drivers in my life.

In my family, I am a first generation political activist but certainly not the first 'stirrer'. From a politicised vantage point, I now frequently see the world in terms of power – and how it is manifested and maintained both consciously and unconsciously. I now recognise that I am a beneficiary of a colonial system, which has systemically breached Te Tiriti to advance the aspirations of settlers of English descent and minimise indigenous control and sovereignty. Likewise part of my life experience is one of witnessing and experiencing sexism, racism and other forms of violence. I acquired my critical understanding of the history of Aotearoa and the ongoing process of colonisation through entering into a process of what revolutionary educationist Freire (1970/2000) would call conscientisation and feminists would call consciousness raising (see hooks, 2000; Sarachild, 1978) with other Pākehā Tiriti workers and by being mentored and supported by Māori.

Through this conscientisation process and academic training in political science, public health, and critical management studies, I was taught how to pose critical questions about power and ask which groups in society benefit from a particular policy and/or practice. I was exposed to structural analysis, critiques of patriarchy, capitalism and heterosexism. I inadvertently acquired a critical world view making me suspicious of official accounts and alert for what radical feminist theorist Rich (1980) calls simply the 'lies and silences' of men. Because of this conscientisation I have made an ongoing commitment to being as activist musician, Billy Bragg (1988) sings it, 'active with the activists'. It is as poet and revolutionary Audre Lorde (1984, p. 112) suggests '...learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structures in order to define and seek a world in which we [human beings] can all flourish'.

Professional Involvements
My professional background for the last nineteen years has been in health promotion and public health. Much of this time has been spent working within District Health Boards (DHB) and their earlier manifestations as well as key periods of time working within a national Non-Governmental Organisation (NGO) and a Māori health provider. During this time I have engaged in grass-roots community development work, policy development and analysis, media advocacy, management, contract development, negotiation and monitoring, community consultation, capacity building, strategic planning, project management and been a professional advisor. These experiences have provided

me with a broad understanding of public health as a discipline and I enjoy a strong familiarity with the workings and many of key personalities within the sector.

Public health (discussed in-depth in chapter six) focuses on lifting the overall health status of the population through working with communities to improve and protect health. Public health practitioners tend to not work one-on-one or have patients. Most public health workers are not registered health practitioners but operate broadly under the auspices of the New Zealand Public Health Disability Act 2000 (NZPHDA). Both public health and health promotion competencies have been developed to support robust levels of practice (see Health Promotion Forum, 2011; Public Health Association, 2007). Explicit within the values and principles of these competency documents are commitments to working with Te Tiriti and the elimination of racial inequities.

Racism emerged as a key theme and action area, during a consultation process I undertook with Māori to support the development of a regional public health plan. Through this process, Māori practitioners shared their frustrations with me of the overwhelmingly poor health outcomes for Māori and the institutional and personal racism they saw embedded within the health system. This korero (talk or discussion) was frequently framed around *Te Tiriti o Waitangi* as a founding document of New Zealand that affirmed health as a taonga (treasure) and Māori tino rangatiratanga (sovereignty). This wero (challenge) around explicitly addressing racism was subsequently embedded as an action area within two companion regional strategic health documents (see Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008; Te Tai Tokerau MAPO Trust & Northland DHB, 2008).

Despite two decades of anti-racism work, since working in Māori health I remain both professionally and personally disturbed by what I have witnessed in terms of what appears to me to be racist policy and practice. This discomfort, encouragement from local rangatira (Māori leaders), a supportive workplace and supervisors, motivated my interest in documenting and investigating these experiences. Therefore, I entered into dialogue with others to gain a greater understanding of what is articulated as institutional racism and how it can be transformed. It is with a spirit of kotahitanga (unity) with my research whānau/reference group that I have pursued this collaborative project, in the traditions of activist scholarship. I hope and expect this work will be used as a vehicle for advocacy.

1.3 Local and International Significance

Institutional racism is defined in this research as a pattern of differential access to material resources and power determined by race, which advantages one sector of the population while disadvantaging another (Carmichael & Hamilton, 1967; Jones, 2000; Macpherson, 1999; Ministerial Advisory Committee, 1988; UN, 1966). This research is not concerned with the conscious or unconscious motivations of those whom either enact or enable institutional racism. My chosen

focus is on how institutional racism manifests within public health policy making and funding activities and how it might be transformed.

Examining such racism has significance across several fields of scholarship. A primary motivation of this study has been to contribute to anti-racism praxis within Aotearoa and internationally. I expect to enhance understandings of research methods that are intentionally collaborative and transformative. This study directly contributes to scholarship around health sector policy making and management practices. It has broader application to generic public policy making and public sector management that has a focus on achieving equity in outcomes for indigenous and non-indigenous peoples across social indicators.

This study also has significance to human rights discourses as within this tradition nation states commit to minimum acceptable standards of behaviour. Additionally it holds relevance to scholarship related to indigenous struggles for sovereignty and processes of decolonisation. Within a local context, moreover it has application to *Te Tiriti o Waitangi* discourses, as systemic discrimination against Māori is inconsistent with treaty obligations and from an activist position, requires a response. With an orientation to use research as an intentional contribution to social change, I take up the notion of praxis – the combination of theory/analyses and practice to achieve intentional change.

Anti-Racism Praxis

> I think racism is a Pākehā problem, I think it manifests as institutional racism in organisations and in services provided or not provided, and I think the underlying issue is about power and Pākehā wanting to control resources and through that alienating Māori
>
> (Māori Policy Analyst, 2010, November 16, p. 1).

Māori health advocates, Ratima and Ratima (2003, p. 4), suggest systemic racism affects how indigenous people both live and die. White feminist, McIntosh (1988) maintains that the privileges conferred on white people on the back of structural discrimination profoundly affect the life options and experiences of non-indigenous peoples.

Both the targets and some beneficiaries of racism have longstanding traditions of resistance to systemic discrimination (Kirton, 1997; Mandela, 1994; Walker, 1990). Anti-racism praxis has taken many forms including peaceful and violent revolution, international and domestic legislative protections, anti-racism education and direct-action campaigning through to organisational change. Such activities are pursued to enhance fairness and equity of outcomes between groupings of people.

The bulk of recent scholarship about racism focuses on quantifying and describing inter-personal racism in various settings and its impact on those targeted. Table 1

identifies some sites of racism and Aotearoa based evidence quantifying and describing how it manifests within those settings. My research deliberately examines the specific dynamics of institutional racism and privilege to enrich scholarship within this niche area to support the development of anti-racism praxis.

Table 1: Documented Sites of Racism within Aotearoa

Sites of Racism	Sources of Evidence
Housing	Housing New Zealand, 2007, 1991; Robson & Harris 2007.
Employment	Sutherland & Alexander, 2002.
Income levels	Alexander, Genc & Jaforullah, 2001; Maani, 2004; St John & Wynd, 2008.
Access to goods and services	Howell & Hackwell, 2003 July.
Justice system	Fergusson, Swain-Campbell & Horwood, 2003a, 2003b.
Education system	Reid, 2006.
Health Services	Harris et al., 2006; Te Puni Kōkiri, 2001.

As applied research this study specifically addresses elements of the research agenda developed by the Cooperative Research Centre for Indigenous Health (Paradies, Harris, & Anderson, 2008), and elements of both the Te Tai Tokerau Strategic Public Health and Māori Health Plans (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008; Te Tai Tokerau MAPO Trust & Northland DHB, 2008).

Activist Scholarship

Activist scholarship is an emerging research tradition focussing on exposing injustice and working collaboratively with others to effect change. Within this study, I utilise an activist scholarship approach drawing on the traditions of critical race, feminist, kaupapa (philosophical) Māori theories and Pākehā treaty work. Central to the methodology of the study is dual accountabilities to a research whānau/reference group, made up of both Māori and Pākehā co-enquirers and secondly to an activist network of Tauiwi (Non-Māori) Tiriti workers.

In this study, I utilised co-intentional praxis in my engagement with indigenous co-enquirers. Freire, (1970/2000) uses the term co-intentional to refer to processes through which the oppressed and the coloniser work towards the same end in different ways according to the unique needs and talents of each. The approach recognises, as long-time Tiriti activist M Nairn (2002, p. 203) puts it, "...the descendants of the colonisers have different decolonisation tasks from the descendants of the colonised". This co-intentional approach was underpinned by the utilisation of a Māori ethical framework, *Te Ara Tika*, developed by the Pūtaiora Writing Group (Hudson, Milne, Reynolds, Russell, & Smith, 2010). This framework was utilised from a place of reflection on the impact and power of the advantages of my being a beneficiary of racism, as my cultural heritage would suggest.

The political nature of this work has led to some difficulties accessing information through usual collegial professional channels. This led to me utilise the Official Information Act 1982, and the Ombudsman's office to compel Crown officials to release information about their decision-making and operational practice. The eclectic use of methods within this study is a contribution to activist orientated research.

Public Policy

Public policy is a process used by governments to define an issue needing to be addressed and to inform political decisions around the prioritisation and distribution of public resources. Despite rhetoric from state parties that emphasise the importance of indigenous peoples and at times that active resourcing of indigenous initiatives, a landmark United Nations' report (2009) into *The State of the Worlds Indigenous Peoples* confirms the ongoing nature of major inequities between indigenous and non-indigenous peoples across a range of social, economic and health indicators in most colonial countries.

Addressing these inequities, remain major public policy challenges facing governments whom are simultaneously attempting to achieve a plethora of other priority policies from their respective political agendas. The challenge of resolving ethnic inequities is complicated by the historic and some would say (see M. Jackson, 2000; Mowbray, 2007) ongoing role of the state in both generating and perpetuating ethnic inequities through their policies and practices.

Various studies have specifically examined institutional racism as practiced by state parties in their administration of government activity including policymaking (discussed further in chapters four and eleven). In Aotearoa, this work includes investigations conducted by the Women's Anti-racism Collective (Berridge et al., 1984), the Ministerial Advisory Committee (1988) and M. Jackson (1988). Within Aotearoa, these studies led to a plethora of reforms that temporarily improved service delivery to Māori. In England the recommendations from the enquiry into the police handling of the investigation of the murder of Stephen Lawrence (Macpherson, 1999) have had a more enduring impact on practices pertaining to detecting and preventing systemic racism within the public sector.

Twenty years on, these key New Zealand based studies have not been duplicated. Considerable energy however has been invested in advancing Waitangi Tribunal claims, which frequently expose institutional racism. This study both provides an historical analysis of Crown conduct in relation to public policy and assesses contemporary expressions of state racism in the public health arena.

Public Health Practice

The impact of racism as a determinant of health (see C. Jones, 2002; Paradies, 2007) and inequities in health status between indigenous and non-indigenous peoples (see Robson & Harris, 2007) are recognised within both international

health discourses and locally within public policy (see A. King & Turia, 2002; L Signal, Martin, Cram, & Robson, 2008). These acknowledgements have opened up debate and reflection within the public health sector about the prevalence of institutional racism and how collaborative action can occur to combat it.

Global patterns of morbidity and mortality consistently indicate non-indigenous people have significantly better health than the 400 million indigenous people do. One of the clearest markers of these inequities is differences in life expectancy (see Table 2).

Table 2: Gap in Life Expectancy Differences between Indigenous and Non-Indigenous Peoples

Country	Mexico	Canada	Panama	New Zealand	Guatemala	Nepal	Australia
Years	6	7	10	11	13	20	20

Note: Reproduced from *State of the World's Indigenous Peoples* by Department of Economic and Social Affairs, 2009, p. 159. New York, NY: United Nations.

Reid (2002a) maintains these differences are the outcome of government systems that appear to fail indigenous peoples. Within this study, I suggest institutional racism within the administration of the health sector is a contributing factor to such inequities.

Rights Based Discourses

Attempts to address human activities deemed unjust or unacceptable from a western tradition are often framed in human rights discourse. Based on such an exposition of what every human being is entitled to expect, human rights have been, in more recent times, commonly framed as the civil, political, social, economic and cultural rights in international law. The representatives of state parties within the United Nations significantly drive their articulation and refinement. As indigenous nations are not often recognised as state parties and/or are a numeric minority within larger nation states, indigenous peoples are effective excluded from such fora. Rights within the United Nations framework can take the form of either aspirational declarations or binding instruments (such as covenants and conventions). The success of their implementation is dependent on state parties embedding the obligations of these international agreements into domestic legislation and/or policy.

Within human rights instruments, freedom from racial discrimination is primarily[5] addressed in the *International Convention on the Elimination of All Forms of Racial Discrimination* (ICERD) (United Nations, 1965). This Convention defines racial discrimination as:

> …any distinction, exclusion, restriction or preference based on race, colour, descent, or national or ethnic origin which has the purpose or effect

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[5] Racial discrimination is included within eight of the nine human rights instruments.

of nullifying or impairing the recognition, enjoyment or exercise on an equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life (p. 2).

In terms of indigenous rights general recommendation twenty-three from the Office of the Human Rights Commissioner for Human Rights (2008) explicitly affirms that discrimination against indigenous peoples falls under ICERD.

The right to health is embedded within international human rights instruments such as the *Universal Declaration of Human Rights* (see United Nations, 1948) and the *International Covenant on Economic, Social and Cultural Rights* (see United Nations, 1976b).[6] Article twelve of the latter Covenant specifies "The right of everyone to enjoy the highest attainable standard of physical and mental health". The Committee on Indigenous Health (1999), a sub-committee of the United Nations Permanent Forum on Indigenous Rights, developed the *Geneva Declaration on the Health and Survival of Indigenous Peoples*. This Declaration reaffirms indigenous peoples' rights of self-determination and serves as a reminder to member states of their responsibilities and obligations under international law concerning indigenous health.

Indigenous Peoples' Rights

For centuries before, during and after colonisation indigenous peoples have expressed a concerted conviction and determination to survive and thrive with distinct sovereign identities intact (Department of Economic and Social Affairs, 2009). This sovereignty has been confirmed repeatedly through the signing of treaties between indigenous and colonial nations, as with *Te Tiriti o Waitangi*. As colonial hegemony was established, with the subsequent decline in indigenous populations and power base, indigenous peoples' rights have been systematically eroded.

The process of decolonisation, for both indigenous and non-indigenous peoples, is an ongoing one which activist scholar, Huygens (2007) maintains calls for reconciliation, expressions of resistance, commitment to healing and revived attempts at power-sharing. Kaupapa Māori theorist, LT Smith (1999, p. 98) argues that decolonisation is a "...long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power". Influenced by the revolutionary writings of Fanon (1961/2004), Freire (1970/2000) and Said (1978) decolonisation has become a global movement that has led to self government for some indigenous nations and increased recognition of indigenous peoples' rights for others.

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[6] The right to health is also included within ICERD (United Nations, 1965), *Convention on the Elimination of All Forms of Discrimination against Women* (United Nations, 1979), *International Convention on the Rights of the Child* (United Nations, 1990) and *International Convention on the Rights of Persons with Disabilities* (United Nations, 2008).

The adoption of the *United Nations Declaration on the Rights of Indigenous People* (United Nations, 2007) confirms the international community's commitment to the protection of the individual and collective rights of indigenous people.

Te Tiriti o Waitangi

In 1840, many Māori rangatira signed *Te Tiriti o Waitangi* with a representative of the English Crown to outline the terms and conditions of English settlement of Aotearoa and to define this emerging new relationship (Orange, 1987). The Māori text guaranteed the continuance of Māori tino rangatiratanga, granted the English kāwanatanga (governorship) and promised Māori ōritetanga (equity) with English subjects. Breaches of *Te Tiriti o Waitangi* commitments made to Māori remain contested political ground within Aotearoa and the source of considerable pain, anger and frustration for many (see chapter three for a fuller account).

Māori health champion, Durie (1994b), argues that politicians within successive colonial governments have used institutions such as the police and the education and legislative systems as active mechanisms to enact colonial policies. For instance, the health sector was involved in the implementation of legislation banning traditional Māori healers and the education sector enforced the policy of banning Te Reo in schools (Simon & Simon, 2001). Legislation has also been used by politicians to amend retrospectively laws when colonial governments have acted outside of their own rules of fair engagement as in the example, of the Native Land (Validation of Titles) Amendment Act 1894[7] and the more recent Foreshore and Seabed Act 2004.[8]

Crown officials at the Waitangi Tribunal confirmed (Crown official, personal conversation, April 15, 2011) that there has been eighty nine separate Tribunal claims related to Crown administration of the health system. Given this history, Māori health advocates, Reid and Robson (2007, p. 3), assert, "Māori have the right to monitor the Crown and to evaluate Crown action and inaction". They maintain these rights derive from both the rights of Māori as indigenous peoples and as parties to *Te Tiriti o Waitangi*. The Crown's performance in relation to Te Tiriti is also of interest to other New Zealanders, who desire the government to act with integrity around indigenous and treaty rights.

1.4 Guide to the Thesis

This study does not fastidiously follow a linear path of introduction and/or background, literature review, methodology, results, discussion, conclusion and/or recommendations. Element of this convention have been retained but for instance the literature review is split through chapters three, four and five and a discrete section on anti-racism literature is presented in chapter eleven so it can be can be read in the context of the findings from this study. In the tradition of critical race

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[7] Also known by its nickname Validation of Invalid Land Sales Act 1894
[8] This legislation was later repealed by the National-led coalition government.

theory, some relevant literature has also been utilised to contextualise counter narratives in both chapters eight and ten.

This study makes a clear distinction between master narratives (the dominant discourses of the state) and counter narratives (the perspectives of those targeted by racism) which are explained in chapter two. Master narratives are presented in chapters seven and nine (and to some extent chapter five) based on a desktop review of Crown documents without critique. Likewise, the voices of counter narratives stand similarly uncontested in chapters eight and ten.

This study is a structural analysis identifying how racism manifests and examines emerging directions from this study about how to transform institutional racism in health policy and funding practices. The nuances of the complexity of the operational realities of working in the public service, developing health policy making and funding practices, from the perspective of Crown officials are not the focus of this study. Nor is this study a piece of appreciative enquiry looking at the strengths of the Crown's current efforts to address racism.

The argument outlined in this study is a cumulative one, establishing a pattern of behaviour by the Crown in their treatment and engagement with Māori. Individual chapters stand alone but make most sense when read in sequence and read as one entire piece of work. The following section is a navigational tool for the reader with a synopsis of each chapter and an explanation of my use of Te Reo Māori.

Chapter One – Introduction presents my research aims and its local and international significance in terms of contribution to anti-racism praxis, activist scholarship, public policy, public health, human rights and *Te Tiriti o Waitangi* discourses. I introduce my personal and professional background and activist intent to transform institutional racism.

Chapter Two– Methodology and Method presents an overview of the overlapping influences on my methodological approaches. Specifically it examines activist scholarship, critical race, feminist and kaupapa Māori theory and Pākehā Tiriti work. In this chapter, I also provide a description of the data-gathering methods and forms of analysis adopted within this study, including ethical approvals gained and the detail of my application of the Te Ara Tika ethical framework.

Chapter Three – Historical Patterns of Institutional Racism provides an historical analysis of colonisation, assimilation, biculturalism and neoliberalism as macro themes influencing Māori and Crown relations. Drawing on decades of Waitangi Tribunal reports this chapter illustrates the continuity of institutional racism in Aotearoa since 1840 and traces how it became normalised Crown practice.

Chapter Four – Theorising Institutional Racism and Privilege reviews three macro themes of racism literature. It examines the activist traditions of structural analysis, the contrasting libertarian discourses that deny the existence of institutional racism and emerging state acknowledgements of racism within historic Crown practices and contemporary administration of the public sector.

Chapter Five - Controls to Prevent State Racism examines *Te Tiriti o Waitangi* obligations and human rights instruments as controls on potentially discriminatory behaviour by state parties and Crown officials. This chapter, based on a desktop review of Crown documents, presents checks and balances within the New Zealand public sector broadly aimed at promoting ethical non-discriminatory conduct, and enabling citizen participation.

Chapter Six – Traditions of Public Health provides an overview of the theory and practice of public health as a backdrop to my examination of public health policy making and funding practices. The chapter examines indigenous health traditions with a particular focus on Māori public health traditions. The origins of generic public health are explored and key elements of current practice in Aotearoa.

Chapter Seven – Master Health Policy Narratives introduces the current structure of the health sector. Drawing on a desktop review of Crown documents, as representations of master narratives, the bulk of this chapter outlines health policy over the last decade examining the policy platforms of both the Labour-led and National-led governments. This analysis is supplemented by a review of strategic policy documents at DHB level.

Chapter Eight – Counter Narratives: Racism within the Policy Cycle examines how racism and privilege manifest within the various stages of Crown policy development. Drawing on counter narratives, co-funding[9] field notes and literature it uses the stages model of policy development; addressesing the processes of agenda setting, policy formation, decision-making and policy evaluation.

Chapter Nine – Crown Funding Practices drawing on a desktop review of Crown documents this chapter provides an overview of the elaborate web of operational protocols that guide public health procurement. This chapter also presents a macro-level quantitative funding analysis of public health and Māori health investment generated through a series of Official Information Requests (OIR).

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[9] Co-funding in this instance refers to a treaty relationship between two Crown agencies (Ministry of Health and Northland DHB) and an iwi-based Māori organisation (Te Tai Tokerau MAPO Trust). Through this relationship all local health funding decisions are done collaboratively to ensure Māori health needs are met and Māori are involved in decision-making at all levels (Discussed more fully in chapter five).

Chapter Ten – Counter Narratives: Differential Treatment of Public Health Providers Drawing on a survey of public health providers, field notes and counter narratives in this chapter I examine the experiences of different groupings of public health providers in their engagement with Crown officials. Specifically I examine relationships and level of influence, contracting and monitoring experiences and funding and financial accountability.

Chapter Eleven – Transforming Institutional Racism provides an overview of some of the theoretical considerations from anti-racism literature. Drawing on the findings of this study and writings on anti-racism praxis I propose pathways for transforming institutional racism at structural and organisational levels, examine how to strengthen controls on state parties and strategies to enhance racial climate.

Chapter Twelve – Looking Back (into) and Forward (from the Research) summarises the key local and international contributions of this study. It also examines the implications of this work to theory, research and practice and the limitations of the present study.

Use of Te Reo Māori

English is my first language, but not the first language of New Zealand nor the only official language of this country. My use of Te Reo Māori in this thesis is a response to kaupapa Māori theory and is a way of positioning Māori experience as ordinary. I have utilised a range of Māori kupu (words) and concepts that are variously defined briefly within the associated text or in footnotes. These explanations do not capture the layered complexity of Māori worldviews and are not offered as authoritative linguistic accounts (Alex Barnes, Personal Communication, 2011, October 28). Except for direct quotations, and the names of publications, macrons are used throughout this document to signify a double vowel as recommended by Te Taura Whiri i Te Reo Māori (Māori Language Commission, n.d).

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CHAPTER TWO: METHODOLOGY AND METHOD

2.0 Introduction

> After all, it is only in the raising of important questions and the naming of the un-nameable that we will be able to focus our tremendous personal and intellectual resources on a [racist] system so powerful and pervasive that the majority of Americans are still in denial about its very existence
>
> (C. Jones, 2003, p. 7).

The notion that research is political and involves issues of power holds much currency within debates about social science research (see Harding & Norberg, 2005; Kirby, Greaves, & Reid, 2006; L. Smith, 1999). I maintain an awareness of power dynamics is particular relevant when researching institutional racism and examining the behaviour of the powerful. Activist scholars, Back and Solomos (1993, p. 182) warn such an examination can have both intended and unintended political consequences. Heeding this advice, I utilise activist scholarship as my primary methodological standpoint to make explicit this dynamic and to attempt purposeful consequences.

Within this chapter, I outline my methodological approach and influences, data collection methods and analysis. Although presented here as discrete categories I concur with the assessment of Lincoln and Guba (2000), that methodology philosophies are fluid and shifting with new connections and relationships regularly being uncovered. Central to this chapter is an explicit exploration of my ethical accountabilities as an emerging scholar, a public health practitioner, a health researcher, a Tiriti worker and as someone conducting research in Aotearoa with Māori.

2.1 Methodological Influences

Social change researcher, Park (1993), maintains that research paradigms, knowledge and evidence fall into three main groupings: the instrumental, interactive and critical paradigms. The instrumental paradigm is characterised by scientific, positivist, quantitative knowledge that is concerned with controlling physical and social environments. Constructivist, ethnographic and qualitative knowledge generated from lived experience, focusing on understanding the connections amongst people, influences the interactive paradigm. In contrast, the critical paradigm is drawn from reflective knowledge, such as that derived from feminist, indigenous and queer theory. It is concerned with societal structures and

power relations and how they contribute to creating and perpetuating oppression. Critical approaches in effect raise consciousness about the causes of problems and the means to alleviate them. The interactive and critical paradigms are predominately drawn upon within this study with emphasis on the latter.

In this section, I explicitly examine the disciplines of activist scholarship, feminist, kaupapa Māori theory, Pākehā Tiriti work and various branches of critical theory as methodological influences.

Activist Scholarship

> I place my work within the tradition of radical, politically engaged scholarship... My work is grounded in the politics, practices and languages of the various communities I come from, and the social justice movements to which I am committed (Thobani, 2008, p. 209).

Activist scholarship is founded on the traditions of action and participatory research but argues for the mutual intersection of research and political action to challenge existing power relations. Feminist scholars, Sudbury and Okazawa-Rey (2009, p. 3), define it as "…the production of knowledge and pedagogical practices through active engagement with and in the service of progressive social movements". They maintain that activist scholarship is an attempt to resist neo-liberal commodification of higher education where knowledge is valued for its ability to generate revenue and state power rather than its ability to promote a more just, humane world.

Activist scholars reject what anthropologist, Hale (2008, p. 3), describes as the "privilege-laden option to remain outside the fray". As Cherokee activist, Smith (2009, p. 37) maintains it is not mutually exclusive to be both an activist and a scholar and that research can be used to either maintain the status quo or advance a social justice agenda. The accountability of activist scholars to social movements and the communities with whom they work is fundamental to the approach. Collaboration intent and practice, informed horizontal dialogue between activists and scholars, alongside egalitarian distribution of the benefits from research lie at the heart of activist scholarship. Hale (2008, p. 4) explains:

> …activist scholars work in dialogue, collaboration, alliance with people who are struggling to better their lives; activist scholarship embodies a responsibility for results that these "allies" can recognize as their own, value in their own terms, and use as they see fit.

Kaupapa Māori theorist, Cram (1997, p. 11) makes the interesting distinction between procedural and outcome empowerment. Procedural empowerment she suggests is transient and occurs when research participants feel valued and heard and that participating in the research process was worthwhile. Outcome empowerment, which is more enduring, emerges when successful social and

political action occurs because of that research. She maintains that, if the participants own the research, this social the researcher and/or the community can lead change action. Activist scholars, Back and Solomos (1993) and Neal (1995) maintain the challenge is how to move past anti-racism rhetoric and intent into social change outcomes.

Emphasis on collaborative practice, clear accountability arrangements and the focus on achieving social change outcomes marks this study as an example of activist scholarship. My research questions and methodology have been influenced and shaped by horizontal dialogue with both those targeted by racism and activists working to transform it.

Feminist Methodologies

> There is more than political analysis involved in a commitment to anti-racism:
> the heart and spirit are also involved... While my feminism is rooted in my own
> passion for self-determination as a woman, my involvement in anti-racism
> stretches me beyond a simple perception of self-interest to a more complex
> connection with other women
> (D. Jones, 1992, p. 297).

Rather than one monolithic feminist standpoint Olesen (2005) and Kirby, Greaves and Reid (2006) maintain there is plurality of feminist positions on how to achieve collective social and economic transformation for women. For instance, indigenous feminists often maintain they have more in common with indigenous men than white feminists (Awatere, 1984). Bowles and Klein (1983, p. 122) in their often cited text on feminist theory have identified various common features across value-laden feminist methodologies. These include a commitment to integrating praxis and research a rejection of objectivity and embracing conscious partiality a belief in the value of consciousness-raising and a commitment to pursue social justice.

In keeping with feminist traditions (D. Jones, 1992; Lather, 1989, August) I recognise all research comes from a particular viewpoint whether declared or not but I choose to make explicit my chosen standpoint. Being a feminist for me means recognising the interconnections of oppression and the differential burden of disadvantage on groups of women. It means discerning that patriarchy and systemic racism are more complex than the isolated sexist and racist acts of individual people, that they are part of an oppressive system. Being a feminist for me involves being self-reflective enough to know that the 'personal is political' (see Firestone & Koedt, 1970) and that as a Pākehā woman I am a beneficiary of colonisation, a person of privilege. It is these learning's that have led me to become a Tiriti worker, committed to working towards the decolonisation of Aotearoa.

Beyond the invaluable critical tools of structural analysis, feminist theory has also taught me the value of everyday lived experiences as a source of knowledge and theory. My life as a woman who has experienced discrimination, violence and privilege gives me some insights into the dynamics of oppression and I hold this as valid knowledge to draw on within a research process. Emotionally engaged feminist research traditions as outlined by Blakely (2007) also provide frameworks to share normal human responses of the heart and spirit to difficult issues. One of the ways this narrative can be made visible is through the inclusion of inter-texts as demonstrated by Lather and Smithies (1997) in their unique post-modern text, *Troubling the Angels: Women Living with HIV/AIDS.*

Feminist theory has influenced my choice of topic, gives me permission to be both political and emotional, with a history and culture that transparently influences research process. It also ensures the voices of women are consistently present in my writing.

Pākehā Tiriti Work Traditions

> The purpose of this [Pākehā Tiriti] work is to resource people to create a society based on *Te Tiriti o Waitangi*, founded on sustainable use of resources and communal need, and which is consistent with hapū/iwi/whānau localised development (Network Waitangi Otautahi, 2002, p. 214).

Pākehā Tiriti work is strongly influenced by liberation theorists, feminism and the tino rangatiratanga movement. Acting in a supportive role Pākehā Tiriti workers often work in co-intentional relationships with Māori to support: Māori aspirations of tino rangatiratanga, attempt to prevent further breaches of *Te Tiriti o Waitangi* and work towards achieving constitutional change. Significant energy is also invested in educating and mobilising other Tauiwi to politically engage in processes of decolonisation. Research is increasingly becoming a site of activist activity (see Huygens, 2007; Margaret, 2002).

Central to these traditions (see Herzog, 2002; Huygens, 2001) are attempts at power-sharing. Project Waitangi for instance, Huygens explains (1999, p. 16), was set up to educate Pākehā on treaty issues and operated with a system of Māori monitors to ensure the overall direction and outcomes met the needs of Māori. This accountability structure was influenced by the writings of Ramsden (2002) on cultural safety, which advocated for non-dominant groups to become the experts and monitor effectiveness. Informal accountability arrangements also frequently exist between individual Pākehā Tiriti workers and local groups and networks. Furthermore, it is unusual for practitioners to operate independently of such a network.

Voluntary ethical guidelines (see Network Waitangi Otautahi, 2002) have been adopted within the movement: emphasising the importance of relationships; accountability; indigenous control and leadership. These dual accountabilities to

both Pākehā and Māori ensure a high level of peer review and that interventions are built on prior learnings, as embedded within my approach.

Kaupapa Māori

> [A kaupapa Māori orientation] assumes the taken-for-granted social, political, historical, intellectual, and cultural legitimacy of Māori people, in that it is an orientation in which Māori language, culture, knowledge and values are accepted in their own right
>
> (Bishop, 2005, p. 114).

Te Awekotuku (1991) and Cram (1993) argue historically many Pākehā researchers have failed to recognise the prevalence of dominant Pākehā cultural lens. Cultural anthropologist, A. Salmond (1985) argues that western epistemologies are the standard by which all forms of knowledge are judged is widespread within New Zealand. However within the dominant group lies a committed group of Pākehā working to transform such ethnocentrism and to establish honourable treaty relationships (Margaret, 2009). Exposure to critical discourses via this network led me to consider the challenge of kaupapa Māori theory.

The core of kaupapa Maori theory as I see it is starting reasoning from a Māori paradigm based within Māori cultural specificities, preferences and practices. The concepts of whānau, whakapapa (genealogy) and whanaungatanga[10] are central to this approach (Royal, 1998). Bishop (2005) contends that knowing who you are and being able to acknowledge your connectedness allows you to let go of a focus on self. Kaupapa Māori approaches are often relational and recognise communities as experts in determining their own solutions rather than the researcher assuming the role of 'expert'. It is widely agreed (R. Jones, Crengle, & McCreanor, 2006; Moewaka-Barnes, 2000; Pihama, Cram, & Walker, 2002) that kaupapa Māori is embedded within the dynamic realm of tikanga (cultural protocols). The involvement of kaumātua (koroua - male elder and kuia - female elder) within kaupapa Māori research projects is common practice, as elders are the guardians of tikanga and the consensus makers for the collective (Moewaka-Barnes, 2000).

I suggest that kaupapa Māori theory in its contemporary 'post colonial' form is strongly aligned with the critical tradition in that it seeks to expose power relations that perpetuate the continued oppression of Māori. This critical analysis is driven by indigenous Māori understandings and the tools of structural analysis. Pihama, Cram and Walker (2002, p. 10) purport kaupapa Māori is about the "pushing forward of Māori aspirations and pushing back of Pākehā control and domination". It is about affirming Māori experience as 'ordinary' within Aotearoa. LT Smith (1999) and Pihama et al. (2002) argue that kaupapa Māori research can be a decolonisation process. *Te Tiriti o Waitangi* and more

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[10] Whanaungatanga is the process of establishing and maintaining relationships.

specifically tino rangatiratanga are frequent markers within kaupapa Māori literature (Bishop, 2005). Kaupapa Māori approaches often utilise analysis that locates what is being studied within a wider historical, social, cultural and political context (Keefe et al., 1999).

So where do non-Māori researchers fit into this framework when kaupapa Māori research is in part about challenging the dominance of Pākehā world-views? LT Smith (1996, February) maintains a number of kaupapa Māori theorists have argued that being Māori, identifying as Māori, are all critical elements of kaupapa Māori. Moewaka-Barnes (2000, p. 9), when discussing Tauiwi involvement, warns the challenge of this involvement occurs when "Tauiwi fail to recognise power and methods which spring from their position of 'normality' and privilege". Royal (1998) makes a useful distinction in his writings between mātauranga[11] Māori and kaupapa Māori. He contends kaupapa Māori works with a Māori worldview and has political analysis, while mātauranga Māori works with Māori cosmology and is tikanga based. Bishop (2005, p. 113) confirms that for him kaupapa Māori is "research by Māori, for Māori with the help of invited others". GH Smith (2007; 1992) proposes four potentially overlapping models whereby Pākehā can carry out culturally appropriate research with Māori (see Table 3).

Table 3: Collaborative Pathways for Māori and Pākehā Researchers

Model	Description
Tiaki (mentor)	Research process is guided and mediated by authoritative Māori.
Whāngai (adoption)	Researcher becomes one of the whānau.
Power-sharing	Community assistance is sought by the researcher so the research can be meaningfully carried out.
Empowering outcomes	Research supplies answers and information Māori want to know.

Note. Adapted from "Research issues related to Māori education," by G.H. Smith in M. Hōhepa & G.H. Smith (Eds.), *The issue of research and Māori*, 1992, p.14-22. Auckland, New Zealand: Auckland University. Reprinted with permission.

Recognising Royals' distinction my focus is on kaupapa Māori as opposed to mātauranga Māori. Regarding the later I defer to Māori as the kaitiaki (guardians) of this knowledge. In reviewing GH Smith's models I describe my approach as one of power-sharing with rigorous Māori monitors/mentors. My intentions are that this research may contribute to efforts to advance Māori aspirations.

Critical Theory

> Perhaps the most vital concern of critical theorists is that of emancipation, that theory and practice are indivisible and must be viewed in a dialectic relationship (Pihama, 1993, p. 40).

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I align myself to critical theory in that I seek to critique and challenge hegemonic interests to achieve an emancipatory and transformative agenda. Political theorist and philosopher, Gramsci (1975/2010), reminds researchers to be alert to the

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[11] Mātauranga refers to traditional Māori knowledge.

inequitable power of social relations and the hegemonic depictions of this as natural and inevitable. I am interested in breaking through taken-for-granted views of the world in order to step outside hegemonic paradigms to look with critical eyes back into the neo-colonial system. It is about developing a fresh perspective that calls into question the violently mundane bureaucratic system. As Thomas and Veno (1996, p. 89) argue, a major source of power for dominant groups is simply "the routine application of effectively unchallenged assumptions of social institutions" which support their privilege.

Critical theorists frequently argue that privileged groups have an interest in supporting the status quo to protect their advantage. They also have the resources that allow them to promote ideologies and representations in ways individuals and groups without privilege cannot. Philosopher, Foucault (1969/2002) argues that language is not a neutral description of the 'real world', rather language in the form of discourses and discursive practice has a set of tacit rules that regulate what can and cannot be said. These rules signal who can speak with the blessings of authority and whose constructions are considered unimportant. These power discourses, according to cultural theorist, Hall (2007), provide a way of representing and privileging a particular kind of knowledge about a topic and restrict the other ways in which a topic can be constructed.

Knowledge, 'commonsense' and consciousness, according to critical theorists, are therefore contested sites of resistance (M. Stoddart, 2007). Aligned to the critical tradition I am drawn to explore difficult and uncomfortable issues of privilege and structural inequality to destabilise power relations, generate equity and minimise the barriers to indigenous sovereignty. I embrace an attitude that opens up what critical theorist Kincheloe (2008, p. 60), calls 'the discourse of possibility'. I believe there is a dialectical relationship between human beings and concrete historical and cultural realities, and therefore it is possible to influence and re-shape our environment, social and political institutions.

Critical Race Theory

A critical race theory challenges ahistoricism and the unidisciplinary focus of most analyses and insists on analyzing race and racism by placing them in both historical and contemporary contexts (Solorzano & Yosso, 2002, pp. 26-27).

Originating in the United States, Critical Race Theory (CRT) is primarily concerned with studying racism, how it has been created and maintained, and reshaping power relations. Rejecting notions of racism as "…an intentional albeit irrational, deviation by a conscious wrongdoer", Crenshaw, Gotanda, Peller and Thomas (1995, p. xiv) in their landmark text on CRT, maintain racism is systemic and ingrained. They maintain libertarian discourses of 'colour-blindness' and meritocracy, mask enduring power differentials that remain unaddressed by the temporary gains of the civil rights movement.

Solórzano and Yosso (2002, p. 25) identify several common themes across CRT. These include race and critical consciousness, linkages between racism and other forms of oppression, a commitment to both social justice and challenging the dominant ideology, a valuing of experiential knowledge and a multi-disciplinary approach. Delgado and Stefancic (2001) emphasise the importance of context within CRT and the detail of the lived experiences of marginalised peoples. Ford and Airhihenbuwa (2010) concur regarding the primacy of explicitly incorporating the knowledge of minorities and highlight the attempts of CRT to expand the vocabulary for discussing racial phenomenon.

Storytelling is often used within CRT as a mechanism to examine myths, assumptions, and received wisdoms and is an intricate part of the method of this study. A distinction is made between master narratives or majoritarian stories and counter storytelling (Gillborn, 2006, p. 24). Master narratives according to Solórzano and Yosso (2002, p. 27) encourage cultural deficit thinking by promoting one-dimensional stereotypes and the notion of collective cultural 'failure'. These narratives are not often questioned by the dominant group as they are considered 'natural and normal'.

Counter storytelling in contrast is used to challenge hegemonic discourses. It involves presenting the stories of people whose experiences are not often told. The counter narrative is a way to expose, analyse and challenge master narratives and racial privilege. These stories are sometimes told directly in the first person from the researcher's experience, in the third person by retelling someone else's story or through composite stories, a combination of several people's stories. The stories deliberately utilise 'real-life' experiences inclusive of emotion, while empirical data and literature are used to contextualise these experiences.

2.2 Method and Analysis

From our perspective, social research involves the continuous revision of one's plans and expectations and engaging in a process of self-reflection as a participant in the process of creating knowledge

(Kirby et al., 2006, p. 18).

Given the sensitive and political nature of this research, I utilised a range of data sources (both qualitative and quantitative) and methods (see Figure 2) to examine my research questions - beyond the usual triangulation of data. The formation of a research whānau who oversaw, guided and supported this research journey was central to my method. Data collection strategies included: maintaining a research journal of co-funding experiences, an historical analysis of institutional racism, a literature review, collaborative counter storytelling primarily with Māori leaders, a desktop review of Crown documents, a quantitative analysis of health funding, a telephone survey of public health providers, a series of OIRs and dialogue with Crown officials.
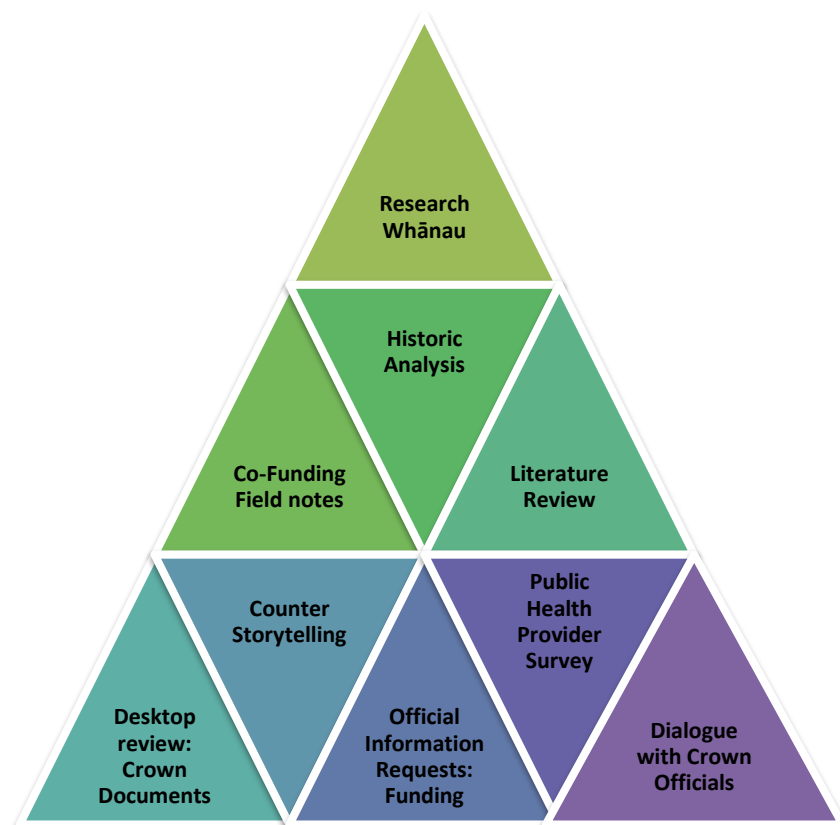
Figure 2: Data Collection Strategy
This figure shows a cross section of the data collection methods utilised within this study. They are introduced in more detail in the following sections.

The Role of Research Whānau

Public health practice and Tiriti related work I am familiar with is predominately collaborative, as are the traditions of activist scholarship. I therefore chose to embed collaboration within my research governance structure. Collaboration is both a pathway for power-sharing and, if authentic, Kirby et al. (2006, p. 30) asserts it helps facilitate shared ownership and propels research findings to a wider audience.

My core mechanism for collaboration was a research whānau/reference group made up of Māori health leaders and a Pākehā crone based within Te Tai Tokerau. I had pre-existing relationships with the individual members of the rōpū (group),

each of whom are recognised leaders within their fields. Collectively they have decades of experience in Māori health and/or management and/or Tiriti work. This includes extensive experience in dealing with Crown agencies and officials from a variety of organisational viewpoints.

The rōpū serve as kaitiaki for this study to ensure the work remained politically relevant and culturally safe. Through their governance role, they endorsed the initial research proposal before it was submitted through the university system. They offered direction around structure and reviewed draft after draft of text. The rōpū provided direction over the selection of counter storytellers and advice about when and how to engage with the Crown, a matter that perplexed me throughout the study. The input of my research whānau and the dynamic cross-cultural debates, have been and continue to be invaluable sources of insight.

Historical Analysis & Literature Review

Kua tawhiti ke te haerenga mai, kia kore e haere tonu. He tino rawa ou mahi, kia kore e mahi nui tonu.

You have come too far, not to go further. You have done too much, not to do more.

(Henare, 1987a).

There are many Māori whakatauākī (proverbs) that articulate the importance of understanding the past to make sense of the present. Indeed kaupapa Māori theory often emphasises the importance of historical socio-political context to understanding contemporary matters. In aligning to this tradition, this study includes a historical analysis to contextualise contemporary manifestations of institutional racism. The voices of indigenous historians are deliberately privileged within this account, which draws heavily on Waitangi Tribunal reports as respected historical sources. Indeed, I undertake a thematic analysis of health related Tiriti claims in chapter five.

Other literature was variously sourced from health, medicine, education, social science, management and psychology databases. Other Crown and activist produced documents accessed for this research are in the public domain. As a PhD candidate, I sought to situate my work in the international arena as a necessary aspect of this qualification and utilise the insights of others to deepen my understanding of racism, justice and activist scholarship. I engaged with these literatures with a robust sense of respect for the local and the possibilities that the local may influence the global. As critical management scholar D. Jones (1992), advocates those writing from the Antipodes need to find the confidence to speak from local perspectives and ensure the strengths of our analysis are not overly dependent on overseas texts.

Master Narratives

Within CRT, master narratives are the discourses of the powerful. Through this study, I examine several sets of master narratives, which articulate best practice and/or ethical conduct for both state parties and Crown officials. These master

narratives include treaty obligations made between England and the hapū of Aotearoa, as outlined in *Te Tiriti o Waitangi* and commitments made through human rights instruments, which articulate agreed levels of conduct for state parties within the international community. I also examine accountability mechanisms within the New Zealand public sector to promote ethical conduct and minimise systemic discrimination.

Having established this web of macro accountabilities, I refined my focus to activities within the public health sector through a desktop review of Crown documents. This desktop review is taken as the Crown's voice for the purposes of this study rather than the viewpoints of individual Crown officials. Through the desktop review, I examine the policy positions and articulations of mandatory conduct in relation to Crown procurement and funding practices between 1999 and 2010. In choosing this timeframe, I deliberately covered both the Labour-led coalition and the current National-led coalition governments to illustrate the continuity of institutional racism.

In relation to policy master narratives, I have used Northland DHB as a case study within chapter seven. This rohe (area) was chosen because this research was instigated in Te Tai Tokerau, the reference group is based in Te Tai Tokerau and a significant amount of my co-funding field notes related to my experiences working with Northland DHB. Having worked and had close contact with a range of DHBs I am not contending that Northland is "typical" of all DHBs but from a master narrative perspective, Northland DHB does have to fulfil the same planning requirements as all DHBs. I do note however that Northland DHB as with other Auckland-based DHBs have treaty-based co-funding partnerships.

Once the bulk of this data collection was complete and preliminary analysis undertaken, I met with a key senior official from the Ministry of Health to clarify points arising from my preliminary findings. For the purposes of this study, the **Senior Crown Official** identifies as a manager with experience of contracting as both a provider and as a contract manager in the Ministry of Health. Their contribution is woven through chapters seven and nine to inform the desktop review. A major theme of this exchange was the challenges and tensions of doing public health policy making and funding activity within the wider Ministry of Health environment.

Together these pieces of analysis provide a platform from which to offer an assessment of Crown performance in relation to its own ethical benchmarks and as a point of reflection for my own findings.

Funding Analysis
Given the passionate conviction from those associated with this research that that allocation of funding was a site of institutional racism I was committed to undertaking a funding analysis. In the first instance, I reviewed Ministry of

Health, *Health Expenditure Trend* reports (2005-10) and Treasury *Vote Health* appropriations for the same period. These documents provided disparate figures and only limited or no information about both public health and Māori health investment. I contacted the Ministry of Health to seek clarification and was passed around a series of officials who were not able to answer my questions.

I then drafted a collection of OIR to the Ministry of Health (see appendix A). From my initial conversation with the Chief Financial Officer (Personal communication, December 10, 2010) it became apparent that the Ministry do not track Māori health expenditure nor maintain oversight of public health expenditure beyond what they directly fund. In order to complete my analysis I sent out a series of OIR to all DHBs (see appendix B). The interchange with DHBs ranged from friendly articulate responses within twenty-four hours, through to hostile administrators, letters from lawyers and refusals to release information. Many of the Crown agencies involved were either unable or unwilling to respond within the required timeframes.

After utilising the services of the Office of the Ombudsmen[12], eventually all Crown agencies were largely compliant. Collating the DHB data took several waves of correspondence to obtain a near complete data set. Due to changes in financial systems where gaps existed in the data, several estimates (as noted in the findings) were incorporated into the analysis.

Counter Narratives

Within CRT, master narratives are frequently contrasted with counter narratives, which are the perspectives of those not often heard. Within a dominant cultural paradigm, the unheard are frequently indigenous and other voices of dissent. Within this study, I gathered counter narratives by engaging in collaborative storytelling with nine Māori leaders and a Pākehā crone. I also documented my experiences of co-funding activity with Crown officials. This information was then investigated further through a survey of public health providers.

Common across many of the epistemological and theoretic perspectives drawn on for this study is a tradition of storytelling. Stories are a way of representing perceived truth. Central to this study is a process of counter storytelling with leaders willing to share their experiences and analysis of Crown conduct. I utilised what Bishop (1996, p. 23) describes as collaborative story telling a co-joint construction of meaning. The mutual telling and retelling of stories by people who are living those stories allows knowledge to be generated that denies distance and separation and promotes commitment and engagement in the research journey. It allows for what Heshusius (1994) calls 'participatory consciousnesses' and deconstructs the traditional position of researcher as all powerful storyteller.

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[12] I made two complaints against DHBs (whom I choose not to identify within this study) in relation to their non-compliance with my OIR.

Discussions primarily took place kanohi ki te kanohi (face to face), others were conducted through extended telephone conversations due to geographic distance and resource limitations. Usually the storytelling was approximately an hour at a time though some marathon sessions took up to three hours (with kai breaks). All sessions were transcribed and then reviewed by storytellers to ensure they were comfortable with their text. Points of interest were identified for further discussion in subsequent encounters. Indeed 75% of the storytellers participated in more than one session.

All the dialogue took place within the context of ongoing relationships. Informal and often in-depth conversation about the unfolding research was ongoing with many of the storytellers beyond the data collection period as part of our ongoing professional and personal relationships. In citing the data, I did a thematic analysis and used direct quotations frequently and minimised paraphrasing. Relevant literature was weaved through the counter narrative excerpts to elaborate a point in the traditions of CRT. Likewise, field notes and the findings of the public health survey supplemented the excerpts.

Recruitment was guided by my research whānau, some of whom participated in storytelling processes themselves. The extensive collective relationship network within this rōpū provided a plethora of potential counter storytellers. I undertook purposeful sampling in that I deliberately worked with information rich cases (Patton, 1987). I also revisited dialogue with counter storytellers from my earlier post-graduate study (Came, 2007, 2008) with refreshed informed consent to deliberately build on this earlier sharing and resumed fruitful lines of enquiry.

Storytelling processes were conducted with people who have worked within Crown agencies, Māori and generic health providers. I secured a range of stakeholders from governance through to senior management as recommended by Griffith, Mason, Yonas, Eng, Jefferies, Pliheik and Parks (2007) from their work dismantling racism. Informed consent was negotiated with counter storytellers (see Appendices A and B). Many of those engaging in the storytelling chose to be identified within the research. The following biographical details introduce the counter storytellers.

Grant Berghan is from Te Tai Tokerau (Northland) with links to Ngā Puhi, Ngāti Wai and Te Rarawa iwi (tribe). He has extensive experience in the health and labour market sectors. He has been a general manager of Māori health, public health and mental health for a DHB, the Chief Executive Officer (CEO) of a regional Māori health provider, and a national Māori Employment Commissioner and Northland regional manager of government work programmes. He has also been an auditor of health programmes, a probation officer, a social worker, and a free-lance journalist for a French (Parisian) weekly newspaper. He has experience in policy and program development and implementation, contracting, funding, advocacy, facilitation and evaluation. He was a government appointed member to the Youth Suicide Advisory Panel and is a current member of the Māori Advisory

Board (Public Health) with the Ministry of Health. He is the Managing Director of Berghan Consultancy Limited, specialising in Māori development issues.

Shane Bradbrook has links to Ngai Tāmanuhiri, Rongowhakāta and Ngāti Kahungunu. He has been involved as a Māori and indigenous advocate in the tobacco resistance movement for the last decade at both national and international levels with the primary role of advancing change at a political and policy level on tobacco use issues. Winner of several academic fellowships Shane was also the recipient of the international Nigel Gray Award in recognition of his work in tobacco control. He has been involved in various governance and advisory roles including session chair for United Nations indigenous forums and represented Aotearoa on the development of the *Framework Convention on Tobacco Control* (World Health Organization, 2003). He has received a world first apology from a tobacco company for the sale of Māori mix cigarettes, successfully advocated for the removal of cigarette brand from the New Zealand market, and worked extensively with a range of Pacific Island nations around tobacco issues. He continues to pursue passionately his vision: "Kia mau te kaupapa tupeka kore mō ngā uri Māori" as the ultimate expression that will greatly improve the overall physical, economic, social and cultural well-being of Māori.

Susan Friar da Silva is a sixth generation Pākehā from an old Auckland family. She has been interested in issues of racism since attending a workshop of Mitzi Nairn in 1979 and has worked in Tiriti issues since 1985. Susan currently teaches on the social service programme at North Tec and provides professional training on Te Tiriti issues and cultural competencies to various health, education and community organisations through her consultancy Silva Service. Susan is an active member of Network Waitangi Whangarei.

Louise Kuraia is Ngā Puhi me Ngai Tai ki Tainui, of the Davis whānau from Karetu (Bay of Islands) and Torere (Bay of Plenty) and Makene whānau from Mangataipa (Far North). She also has Welsh, Scottish, Irish and English heritage. Louise was born in Kawakawa, Te Tai Tokerau and bought up and schooled in Otara and Otahuhu (South Auckland) and is an alumnus of the University of Auckland's Faculties of Art and Law. In 1994, Louise started in the health sector, coming to specialise over sixteen years in Māori health provider, services and workforce development; policy and structural analysis; and funding and planning. Louise spent four years at North Health and the Health Funding Authority (HFA) then twelve years in Whangarei with Te Tai Tokerau MAPO. Louise was Executive Director of the Amokura Family Violence Prevention Consortium to June 2011, and it is currently working for Te Tai Tokerau Whānau Ora Collective, which brings together five Māori health, education, community and social service providers serving 86% of the Tai Tokerau Māori population under the *Whānau Ora* banner. Louise is married to Anton (Samoan, Cook Islands and Pākehā), a constable with Whangarei Police, and they are the proud parents of three boys Seb, Julius and Luca.

The counter storyteller identified as **Māori Provider CEO** has decades of experience in iwi development and the wider health sector. They have governance experience and have been involved in a range of regional and national advisory groups for Crown agencies. They have also led out a number of innovative intersectoral initiatives.

Maxine Shortland has links to Ngāti Hine, Ngā Puhi, Ngāti Wai and Ngāti Porou. She has more than twenty years experience within the health sector working within Māori and non-Māori providers, most recently in senior management roles. She has participated in a range of regional and national reference and advisory groups advocating for Māori health. Maxine currently manages Mātauranga Whānui, which is a service of the Ngāti Hine Health Trust. She recently was awarded the University of Auckland Dame Mira Szaszy Alumni, Māori Business Leaders Award for her contribution to Māori health.

The counter storyteller identified as **Senior Māori Health Advisor** has worked within the Ministry of Health across a number of its departments. They have previously worked as a Manager within a Māori Provider and employed as a public health practitioner within a DHB. They have sat on a range of health advisory groups at national and regional level, and have an extensive background in community and hapū development. They also have extensive experience in program development, implementation, contracting, advocacy and facilitation. They are passionate about working for Māori communities.

The counter storyteller identified as a **Senior Māori Executive** is a very experienced senior manager having worked for both Māori and mainstream organisations and whose whakapapa[13] is intact. They have considerable governance experience and have been involved extensively in Crown regional and national advisory groups, advocating for Māori health and *Te Tiriti o Waitangi*. They have been nationally recognised on several occasions for their contribution to Māori health, and presented and published on Māori health nationally and internationally. They have been involved in the development and rollout of a number of significant initiatives within the health sector.

Hayden Wano Registered Comprehensive Nurse, Post Graduate Diploma in Health Services Management, Advanced Diploma in Nursing, Masters in Business Administration, and Fellow of the Australasian College of Health Service Executives. Hayden is of Te Atiawa, Taranaki and Ngati Awa Iwi descent and is currently Chairman of Te Niho o Te Atiawa House, Parihaka. Hayden is married to Antonia with three adult children and one grandchild. He is a keen surfer and spectator of a variety of sporting activities and has a particular interest

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[13] Whakapapa meaning Māori identity in this context.

in local and indigenous art. He has over twenty years experience in senior health management, and is currently CEO of Tui Ora Ltd and General Manager Iwi and Community, Midlands Health Network. Hayden has over thirty five years health sector experience in mental health, community and medical services. He has held positions as Director of Clinical Services with Taranaki Healthcare, and Chairman of Taranaki DHB 2000-2007. Hayden also holds a number of other governance positions, including Chairmanship of the Health Sponsorship Council and is a member of the recently established National Health Board (NHB).

The counter storyteller identified as **Māori Policy Analyst was** born in Tolaga Bay and of Ngāti Porou, Ngā Puhi, and Te Whānau ā Apanui descent. She has two children and one mokopuna. She went to school in Tolaga Bay, Gisborne and Napier. She trained as a registered general and obstetric nurse at Napier Hospital and went on from there to complete a Bachelor of Social Science at Massey University with first class honours and a Doctorate in Philosophy at Waikato University. She has worked in the health sector as a registered nurse until seconded by iwi to assist in the establishment of Māori provider services. Her areas of expertise are Māori health and policy. Between times, she has been politically active in an endeavour to address the impact of colonisation on whānau, hapū and iwi.

Co-funding Field Notes

During the course of defining my research topic and during the preliminary writing of this thesis, I worked for a distinctive Māori co-funding organisation, Te Tai Tokerau MAPO Trust. From this vantage point, I was able to witness firsthand the behaviour of a range of Crown officials in their dealings with a cross section of public health providers. Through the course of my standard professional practice, my work was subject to detailed and systematic documentation for both internal and external reporting purposes.

As part of my research process, I kept a reflective research diary recording my participant-observations of racism through the course of my professional work. These notes are reflective accounts of incidents and include information about how I felt about those experiences, in part as a mechanism to deal with my rage at what I was witnessing. These notes form part of a structural analysis of how racism manifests within the health system within this study. Although individual Crown officials appear within these field notes they are not identifiable so are protected from potential harm. Indeed considerable care was taken that in my willingness to expose aspects of my own analysis and responses I did not expose the identity of others.

Public Health Provider Survey

Paradies (2006a, p. 147) argues that actions and/or behaviours can only be objectively named racism when a comparison is possible. Heeding this insight, part way into my research process I made a decision to undertake a survey of

public health providers. This survey (see appendix C) was a means to both test themes emerging from counter narratives with Māori and benchmark the experiences of different groupings of public health providers in their dealings with Crown agencies.

The survey was targeted at health providers who were contracted to deliver public health services by the Ministry of Health and/or a DHB(s) as of December 2010. Fifty-six senior managers from public health providers agreed to participate in the survey out of a possible sample size of 243 providers. This survey therefore represents the viewpoints of nearly 25% of the public health sector but certainly not the entirety of the sector.

Recruitment occurred through my strong existing networks and relationships within the sector and involved a broad cross section of providers. These relationships were formed through nearly twenty years in the sector working in Taranaki, Waikato, Te Tai Tokerau and nationally (based in Auckland), attending conferences, workshops, seminars, hui and fono. The cohort included both small and large providers, located within both rural and urban settings. Senior managers from Public Health Units (PHU) (13), Primary Healthcare Organisations (PHO) and/or Community Health Trusts (10), national and local NGOs (19) and Māori health providers (14) all participated.[14]

The survey took place via the telephone to minimise confusion in relation to the questions and to ensure a high return rate.[15] The survey benchmarked providers' experiences of Crown officials in relation to the key areas of contracting and service delivery, relationships and influence, funding and financial accountabilities. The findings of the survey were analysed at group level and are presented in the body of this study in graph form utilising percentages of each group to enable easy comparison across the groupings.

Dissemination and Mobilisation Strategy

Within activist scholarship, dissemination of findings and mobilising people into action around those findings are an integral part of the research process. My dissemination strategy (see Appendix D) was developed with my research whānau. The strategy identified several communities of interest, those within Te Ao Māori (the Māori world), Crown agencies, the public health, academic and activist communities and beyond.

A range of dissemination/mobilisation strategies have been and will be implemented including working with Māori and mainstream media, presenting at conferences and hui, writing journal articles, reports and articles for newsletters.

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[14] At the time of data collection it was agreed with public health providers that they would not be identified through this research.
[15] Only three providers declined to participate in the survey as they were undergoing significant restructuring during the timeframe of the data collection.

My intention is also to set up briefing meetings with Crown officials, mobilise professional and activist networks and write to governance boards of Crown agencies. Engagement with each community of interest will be tailored to achieve a range of specific objectives, which will be updated and refreshed as new parties mobilise against institutional racism. Appendix E outlines the presentations and papers already developed in relation to this study and those that are forthcoming.

2.3 Ethical Accountabilities

> Of course, work in this field [researching racism] will, inevitably, be fraught with controversy, because the exposure raises important themes of accountability, agency, and human rights (Krieger, 2003, p. 197).

Institutional racism is a sensitive issue to research. The very expression of the concept creates tensions and draws attention to issues of systemic power that are attributable to 'race'. Given this context and the likely exposure of institutional racism through this research, particular ethical issues emerged for all stakeholders and in particular for me, with my explicit action orientation. Rather than engage exclusively with the Waikato School of Management (n.d.) requirements in considering the ethical elements of this research I acknowledge my multiple accountabilities as a public health researcher, a Tiriti worker and someone conducting research with Māori (see Figure 3). Within this research, I endeavoured to respect the norms set out across these traditions.

Figure 3: **Ethical Frameworks**
This figure refers to the Waikato Management School (n.d.) ethics guidelines, *Te Ara Tika* (Hudson et al., 2010) ethical framework, the Health Research Council's (2010) guidelines for research that involves Māori, the ethical guidelines developed by the Health Promotion Forum (2011) for health promotion practitioners and the Pākehā treaty worker (Network Waitangi Otautahi, 2002) guidelines.

Approval was granted by the ethics committee of the Waikato Management School for the method and methodological approach for this research. This ethical process required me to describe my research questions and methods including their anticipated benefits and any plans for collaboration and research outputs. Given the centrality of people in this research, my application specifically addressed issues of informed consent (see appendix F and G) and the rights of participants to privacy, confidentiality and a clear means of disassociation from the research. The application also addressed issues of minimising deception and risk to participants and outlined how I would exercise social and cultural sensitivity.

Informed consent was not secured from those Crown officials that appear within my field notes. This considered decision was taken because in the first instance this study is a piece of structural analysis, looking at the system of racism not the actions of individuals. Secondly, I maintain, as a point of principle the behaviour of all public officials should be open to scrutiny to protect the public's interests. Thirdly, I suggest officials and/or managers perpetuating institutional racism would be unlikely to consent to participate in a research project about racism. Given that individual Crown officials are protected through their anonymity within my field notes, I suggest the larger potential harm or ethical risk that needs to be managed lies in the uninterrupted continuation of systemic racism.

Within my professional life, I am ethically accountable to *Ngā Kaiakatanga Hauora mō Aotearoa* (Health Promotion Forum, 2011). These guidelines emphasise the importance of reflective, evidence-based practice and a commitment to working in collaborative ways that benefit communities. They address the responsibility to increase individual and group autonomy and a duty to work with those whose life conditions place them at greatest risk. They also underscore the importance of Te Tiriti, equitable health outcomes for Māori and the importance of actions, which reflect Māori aspirations of self-determination.

The only misalignment in relation to these guidelines was my decision against working collaboratively with Crown officials within the governance and implementation of this study. This decision was taken so that this work could be driven by the experiences of those targeted by racism rather than being influenced by the perspectives of those working within Crown agencies. I relation to the dissemination of the findings of this research and their implementation, in dialogue with my governance group, I expect this process to involve collaboration with Crown officials.

The Health Research Council (2010) maintains that all health research in Aotearoa is relevant to Māori; therefore, their guidelines on research involving Māori are always applicable. These guidelines establish a benchmark for good practice to

ensure research outcomes maintain or enhance mana[16] Māori. They address the application of the *Treaty of Waitangi*, informed consent, ongoing consultation and collaboration with Māori communities, inequities in health between Māori and non-Māori, and the importance of effective implementation and completion of research. The primary components of these guidelines are addressed through the governance structure of this study.

Within the Pākehā Tiriti movement, there exist various articulations of desired ethical behaviour for Tauiwi when supporting Māori achieving tino rangatiratanga (Huygens, 1999, 2002; Network Waitangi Otautahi, 2002). A related paper I co-authored with Tiriti trainer, da Silva (2011) specifically addresses some of the complexities of ethical behaviour for Pākehā in light of systemic breaches of *Te Tiriti o Waitangi* and the enduring impact of colonisation. The paper emphasises the importance of developing core political competencies and co-intentional relationships with Māori.

Te Ara Tika Ethical Framework

> All research in New Zealand is of interest to Māori, and research, which includes Māori, is of paramount importance to Māori (Hudson et al., 2010, p. 1).

Māori had been wrestling with ethical issues in this country for hundreds of years prior to European contact. Out of acknowledgement of Māori as tangata whenua (people of the land), I chose to explicitly engage with *Te Ara Tika Guidelines for Māori Research Ethics* developed by the Pūtaiora Writing Group (Hudson et al., 2010). This tikanga based framework draws on the previous contributions of kaupapa Māori ethicists, Te Awekotuku (1991), LT Smith (1999), Cram (1993) and Hudson (2004). As well as mitigating risk, the framework aims to provide the means to assess whether research can enhance relationships, and address the concepts of justice and reciprocity to produce tangible outcomes and equitable benefit sharing of the outcomes of research.

The framework (see Figure 4) incorporates the elements of whakapapa, mana, tika (correct) and manaakitanga (hospitality). As a progressive framework, it outlines minimum, good and best practice standards.

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[16] Mana refers to power and authority bestowed, gained or inherited (Hudson et al., 2010, p. 13).

Figure 4: **Te Ara Tika Ethical Framework**
From *Te Ara Tika guidelines for Māori, research ethics: A framework for researchers and ethics committee members* (p.4), by M. Hudson, M. Milne, P. Reynolds, K. Russell & B. Smith. (2010). Wellington, New Zealand: Health Research Council. Reprinted with permission.

In the following subsections, I address the components of this emerging framework as they relate to my research.

Whakapapa - He aha te whakapapa o tēnei kaupapa?[17]

The whakapapa element of *Te Ara Tika* framework addresses issues surrounding the initial and ongoing consultation and engagement with Māori, and Māori control over processes. As introduced earlier I have been engaged in anti-racism Tiriti work for many years and most recently, my professional work has focused on Māori public health. I have been involved in various collaborative projects with Māori colleagues including developing joint submissions, strategic planning and service development. Over time, I have built trusting relationships with some Māori individuals and groups.

My research topic emerged directly out of dialogue with Māori working in the health sector and as an action area within both the Te Tai Tokerau Public Health and Māori Health plans. My former employer (Te Tai Tokerau MAPO Trust) supported this study and local Māori health leadership chose to tautoko (support) the research through active participation within my research whānau. This rōpū has acted as kaitiaki for the project, signed off the initial proposal and has made a significant ongoing contribution into the research process via regular face-to-face

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[17] He aha te whakapapa o tēnei kaupapa refers to what are the origins of this research?

meetings. Their input assisted defining the structure, direction and detail of the study.

My relationships with Māori counter storytellers pre-dated this study and I expect it will be ongoing. I have accommodated the preferences of counter storytellers in terms of a level of disclosure of both their identity and the inclusion and exclusion of particular incidents and experiences they shared. Informed consent was obtained with all research participants and findings shared. The dissemination strategy for the study was developed with my research whānau and it prioritises distributing the findings with Māori stakeholders. The intent of this applied study has consistently been that the findings be utilised to transform racism within the health sector. That is, to remove barriers to the success of Māori providers and thereby contribute to improving health outcomes for whānau.

Tika – Me pehea e tika ai tēnei kaupapa?[18]

The tika element of *Te Ara Tika* framework addresses issues surrounding research design. In particular, it assesses Māori participation, use of Māori research paradigms and relevant sampling and recruitment processes. This study emerged out of dialogue with Māori, a pair of regional strategic health plans, an indigenous research agenda and the endorsement and ongoing tautoko of local Māori health leadership.

Māori have been involved throughout this research journey from conception, development, implementation and dissemination. As a doctoral student, this study has been a steep learning curve and I have not positioned myself as a research authority. Rather I have engaged with my research whānau as a co-enquirer, retaining the responsibility for the graft of the study. I understand there has been mutual learning about both doing activist scholarship and the dynamics of institutional racism. Opportunities to share findings and discuss research methodology and method with interested Māori stakeholders have been taken and I have remained engaged in local Māori health development as my capacity permitted.

Kaupapa Māori theory was a key methodological influence on this study. My engagement with kaupapa Māori led me to elevate indigenous voices through the study and incorporate critical structural analysis of state behaviour. Within the study I attempted to actively manage my Pākehā ethnocentrism and affirm Māori experience as ordinary within this study for instance through my use of Te Reo. My research whānau provided useful ongoing political and cultural advice to ensure the work remained relevant.

At this point, it is unclear what outcomes will result from this study and therefore the potential impact on Māori. This study may support the conscientisation around issues of institutional racism and lead to more effective activism. It may lead to

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[18] Me pehea e tika ai tēnei kaupapa refers to how will the project proceed correctly?

positive changes in Crown practice in relation to policy-making, funding practices that improve the operating environment for Māori providers. It may lead to further investigation of racism within the health sector and other related sectors that transform institutional racism.

Manaakitanga – Mā wai e manaaki tēnei kaupapa?[19]

The manaakitanga element of *Te Ara Tika* framework addresses issues surrounding appropriate cultural behaviour, social responsibility and spiritual integrity. It assesses whether the mana of both parties are upheld through the research process.

I recognise that for me this study is both an academic and a spiritual journey about putting things right. This study has an activist orientation, and my intention is to identify the detail of how Māori are systematically disadvantaged within the administration of the public health sector. I respect the challenging role Crown officials fulfil within the health sector and acknowledge the web of personal and professional relationships I have with those officials.

Standard research practices of informed consent have preserved the confidentiality of research participants who have chosen not to be identified. Many within this study have however chosen to be identified alongside their counter narratives, to both demonstrate their tautoko of the kaupapa and to be transparent and specific in their challenge to Crown agencies. All counter storytellers were given the opportunity to review their contributions in light of the final draft to ensure they were comfortable with the representation.

As a Pākehā Tiriti worker, I have deliberately examined over time my own cultural assumptions and idiosyncrasies to establish a base of cultural competency that I continue to strengthen. Alongside this self-development work I have considerable experience working with Māori in assorted contexts and I have developed some proficiency in Te Reo me ōna tikanga. Within this study, this knowledge base was enhanced by cultural and political advice, and guidance from my research whānau and others.

Whakawhanaungatanga[20] was practised throughout the research process with counter storytellers, my research whānau and with many participating public health providers. It was not practiced however in the extraction of funding data from public health funders through official information channels. Manaakitanga was practiced through the sharing of food and use of karakia (prayer) with my research whānau and some counter storytellers. Care was taken to take breaks during storytelling to process emotionally charged content and work within agreed timeframes.

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[19] Mā wai e manaaki tēnei kaupapa refers to who will ensure respect is maintained?
[20] Whakawhanaungatanga refers to the active process of relationship building and getting to know one another.

Mana – Kei a wai te mana mō tēnei kaupapa?[21]

The mana element of *Te Ara Tika* framework addresses elements of equity and distributive justice. Specifically it focuses on issues surrounding ownership of data, collective consent and reciprocity with tangata whenua and more particularly mana whenua (local people).

This study is the product of the combined efforts of my research whānau, my academic supervisors, a community of supporters and me. As an activist scholarship project, there is an implicit responsibility amongst my research whānau and myself to present, publish and otherwise utilise these findings. As a doctoral student, I have assumed the bulk of this responsibility and will continue to co-present and publish with members of my research whānau and counter storytellers as opportunities present. Likewise, there will be occasions, particularly within Māori settings, where Māori members of my research whānau or counter storytellers may represent this study. The detail of my dissemination strategy is outlined in Appendix D.

This study emerged out of dialogue with Māori and will be returned to that same community. As a Pākehā practitioner, I was welcomed into the Māori health community and was granted privileged access. Through this access, I gained much, in terms of deeper understanding of Māori public health and the wider operating environment within which Māori providers engage. This exposure made me a more versatile and resourceful public health practitioner and academic. The process of collecting Māori stories, witnessing and analysing Crown behaviour and synthesising this information into a useable evidence base is my koha (gift) to the Māori health community.

Collective consent was obtained for this study through the agreement of senior Māori decision-makers to be part of the research whānau. The Māori providers they represent have governance structures that variously represent local whānau, hapū and iwi across Ngāpuhi nui tonu. Other interested local Māori providers not formally represented within my research whānau were kept up to date with key developments in the research.

It is important to acknowledge that given the exposure of systemic discrimination as practiced by Crown agencies against Māori providers in this study, those that participated whether as research whānau members or as counter storytellers, were both gallant and brave. Such informed contributions and participation were not without professional and personal risk within the constraints of the current operating environment.

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[21] Kei a wai te mana mō tēnei kaupapa refers to who has control over the study?

In recognition of Royal's (1998) distinction between mātauranga Māori and kaupapa Māori, as a Pākehā researcher, I have chosen not to work with the former.

2.4 Summary

My activist scholarship standpoint has emerged from my background and experiences with feminism, Pākehā Tiriti work, kaupapa Māori theory and critical race theory. Common across these traditions are scepticism of the dominant hegemony, recognition of the partiality of knowledge and a desire to rebalance inequitable power differentials. Each tradition has also contributed unique insights into the challenge of how to conduct transformative research, as detailed within this chapter.

The basis of my method was juxtaposing master and counter narratives in relation to Crown policy making and funding practices utilising qualitative analysis. As my preliminary findings emerged, I incorporated additional quantitative elements to my approach. I maintain this blending of both qualitative and quantitative traditions, under the mantel of activist scholarship, strengthened the evidence base from which my research questions were assessed.

Crucial to my method was a dual accountability mechanism both to my research whānau, made up predominately of Māori health leadership and to Pākehā Tiriti workers active in the struggle to support Māori achieve tino rangatiratanga. These arrangements contributed to the political relevance and cultural safety of my practice, while technical academic input was maintained through my university based academic supervisors.

The sensitivities aroused when naming institutional racism and the strong collaborative and cross-cultural elements of this research, led me to engage with a variety of ethical frameworks - principally the *Te Ara Tika* framework (Hudson et al., 2010). This framework, which includes the ethical elements of whakapapa, mana, tika and manaakitanga, would be of benefit I believe for many Tauiwi researchers writing in the context of Aotearoa.

The following chapter serves as an historical backbone to this thesis; it examines historical patterns of institutional racism. This analysis serves as a precursor to theorising racism and privilege within the context of the contemporary administration of the public service.

CHAPTER THREE: HISTORICAL PATTERNS OF INSTITUTIONAL RACISM WITHIN CROWN POLICY

3.0 Introduction

> ...walking into the future facing the past (Kawharu, 2001, p. 7).

Contemporary policy and funding practices in Aotearoa have been influenced by both a hundred and seventy years of engagement between Māori and Pākehā, since the signing of *Te Tiriti o Waitangi*, and perennial debate about the implications and relevance of it. Indigenous advocate, M. Jackson (2000, pp. 6-7) contends that indigenous perceptions of government institutions, policies and practices are shaped by historical and contemporary experiences. He maintains that it: "...is an unwise person who attempts to discount the continuity between past and present and in the Māori context it would be culturally impossible and intellectually incomprehensible to do so".

Within this chapter, I examine the processes of colonisation, assimilation and the rhetoric of biculturalism and neoliberalism, as significant markers in public policy affecting Māori since 1840. These themes are also briefly discussed in the context of Australia and Canada as two examples of other English settler dominions; however, I retain a primary focus on their application in Aotearoa.

Terminology

There is much debate about the meaning, shape, significance and influence of a number of the social institutions that are pivotal to my research. In this section I explain my usage of the terms *Te Tiriti o Waitangi*, *Treaty of Waitangi*, the Crown, the colonial or settler government, Crown officials and the state.

Unless otherwise specified the use of *Te Tiriti o Waitangi* or Te Tiriti refers to the Māori text of the Treaty of Waitangi, as developed by Henry Williams in Te Reo. Within the Māori text, Māori tino rangatiratanga was reconfirmed, kāwanatanga was transferred, and British promises of ōritetanga were accepted. Capitalisation distinguishes generic use of the term 'treaty' from references to the English language version of the *Treaty of Waitangi* as developed by William Hobson. Within the English text, which only a handful of rangatira signed, Māori ceded sovereignty.

"The Crown" in the first instance refers to the Queen and/or King of England as the co-signatory of *Te Tiriti o Waitangi*. In the context of the nineteenth century, this term also includes assorted military governors who acted upon royal direction and were delegated to fulfil kāwanatanga responsibilities. In 1907, England granted New Zealand dominion status introducing a Governor General to be Head of State on behalf of the Queen. To mark this distinct period I refer to the governance arrangements between 1840 until 1907 as either "the 'colonial' or 'settler' government".

After 1907, a unicameral version of the Westminster system of parliamentary democracy was adopted. In accordance with the separation of powers doctrine, Ministers of the Executive branch (cabinet) determine government policy and gain their legitimacy from the broader legislature (parliament), which in turn is accountable to a separate and third power, the judiciary. In the interests of clarity where possible within the text, I refer to the actions of specific governments, for instance the Labour-led or National-led coalition governments. The majority coalition at any given time assumes responsibility to run the country and select from within their grouping, Crown Ministers to lead discrete areas of political and economic activity.

Those that work in the public service in principle work for Ministers of the Crown to enact their decisions and policy directives. In practice, Crown officials of long standing carry much institutional memory and knowledge; a newly branded Minister may need to rely on. Assorted legislation and codes of conduct define the parameters of both group's professional conduct and the scope of their responsibilities (see chapter five). The public service, inclusive of both DHB and Ministry of Health employees, are considered Crown officials.

"The state" is a construct of the eighteenth century, with the overthrow of a substantive number of kingdoms and duchies in favour of a more inclusive non-hereditary governance system. Widely used as a term within Marxist analysis, I use the term 'the state' as a generic international term to refer to the collective of elected politicians, Crown officials, judiciary and military who run a country on behalf of its citizens.

In introducing these terms, I acknowledge the complexity of competing and conflicting individual views and competencies of those within kāwanatanga roles across Crown agencies, most notably Māori subaltern. However, I remain interested in their collective accountability and responsibilities in this study.

3.1 Colonisation as Global Practice

> The white man was hungry and greedy for land, and the black man shared the land with him as they shared the air and water; land was not for man to possess. But the white man took the land as you might seize another man's horse
>
> (Mandela, 1994, p. 27).

M. Jackson (1995, April, p. 2) defines colonisation as a political and economic process by which one nation assumes it has the right to takeover another nation. The term itself was coined in the fifteenth century in the time of the "great explorers", to describe the tradition of monarchs expanding their territories and then establishing trading posts and/or missions (Ferro, 1997, p. 1). European colonisation fanned out from Europe to cover Africa, the Americas and the Pacific until independence of assorted kinds was granted in the twentieth century. The British Empire, made up of dominions, colonies, protectorates, mandates and territories, covered a quarter of the world's population and made England a colonial superpower for over a century.

Colonial processes are characterised by nations actively extending their territories to feed expansionist capitalist economies, to expand markets, extract raw materials, off-load excess population and in the pursuit of glory for "the empire". Embedded within this are the standard processes of colonisation whereby the colonisers impose the mechanisms of western or eastern civilisation through attempting to take control of indigenous spirituality, land, law, language, education, health, family structures and finally culture. Fanon (1961/2004, p. 32) contends the white people's Christian church is a key element of colonisation; he explains the church "…does not call the native to God's ways but to the ways of the white man, of the master, of the oppressor". Colonisation is inherently racist.

According to activist scholar Steven (1990), methods of colonisation are tailored locally, depending on both the response of the indigenous peoples and/or the specific economic and social circumstances within the colonising country. Colonisation can be achieved through military invasion, mass immigration, the use of imperial devices such as treaties and proclamations of discovery or annexation. English colonising techniques were eclectic. In Canada, a mixed approach was taken including treaties with indigenous groupings and a royal proclamation reinforced by use of military force. In Australia, the English used the legal doctrine of terra nullius[22] (territory belonging to no one), as their justification for taking possession of land, they considered unoccupied (L. Jackson & Ward, 1999).

The structural impact of colonisation has been devastating for many of the 370 million indigenous peoples on the planet. Gracey and King (2009, p. 66) in their substantive review of indigenous health for *The Lancet* argue that the:

> …fabric of traditional societies was shredded by colonisation. Traditional life was suppressed by alien regulations imposed on people who had lived, sometimes for many thousands of years, with well-established, languages, dress, religions, sacred ceremonies, rituals, healers and remedies. This

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[22] This was overturned within Australian law through the High Court's Mabo decision in 1993 (Augoustinos, Tuffin, & Rapley, 1999, p. 355).

legalised disruption was worsened by socioeconomic and political marginalisation, and by racial prejudice, which was often entrenched and institutionalised. This process was hastened by the often-brutal dispossession of traditional lands, and subsequent poverty, undereducation, unemployment, exploitation by unscrupulous employers and landlords, and increasingly dependence on social welfare...

The processes of colonisation directly and indirectly led to the significant decline of indigenous people through diverse sources of introduced mortality and morbidity, such as heightened levels of warfare, disease, land confiscation, destruction of economic base, legislative injustice and systemic discrimination. Robson (2007) contends that the adverse physical, social, emotional and mental health impacts of colonisation are a dominant determining factor in the health of both indigenous and non-indigenous people and is recognised as such in literature on health and inequities.

Colonisation is described as a process that happened in the past and one that continues to shape contemporary realities of millions of people across the planet (Kirkwood, Liu, & Weatherall, 2005). The colonial portrayal of the native as 'inferior', 'primitive' or 'barbaric' in contrast to the 'civilised' coloniser, fuelled through Darwinist beliefs[23] in racial hierarchies, has provided a potent enduring ideological justification for what Ramsden (2002, p. 28) calls the "juggernaut of colonisation". The past cannot be changed, but the challenge before indigenous and non-indigenous peoples alike is how this juggernaut can be successfully redirected and how can what Fanon (1961/2004, p. 27) calls decolonising processes, be activated to reform destructive colonial power relations.

Colonisation of Aotearoa

Māori are the indigenous people of Aotearoa and have lived here for a millennium. Māori society was traditionally organised in kinship groups formed by people who identified with a common ancestor. The world was divided up into physical and spiritual realms and social norms were influenced by the relationship between tapu (that which was made risky) and noa (that which was made safe/normal) (Durie, 1994b). For much of this time there was an abundance of food from cultivation, fishing and hunting which was traded amongst different hapū (sub-tribes) for scarcer goods (Walker, 1990). According to Durie (1994b, p. 8) Māori had, well-developed education, justice and health systems, which had been handed down for many generations, centred on a communal extended whānau lifestyle.

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[23] Within a New Zealand context this was further fuelled by Darwin's visit to New Zealand in 1835. Lange (1999, p. 57) outlines Darwin's observations: "there appears to be some… mysterious agency generally at work. Wherever the European has trod, death seems to pursue the aboriginal… The varieties of man seem to act upon each other; in the same way as different species of animals – the stronger extirpating the weaker".

Early contact between Māori and Pākehā from the early nineteenth century onwards occurred predominately in coastal regions of Aotearoa through whalers, sealers and eventually missionaries. Māori embraced the opportunities of trade and industry opened up by the new arrivals and some travelled extensively to learn more about these strange white people who were arriving on their shores (Kelsey, 1984). Initially Māori and Pākehā worked together well, but over time relationships deteriorated as some Pākehā exploited the full freedom of being beyond the reach of their respective governments. The lawlessness, alcohol abuse and prostitution, according to Tiriti educators, Consedine and Consedine (2001) quickly began to impact negatively on Māori. This set the scene for a willingness to come to some arrangement with the presumed authorities of those causing havoc. This situation drew Aotearoa into a process that might have played out differently, had for example, Māori chosen merely to banish or destroy these new comers to their lands. England took the opportunity to colonise and thus to control not only its own emigrants, but also all who now lived on this land.

In the following sub-section, I examine colonisation as practiced in Aotearoa more closely through examining: the signing of *Te Tiriti o Waitangi* 1840 and its precursor *He Whakaputanga o Te Rangatiratanga o Nu Tireni* 1835 (Declaration of Independence), the marginalisation of rangatiratanga through the establishment of Pākehā hegemony, and the settler governments' collusion with land alienation. I also consider the role Pākehā attitudes and privilege contribute to colonisation and the physical and cultural impact of these processes.

He Whakaputanga o Te Rangatiratanga o Nu Tireni and Te Tiriti o Waitangi

In 1835 Northern, rangatira came together under the banner of the United Tribes of Aotearoa to discuss the new arrivals problematic behaviour and other international developments. Together they developed *He Whakaputanga,* which declared Aotearoa a sovereign nation to the international community in part inspired by the American Declaration of Independence. Durie (1998, p. 247) argues this Declaration marked a break from traditionally exclusive tribal orientation in Aotearoa with the introduction of a "confederated approach to governance". This strategy allowed Māori to present a united front in dealing with the new predominately Anglo-Celtic arrivals. It also resulted in Māori being recognised by the English colonial office as a political entity so Māori could later enter into treaty negotiations as a sovereign partner (Wickliffe & Dickson, 2000).

The new arrivals wayward behaviour persisted and they entered into a variety of what later came to be considered questionable land deals with Māori. In 1840, in an attempt to restore some order in the land, Māori signed *Te Tiriti o Waitangi* with a representative of the English Crown. Both Lord Normanby's[24] instructions to Governor Hobson, the English lead negotiator, and the preamble to Te Tiriti

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[24] Lord Normanby was the Secretary of State for the Colonies for the British in 1840.

according to Māori health advocates, E. Pōmare, et al. (1995, p. 27) show that, at least in part, the motivation of the English to develop a treaty was due to concerns about Māori health and wellbeing. At the time of this peacetime negotiation, Māori controlled the bulk of land and outnumbered Pākehā thirty to one (Pool & Kukutai, n.d.).

Two versions of this treaty were developed, one in Te Reo and an English language version, the later securing only a handful of signatures.[25] An international interpretative rule in the form of contra proferentem indicates that in cases of ambiguity, a treaty is to be interpreted against the party drafting it (Te Puni Kōkiri, 2002, p. 19). In this case, Te Tiriti recognised Māori tino rangatiratanga, granted the English kāwanatanga, and promised Māori ōritetanga with English subjects. When signing *Te Tiriti o Waitangi* in Kaitaia the kōrero of rangatira, Panakareo reflected the understanding of many Māori that, "the shadow of the land goes to the Queen but the substance remains with us" (as cited in Walker, 1990, p. 98).

Assumption of Pākehā Sovereignty

It took only months for the promises of Te Tiriti to be broken. In November 1840 a Royal Charter was issued that enabled Governor Hobson to both survey the entirety of Aotearoa and declare all 'waste' and uncleared lands to be Crown land (Walker, 1990, p. 99). This immediately led to the alienation of significant tracts of Māori land. The resulting disputes between Māori, Crown agents and settlers around land and sovereignty led to a series of armed conflicts - the Land Wars of 1845-1872. Historian Belich (1986, p. 15) argues Governor Grey's extensive use of military force was critical to his assertion of sovereignty on behalf of the English, with 18,000 colonial troops involved at the height of the conflicts, controlling approximately 60,000 indigenous peoples. Crown violence was considered a legitimate means to quell resistance.

New Zealand became a self-governing colony with its own legislature through, the English statute, the New Zealand Constitution Act 1852. This legislation disenfranchised most Māori from participating in government through an individual property qualification that did not recognise communally owned land.[26] It was also one of the primary breaches of Te Tiriti due to its contested interpretation that Māori had ceded sovereignty, thus clearing the way to create New Zealand's irregular constitutional arrangements. Former Attorney General, Wilson (1995) maintains that by the early 1860s the settler government has assumed control of Māori affairs primarily to facilitate settler access to Māori land.

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[25] Some major chiefs Te Wherowhero of Waikato and Te Heuheu of Tūwharetoa refused to sign resulting in the most populous Māori districts in the centre of the North Island being effectively outside Te Tiriti. Other chiefs signed twice in return for blankets and tobacco, while still others took their blankets back and asked for the return of their signatures.

[26] This legislation was drafted with input from both Governor Grey and New Zealand Company leader Wakefield.

With the Maori Representation Act 1867, Māori were further marginalised through the introduction of a democratic representation system where Māori as a numerical minority were structurally outnumbered. The only concessions to Māori as treaty partners within this legislation were the inclusion of both a Māori roll and the establishment of four designated Māori seats, in a parliament of seventy. Spoonley (1993, p. 75) contends that for over one hundred years there has not been equivalence between Māori and non-Māori voting[27]:

> …as the number of general seats has been steadily increased according to a formula that ties population change to the number of electorates. The Māori seats are not subject to the same formula.

In 1867 if, parity had been applied, for instance sixteen Māori seats would have resulted, and potentially a modified colonial political environment.

No such moderation occurred as Pākehā political, economic, ideological hegemony was systematically established by force, by parliament, by democracy and the every-day workings of kāwanatanga as practiced by the settler government. The Ministerial Advisory Committee to the Department of Social Welfare (DSW) (1988, pp. 59-60) asserted that during successive colonial governments':

> …chosen administrators supplant[ed] traditional [Māori] leaders; the state's agents impose[d] new structure; legal-judicial processes replace[d] the traditional tribal law; and most significantly, permanent government forces enforce[d] the new rules... In one sweep, they [Māori] were stripped of autonomous government, their legal basis of communal solidarity, their social and spiritual being.

By the 1870s following the mass Anglo-Celtic migrations of the 1860s from the United Kingdom to Aotearoa and the introduction of profit-driven capitalist economy, Pākehā hegemony was effectively entrenched. This allowed Chief Justice Prendergast in the precedent setting case Wi Parata v The Bishop of Wellington (1877) to dismiss the *Treaty of Waitangi* as "a simple nullity" with no legal status. In the 1882 sitting of parliament, Hon. Robert Trimble, a Taranaki Member of Parliament was reported to have indicated that he "...wished to relegate the *Treaty of Waitangi* to the wastepaper basket" (as cited in Rusden, 1883, p. 458). This judicial denial of rangatiratanga and parliamentary

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[27] The number of Māori seats increased from four to seven in 2006 despite significant increases in Māori population and enrolments on the Māori roll over the decades prior to this.

marginalisation circumvented Māori efforts to secure legal redress for historic and contemporary treaty breaches for decades.[28]

Settler Government Collusion with Land Alienation

> Because the [Māori] land could not be 'owned' in a common-law sense by an individual, the authority of rangatiratanga was applied to ensure a balance between the just and communal needs and interests of the iwi and the sustainable protection of Papatūānuku [earth mother] herself. The result was a system of food production and distribution which was just – he waka eke noa – a waka [canoe] in which all can share and to which all must give protection
>
> (M. Jackson, 1993, p. 72).

The new settlers' quest for land, by fair and foul method,[29] dominated the thirty years after the signing of Te Tiriti and was a significant contributor to the Land Wars (Belich, 1986). For many settlers, land was a practical necessity for survival, to shelter one's family and to plant crops and/or graze animals, to earn a living and feed one's family. Land was also seen as an economic asset, a marker of status and a pathway to independence. It belonged primarily to individual men.

Whenua according to Rickard (1977, p. 5) in the first instance is land. Nevertheless for many Māori, she maintains whenua is also:

> ...the placenta within the mother that feeds the child before birth. And when it is born this whenua is treated with respect, dignity, and taken to a place in the earth and dedicated to Papatūānuku… And there it will nurture the child. You know our food and living come from the earth, and there is the whenua of the child [that] stays and says, "This is your bit of land. No matter where you wander in the world I will be here and at the end of your days you can come back and this is your papakāinga (home) and this – I will receive you in death" (p. 5).

Within this paradigm, the notion of "selling" land and individual "ownership" of land is nonsensical, as you would be selling your ancestors' bones or the tūrangawaewae (place to stand) of your mokopuna (grandchildren).

By the 1890s, the settlers' zealous pursuit of land, fuelled by the New Zealand Company[30], had resulted in the alienation of more than half of all Māori land holdings. A powerful agent in this alienation was the Native Land Court

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[28] Prior to this, the settler government had already unilaterally redefined Te Tiriti by waiving Crown pre-emption rights to enable direct purchasing of Māori land by third parties, specifically the New Zealand Company.

[29] At times the land was brought from anyone who would accept payment regardless of their title, and was paid for with blankets, tobacco, a few guns, and a pile of bits and pieces (Scott, 1981).

[30] The New Zealand Company was established in 1837 with the aim of the systematic colonisation of New Zealand. It established settlements in Wellington, Nelson, Whanganui, New Plymouth and Christchurch.

established in 1867, which functioned to transform tribal land from communal to individual title. Māori historian, Walker (1993, p. 120) explains:

> Those named on the title to a block of tribal land were regarded as trustees by their people, but were treated as owners by the law, with the power to alienate. They were readily seduced or suborned into conveying the title to land sharks and shyster lawyers by a corrupt process of advancing credit, fostering debts and threatening legal action for non-payment. The net result was wholesale dispossession of a people of their patrimony.

Not unexpectedly, Māori engaged in active and passive resistance to this alienation as collective tribal lands had long been something worth fighting for (Scott, 1981). Having exhausted other avenues the Land Wars were the setting where Māori, settlers and the Crown attempted to resolve competing interests. Central to this conflict were the settlers' colonial beliefs of Pākehā cultural superiority and a sense of entitlement to both resources and land. In the wake of the land wars, assorted colonial governments indiscriminately confiscated land as penalty for Māori assertions of rangatiratanga and assumed responsibility to administer Māori land through perpetual leases at peppercorn rentals to Pākehā settlers, which further marginalised Māori owners (Walker, 1990, p. 138).

Throughout the Land Wars, legislation was consistently used to advance the aspirations of settlers and disadvantage Māori. Through a detailed review of New Zealand legislation M. Jackson (1993, p. 77) identified over a hundred pieces of legislation and regulation directed at removing land from Māori through the period between 1840 and 1990 inclusive of the Land Wars. Examples included Māori resistance to land alienation in Taranaki[31] led to the Suppression of Rebellion Act 1863, which meant if Māori fought to retain land Māori were deemed to be in rebellion against the Crown and land could be seized. The Maori Prisoners Detention Act 1880 enabled Māori political prisoners to be imprisoned without trials.

The loss of life, land confiscations and resulting destruction of Māori economic base and legislative interventions by the settler government through this time remains a low point in New Zealand history. This traumatic period continues to be unravelled over a hundred years later through the Waitangi Tribunal reconciliation processes.

Pākehā Settler Attitudes and Privilege

> They conveniently forget that their prosperity, and indeed the wealth of the country as a whole (wealth from which Māori, on the whole have been excluded)

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[31] The Sim Commission in 1927 found the Māori were never in rebellion; rather they had been forced into the position of taking up arms to protect the property guaranteed them by the Te Tiriti (Waitangi Tribunal, 1996).

> has been built on the backs of Māori – created out of stolen land and resources and cemented through the exploitation of Māori labour (Mikaere, 2001, p. 137).

For colonisation to be successful in the context of Aotearoa, it required the active participation of Pākehā settlers. Early colonial attitudes as documented in the *Southern Cross*[32] *("The Aboriginals," 1844, July 6, p. 2)* reflect a confident white supremacist belief system prevalent amongst many settlers at this time:

> The native race is physically, organically, intellectually and morally, far inferior to the European. No cultivation, no education will create in the mind of the present native race that refinement of feeling, that delicate sensibility and sympathy, which characterise the educated European… the Maori is an inferior branch of the human family.

Similarly within my own family documents my great grandfather Smith (Personal correspondence, October 1, 1939), who was living in central Auckland in the early 1840s, noted: that for a girl/woman "...to walk as far as Newmarket there was not only the danger of being lost in the scrub, but also parties of marauding Maoris (sic) often constituted a menace to the city's first settlers". Although there was/is no monolithic Pākehā view, historian, Lange argues (1999, p. 60) "unbridled racism" was certainly found amongst nineteenth century settlers which influenced and shaped settler interactions with Māori and enabled colonisation.

The impact of these attitudes was likely to have been compounded by the mass Anglo-Celtic migration which led to settlers outnumbering Māori by 1850 (Denoon, Smith, & Wyndham, 2000). This mass immigration was in part a result of misleading immigration/real estate advertising by the New Zealand Company (Burns & Richardson, 1989). This numerical shift in the balance of power between Māori and Pākehā served to consolidate the Pākehā position.

For both Māori and Pākehā the legacy of the Land Wars continues, particularly for land-owning Pākehā like my own family, with multiple generations benefiting from access to land. The systematic alienation of Māori land both resulted in the "indigenisation of poverty" in this country (M. Jackson, 1993), and provided opportunities for my ancestors and other Pākehā to become farmers, horticulturalists and to make a secure (albeit weather-affected) livelihood. Steven (1990) contends Pākehā through the period 1860-1890 had one of the highest standards of living in the world.[33]

This privileging of settlers inherent in the colonisation process is both structural and, for me, personal. In conducting treaty education in Taranaki with a kuia from

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[32] The *Southern Cross* was an early colonial newspaper.
[33] Pākehā also enjoyed amongst the lowest death rates in the world from the mid-nineteenth to the mid-twentieth centuries. The rigors of the voyage out, shipping costs and disease inspections, and the prospect of heavy labour once here, meant the poorest and least-healthy seldom made the trip.

Parihaka we shared stories of our ancestors with our co-learners, how her ancestors became farm labourers while mine became farm owners. Such is the clear-cut impact of this enduring land grab and the transfer of resources by fair and foul means between indigenous and Pākehā New Zealanders. Awatere (1984, p. 35) powerfully explains the privileging inherent in colonisation:

> All white people share in the benefits of the alienation of Maori land, in the imposition of European cultural values of individualism, materialism, in the imposition of their concepts of spirituality and in the imposition of the English language.

Impact of Colonisation: Genocide and Physical Survival

> Genocide denied, however, remains genocide, no matter how out of the sight and mind of polite society it may be rendered in the denial (Churchill, 1999, p. 228).

The direct and indirect impact of colonisation on Māori meant by 1900 the estimated population stood at 42,000 reduced from 150,000 a century before (Pool & Kukutai, n.d.). Similarly land owned by Māori was reduced from twenty six million to just under three million acres (Durie, 1994b, p. 37). This dramatic population drop can be linked to the unintended introduction of infectious disease such as measles, tuberculosis, influenza and whooping cough and the deliberate introduction of muskets,[34] alcohol, money and tobacco. Figure 5, developed by educationalists, Gledhill, Sinclair, B. Jackson and Webber (1982, p. 34) is a pictorial representation of some of the forces impacting on traditional Māori society as a result of colonisation - including the mixed contribution of missionaries.
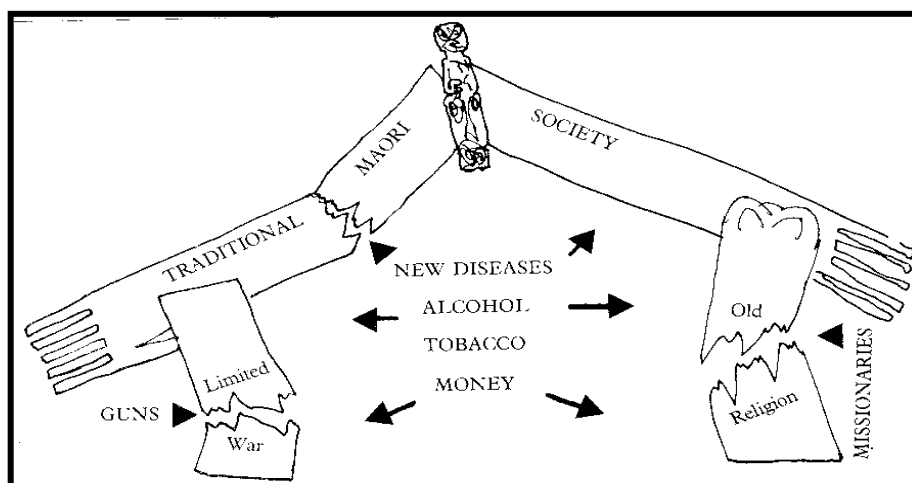
Figure 5: **The Effect of European Ways [Colonisation] on Old Māori Society**
From *Aspects of our past: A selective history of New Zealand, 1840-1980* p.34. D. Gledhill; A. Sinclair; B. Jackson & B. Webber 1982 Auckland, New Zealand: Macmillan. Reprinted with permission.

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[34] Approximately 30,000 people were killed by introduced muskets between 1810 and 1835 (Durie, 1994b, p. 35).

Popular Pākehā discourse of the time held that Māori were facing possible extinction as an ethnic group. A colonial politician, Hon. Isaac Featherston noted in 1856 (as cited in Buck, 1924, p. 363) that "…the Maoris (sic) are dying out, and nothing can save them. Our plain duty as good, compassionate colonists is to smooth down their dying pillow. Then history will have nothing to reproach us with". Hon. Alfred Newman (1882, p. 477) a former Minister of Health predicted, "all things considered the disappearance of the race is scarcely a subject for much regret. They are dying out in a quick, easy way, and are being supplanted by a superior race".[35]

Tiriti scholar, Williams (2001, p. 243), notes that some Māori commentators have described this phase of colonisation as genocide, the systematic and deliberate destruction of Māori. Māori activist, S. Jackson (1993, p. 215) explains:

> …some of the operations approved by the Colonial Office in the nineteenth century involved extermination, as when Von Tempsky[36] and Major McDonnell left Wanganui in December 1866 and marched to New Plymouth, killing every Māori in sight.

Within the Waitangi report on the Taranaki claim (Waitangi Tribunal, 1996, p. 312) the authors describe the experiences of local Māori as "the raupatu (conquest/confiscation) without end…the holocaust of Taranaki history".[37]

Māori resistance and resilience in the face of this colonial onslaught remained resolute, as captured in the following whakatauākī of the time credited to Wiremu Wiremu (as cited in Kawharu, 2008, p. 76).

Te toka tū moana	The rock stands in the sea,
Ka tū ka tū ka tū	Stands, stands, stands.
Ahakoa ī awhatia mai te rangi	Although the weather may be stormy
Whakapākākātiā ī te whitinga o teērā	And the rock may be roasted by the sun,
Te toka tū moana	The rock stands in the sea,
Ka tū ka tū ka tū	Stands, stands, stands

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[35] Other Pākehā commentary at the time from the *New Zealand Herald* in (as cited in Sorrenson, 1956, p. 156) ironically noted: "it is sad to think that those natives who have least to do with Europeans are in every respect the best of their race; but so it is".

[36] To this day street names in Taranaki and elsewhere continue to act as a memorial to Von Tempsky and other colonial and military leaders responsible for such atrocities.

[37] On 5th November 1881 the unfortified and undefended village of Parihaka, the largest and most prosperous Māori village in the country, was invaded and destroyed by 1,500 troops and militia. Te Whiti o Rongomai and his fellow chief, Tohu Kākahi were arrested and held without trial in the South Island for 16 months, while their land was surveyed and sold to settlers. Only after the return of the chiefs from exile were the long-awaited reserves marked out, and they were immediately placed in the hands of the Public Trustee and compulsorily perpetually leased to Pākehā (Scott, 1981). Les Robinson (Personal communication, November 5, 2011) reported he had recently received payment of about $12 for the last 2-3 years of his share of the rent monies from lease-hold land held by Pākehā farmers, which have never been realigned to market rental prices.

3.2 The Quest for Assimilation

> The connection between racism and assimilation is inescapable: in seeking to recreate us in their own image, our colonisers have been practising yet another form of genocide
> (Mikaere, 2001, p. 134).

Colonisation and its associate, assimilation, are an interrelated and overlapping phenomenon. Whereas colonisation is about seizing resources and securing sovereignty, Walker (1990) argues, assimilation is a process of marginalising indigenous cultural practices and ways of life. It is the deliberate policy of absorbing a minority culture into a dominant one, based on a fundamental assumption of the superiority of the dominant group and the irrelevance of minority culture(s) (Department of Economic and Social Affairs, 2009, p. 141). As a global instrument of colonisation Mowbray (2007, p. 10) contends assimilation policies aim "to 'civilise' and incorporate indigenous peoples, to bring them under the control of 'colonial' states.

Ramsden (1994) maintains assimilation slowly and systematically transforms indigenous values and ways of doing things from being "ordinary" to "exotic" within their own countries. This process reflects a significant shift in power-base, enabled through substantive changes in population and implemented through mono-cultural legislation, policy and regulation.

Critical pathways of assimilationist policy are alienation of land, language and indigenous identity. Loss of access to traditional lands has the effect of denying indigenous people material and spiritual sustenance. Loss of traditional languages is soul destroying, as language is an important component of identity and "…is fundamental to understanding values, beliefs, ideology and other intangible aspects of culture" (Department of Economic and Social Affairs, 2009, p. 57). Anthropologist, Brody (2000), contends the destruction of indigenous languages can be considered a form of linguistic genocide.

Globally and locally indigenous peoples have resisted assimilation policies, with various degrees of success with Māori often being at the forefront of this international resistance. Of contemporary international and local significance in relation to discussions on assimilation is the *United Nations Declaration on the Rights of Indigenous People* (United Nations, 2007). Negotiated over a twenty-year period, article eight (2007, p. 5) of the Declaration specifically maintains: "Indigenous peoples and individuals have the right not to be subjected to forced assimilation or destruction of their culture".

As part of the Canadian government's assimilation, platform indigenous peoples were sent to residential native schools. This process had the structural effects of disrupting families, loss of indigenous knowledge, languages and traditions and the systemic devaluing of indigenous identity (M. King, Smith, & Gracey, 2009,

p. 78). While in Canada in 2006, I visited the Micmac reservation in Nova Scotia and read first-person accounts of Micmac people's experiences of native schools, including the practice of children's mouths being taped shut so they could not speak indigenous languages.

The depth of Australia's assimilation legacy was the seventy year Stolen Generation policy of removing children from their Aboriginal and Torres Strait Islander families 'for their own good' to become part of white Australian families. The following first-person account is from the *Bring Them Home* (Lavarch, 1997, p. 4) a national inquiry report into the stolen generation:

> Our life pattern was created by the government policies and are forever with me, as though an invisible anchor around my neck. The moments that should be shared and rejoiced by a family unit, for [my brother], mum, and I are forever lost. The stolen years that are worth more than any treasure are irrecoverable.

Assimilation in Aotearoa

On 6th February 1840, Governor Hobson first proclaimed the famous words "He iwi kotahi tātou"[38] to Māori rangatira as they signed Te Tiriti, which is often translated to mean 'we are one people' (L. Cox, 1993, p. 75). Variations of this assimilationist catch-call have permeated race relations in this country ever since, whether it is the 'amalgamation' policies of Governor Grey through to the 'integration' policies outlined in the Hunn Report. This dominant race relations discourse continues to "…position Māori as marginalised 'other', with Pākehā culture and authority the naturalised and unacknowledged centre" (Huygens, 2006, p. 367).

The settler governments' transparent assimilation intent was revealed in the preamble to the 1844 Native Trust Act (p.140):

> Her Majesty's Government has recognised the duty of endeavouring by all practicable means to avert the like disasters from the native people of these islands [New Zealand] which object may be best obtained by assimilating as speedily as possible the habits and usages of the Native to those of the European population.

Fleras and Spoonley (1999, p. 114) argue that few Pākehā disputed the inevitability or desirability of assimilation as a policy. Rather it was "only a question related to the magnitude or pace of absorption, whether rapid or gradual, piecemeal or wholesale, were left open for debate".

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[38] Reid (2002b, p. 60) reports that actually Hobson's first said the words "He iwi tahi [sic] tātou" to Heke who corrected his grammar.

Successful implementation of assimilation was always dependent on the breakdown of Māori communal ways of life. Land reform and the introduction of capitalism were key mechanisms to disrupting collective ownership. M. Jackson (1993, p. 72) maintains much colonial policy required land to be removed from indigenous peoples and then its use restructured from resource distribution based on communal need, to that of individual profit.

The primacy of English language and the normalisation of Pākehā values and beliefs through the colonial education system was another critical pathway to advance assimilationist policies. Health policy was also influenced by assimilationist agendas. The Hunn report (1961) outlines the outcome of these assimilation policies over times, which were substantive socio-economic inequities between Māori and Pākehā (see discussion later in this chapter).

Māori responses to the assimilation policies of the Crown were diverse. Tainui and Ngāti Tūwharetoa with mixed support from other iwi established a Kīngitanga movement in an attempt to hold the Crown to account regarding their treaty promises and to reduce alienation of land (R. Hill, 2004). Also centred within the North Island were assorted kotahitanga movements to bring together multiple iwi for a common purpose of establishing parallel parliamentary systems and protecting Māori collective interests. In contrast, the Young Māori Party originating from Te Aute College in the Hawkes Bay embraced western education and assimilation policies, believing it was the only way Māori would survive. Hon. Apirana Ngata (as cited in R. Hill, 2004, p. 44) advocated this position:

E tipu e rea, mo nga rā o tōu ao,	Grow up o tender youth, in the time of your generation,
Tō ringa ki ngā rākau ā te Pākehā	Your hand reaching for the Pākehā tools
Hei arā mō te tinana.	For your physical well-being.
Tō ngākau ki ngā taonga ā o tipuna Māori	Your heart dedicated to the treasures of your ancestors
Hei tikitiki mo te māhuna.	As a plume upon your head.

Suppression of Te Reo me ōna Tikanga
Te Reo is a unique taonga of Aotearoa and is a crucial origin and medium of Māori thinking and knowledge (S. Jackson, 1993). The worldview and cosmology embedded within language makes it an essential means to transfer cultural knowledge. Understanding the importance of language, many of the early settlers to Aotearoa were bilingual as were many Māori by the turn of the nineteenth century. For instance, my great great grandfather Bradbury became bilingual, after being shipwrecked in the 1840s, thus enabling him to become a successful trader with Māori (Borrows, 1969, p. 134). Missionaries translated the bible into Māori to facilitate their efforts to convert Māori to Christianity. Church authorities and later the colonial government's proceedings were recorded in both Te Reo and English (Waitangi Tribunal, 1986).

With the passing of the Native Education Act 1847, this de facto bilingual position changed, with English established as the only official language and as the medium of instruction in schools combined with the prohibition of tikanga (Pihama, 2001). Biggs (1968) asserts that access to public funds for education became conditional on compliance with this policy. Oral testimony during the Te Reo Māori Waitangi claim (Waitangi Tribunal, 1986) asserted there was widespread use of corporal punishment for speaking Māori in the classroom and in the school playground. Rangatira Henare during the hearings (1986, p. 16) recalled advice from a school inspector, "English is the bread-and-butter language, and if you want to earn your bread and butter you must speak English".

Pihama (2001, p. 48) describes the mono-cultural colonial education system's efforts to suppress Te Reo me ōna tikanga as a campaign "...to remove Māori thinking from the face of the earth". McGregor (2001, p. 1) cites Pope, the Organising Inspector for Native schools, as saying that the native schools mission was "...to bring an untutored but intelligent and high spirited people into line with our [white] civilisation". Until the 1930s, many schools were designed to equip Māori men for menial agricultural work and Māori women for domesticity (Pihama, 2001, p. 223). This had the effect of excluding Māori from positions of power and status within Crown institutions upon completion of their education.

The destructiveness of this approach in relation to language can be tracked in the rate of Māori schoolchildren able to speak Te Reo. According to evidence provided to Briggs by the Waitangi Tribunal (as cited in 1986, p. 18) within this environment it plummeted from 90% in 1900, down to 55% by 1950 to a low-point of 5% in 1975. A change in policy direction did not occur until 1970, when the then Minister of Education, Hon. Brian Talboys, instructed teachers to use correct pronunciation of Māori words and phrases in primary schools and Māori language became an option at other school levels (Williams, 2001, p. 142).

The subsequent Te Reo Waitangi claim confirmed the Crown had breached *Te Tiriti o Waitangi/Treaty of Waitangi* concerning its obligations to protect Te Reo as a taonga. The establishment of both Te Taurawhiri i Te Reo Māori and reinstatement of Te Reo as an official language have complimented a Māori-led revitalisation of Te Reo through the Kōhanga Reo (language nest) and Kura Kaupapa (Māori language school) movements. The significance of Te Reo is outlined in the whakataukī shared by a witness during those hearings (1986, p. 13):

> Ka ngaro Te Reo, ka ngaro tauā, pērā i te ngaro o te Moa
>
> If the language be lost, man will be lost, as dead as the moa.

According to the latest Māori language survey, efforts to revitalise Te Reo still need to be strengthened and expanded in order to avoid language decline (Te Puni Kōkiri, 2010).

Provision of Healthcare

In parallel to education policy, the thrust of colonial health policy was also to "civilise Māori". Crown provision of healthcare up until the twentieth century was predominately conceptualised and delivered from a colonial bio-medical worldview, with a frequent dismissal of traditional Māori expertise and knowledge. Pope's (1884) widely utilised tract *Health for Māori: A Manual for Native Schools* (as cited in Williams, 2001, p. 188) reflected the official discourse of the time:

> Maori were unhealthy, he [Pope] stated, because of poor diet, badly ventilated whare [house], overcrowding, belief in witchcraft, poor hygiene and sanitation, inadequate clothing, too much liquor and poor water supplies.

For the first quarter of the twentieth century, western educated Māori leaders such as Hon. Maui Pōmare, Hon. Apirana Ngata, Hon. Te Rangi Hīroa and Hon. James Carroll were at the forefront of substantive health reform programmes. Able to operate equally and ably in both Māori and Pākehā dominated environments these leaders from the influential Young Māori Party undertook a radical program of reform to address endemic sewage, sanitation, water and housing problems (R. Hill, 2004). In pragmatic and ultimately successful efforts to turn around Māori population decline, these leaders actively sought the adaptation of western knowledge and technology to enhance the health of Māori. Lange (1999, p. 118) maintain their observations led them to believe that:

> Extinction *was* inevitable, not of Maori identity, but of a *separate* Maori identity: the rate of miscegenation would greatly increase and within a lifetime, the two races would be completely fused.

During this period, the health sector was administered with substantive inequities. For instance, less than £3,000 annually was invested in Māori health between 1900 and 1920, which was shared amongst approximately 46,000 people (Lange, 1999, p. 181). The 1918 influenza pandemic exposed racism and differential outcomes and racism within the developing colonial system with Māori death rates ten times higher than Pākehā. Travel restrictions were imposed on Māori entering built up areas and even Māori members of parliament had to apply for permission to travel (Williams, 2001, p. 54).

Significant health legislation of this time included the Native Land Act 1909, which aimed to stop Māori women from breastfeeding their babies and looking after whāngai (adopted) children (Mikaere, 2000). The more widely known Tohunga Suppression Act 1907 significantly restricted the use of traditional Māori rongoā (medicine) and healers in favour of western-trained doctors. The assimilationist intent of both was transparent.

By 1930 with the stabilisation and recovery of the Māori population base, the responsibility for Māori health, Lange (1999, p. 258) contends, was 'mainstreamed' as:

> …there was no longer any recognition of the need for Maori leadership in the development and implementation of health policy as it concerned the Maori population.

With the establishment of the welfare state through the passing of the ground, breaking Social Security Act 1938 the government introduced wide-ranging reforms to establish a free universal health system based on the assumption of equitable access (Quinn, 2009). Together these developments led to decades of official silence in relation to Māori health policy and the formation of universal or 'one sizes fits all' policy initiatives, which assume everyone has the same needs and experiences. These have been of questionable effectiveness for Māori (Fleras & Spoonley, 1999, p. 147).

The Hunn Report: Revealing Ethnic Inequities

In 1961, a substantive report was released on all aspects of law and government policy affecting Māori - the Hunn Report (Hunn, 1961). This widely distributed account was arguably the first systematic attempt to document the racial disadvantage of Māori (Spoonley, 1993, p. 66). It did not however address the privileging or racial advantage experienced by Pākehā.

The report uncovered 264 pieces of legislation that discriminated between Māori and Pākehā and recommended an end to this practice through the repeal of legislation, including the Tohunga Suppression Act 1907 (Williams, 2001). A substantive socio-economic gap was also identified between Māori and Pākehā. Durie (1994b, p. 113) contends this gap showed both that Māori had successfully remained distinctive and that the notion of equitable access to government services was a myth. The report urged that serious attention needed to be given to the racial disadvantage experienced by Māori people.

Rather than propose the enabling of Māori rangatiratanga, the report endorsed an accelerated programme of active integration of the races through urbanisation and a raft of social programmes. Fleras and Spoonley (1999, p. 115) hold "it espoused the retention of Maoritanga within an overall Pakeha framework". In reviewing the report, Thomas and Nikora (1992, p. 235) observed that the integration platform promoted within the report was "assimilation under another name". They argued government policy continued to reflect, "ethnocentric views held by dominant Pakeha concerning the need for Maori to change to suit Pakeha".

The official policy of assimilation was abandoned in the 1960s, with the acknowledgment that the policy had not achieved its expected goals and that Māori culture was an ongoing part of New Zealand society (Bishop & Glynn,

1999). It was briefly replaced by integration policy launched through the Hunn Report, which was also abandoned in the face of concerns about the Crown's role in creating and sustaining disadvantage. Prime Minister, Right Hon. Norman Kirk (1974, p. 2691) explains the official move away from integration:

> So far as the majority and the minority are concerned, integration is precisely what cats do to mice. They integrate them. The majority swallows up the minority; making it sacrifices its culture and traditions and often its belongings to conform to the traditions and culture of the majority.

I assert assimilation traditions continue to hold some currency in contemporary public policy practices in New Zealand. Assimilationist notions of 'one size fits all' policy and the denial of the relevance of indigenous culture to policy development are explored within the context of contemporary health policy in chapter eight.

3.3 Biculturalism

> The vision of a 'biculturalism' in which power is really shared seems to be ever retreating, becoming a mere mirage. Instead, we are confronted by a reality in which Pākehā appropriate Māori cultural resources in the name of the Treaty and of 'cultural sensitivity'
> (D. Jones, 1992, p. 296).

As distinct from assimilation, the subsuming of a minority culture into a dominant culture, biculturalism at a basic level is about the negotiated co-existence and collaboration of two cultures. It is about creating an environment within a single geographic area where two cultures have an opportunity to exist and flourish. Within a Canadian Commission of Inquiry into biculturalism and bilingualism, Davidson and Laurendeau (1967-1970, p. xxxiv) maintain that within an effective bicultural partnership both cultures need to possess the distinct institutions they need, be properly represented within the principal common institutions, and that people interacting with these institutions have the opportunity to express and conserve their own culture.[39]

Bicultural relationships can occur between assorted cultural groupings, but typically emerge from co-existence because of historic conflict or annexation. Movement by a dominant colonial grouping to a point of sharing power, resources and responsibility with an indigenous culture is unusual (Ramsden, 1994). Fleras (1991, p. 182) contends indigenous peoples "...are cast as the 'poor partners' whose minimal powers, inadequate decision-making authority and flimsy financial security make a mockery of any equitable partnership basis".

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[39] Ironically this document refers to the bicultural partnership being between the English and French as 'founding' people in Canada, rendering invisible the experiences and rights of indigenous Canadians.

Various models and approaches have been developed to conceptualise bicultural structural arrangements and ways of working. Durie's (1994b, pp. 103-104) work on bicultural continuums explores both bicultural goals and structural arrangements. He identified bicultural goals ranging from the acquiring of cultural skills and knowledge, better understanding of indigenous issues, and stronger indigenous networks, through to improved outcomes for indigenous peoples and ultimately joint ventures between indigenous and non-indigenous within an agreed upon framework. Figure 6 below shows an adaptation of his conceptualisation of a range of structural arrangements that variously ignore and embrace the power-sharing inherent in biculturalism.
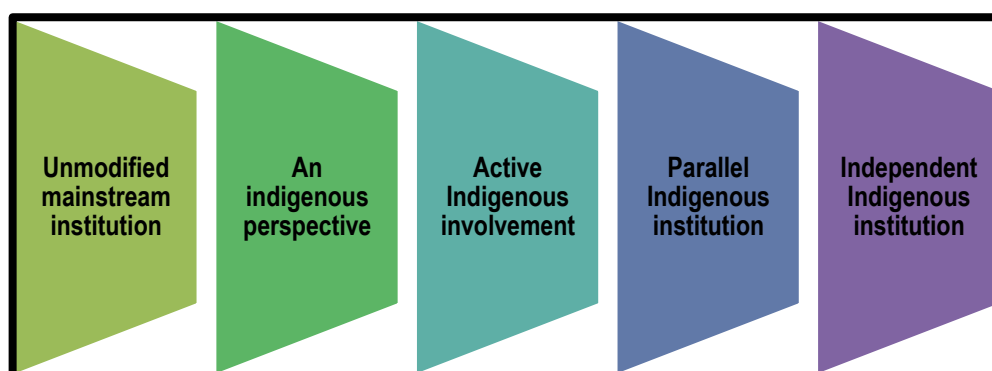
Figure 6: **Bicultural Continuum of Structural Arrangements**
Adapted from *Whaiora: Māori health development*. (p.104). M. Durie, 2004, Auckland, New Zealand: Oxford University Press. P.104. Reprinted with permission.

A growing awareness of both individual and collective human rights remains an international backdrop to the emergence of biculturalism. The successful adoption of ICERD (United Nations, 1965) marked a growing global awareness of the polemic of racism in part influenced by the civil rights and black power movement within the United States. This change in focus of race relations saw increased government efforts to address historical structural disadvantage to promote equity between ethnic groupings (Spoonley, 1993).

Biculturalism and Te Tiriti o Waitangi

> In Aotearoa/New Zealand this new relationship is being forged under the existing infrastructure, which is itself a product of colonialism based on a unitary sovereign; the Crown (Rumbles, 1999, p. 2).

Crown resistance to recognising and addressing *Te Tiriti o Waitangi* and/or Māori sovereignty has been a recurring theme of Māori and Pākehā relations since 1840.[40] Long standing advocacy by Māori and some Pākehā was rewarded in the 1970s and 1980s, with a growing groundswell of recognition and consensus that the Treaty (unspecified text) was the founding document of New Zealand (Durie, 1994b, p. 99). This changing political climate saw the emergence of biculturalism

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[40] The major Ngā Puhi claim, *Te Paparahi o te Raki* (WAI 1040) currently before the Waitangi Tribunal directly addresses issues surrounding the denial by Ngā Puhi that they ever ceded sovereignty to the English.

as a new policy approach to race relations. This growing awareness opened up the possibilities of unwinding what Spoonley (1993, p. 69) calls "the debilitating dominance of Pākehā values and their monopoly of institutional power".

Central to the dynamics of biculturalism within Aotearoa is Te Tiriti, as this Covenant articulates the status and rules of engagement between Māori and the Crown. Despite the multiethnic demographics of Aotearoa, the biculturalism partnership remains paramount due to *Te Tiriti o Waitangi*. The Crown has responsibilities for all New Zealanders but must also protect the interests of Māori as their treaty partner (Durie, 1994b).

State enactment of bicultural policy has been multi-dimensional. It has included both the establishment of the Waitangi Tribunal as an attempt to resolve historical injustices and the development of Crown-defined Treaty principles to aid its contemporary application. Other elements of bicultural philosophy, which retain currency, as introduced in *Te Urupare Rangapu* (Minister of Maori Affairs, 1988), include a two-pronged strategy: the development of a more responsive public service and the devolution of program delivery to Māori providers. The State Sector Act 1988 also required all government departments to establish plans "...which include a commitment to the principles of the *Treaty of Waitangi*, biculturalism and delivery equity to Māori" (Patete, 2008, p. 14).

Kelsey (1990, p. 267) amongst other critics contends biculturalism as practiced by the Crown is not transformative rather a "...more culturally sensitive form of assimilation". Elements of bicultural policy are explored in the subsequent sections.

Resolving Historical Injustices: The Waitangi Tribunal

Passed while the Māori land march[41] was en route to Wellington, the Treaty of Waitangi Act 1975 was the first, and arguably the most important of many pieces of legislation in modern times to consider formally either text (Barrett & Connolly-Stone, 1998). It specifically established the Waitangi Tribunal as an institutional response to resolving historical injustices. The Tribunal was created as a permanent Commission of Inquiry, charged with investigating and making recommendations on claims brought by Māori relating to policies, practices actions or omissions of the Crown that allegedly breached either text (Human Rights Commission, 2007). Since 1985, the Tribunal has been granted the powers to review retrospectively historic breaches dating from 1840, as well as contemporary infringements.[42]

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[41] Led by Whina Cooper the land march involved a large group of Māori and other New Zealanders walking the length of the North Island to Wellington to protest against Māori land loss.
[42] In addition to having the responsibility to define treaty principles the tribunal is: "...empowered to have exclusive authority to determine the meaning and effect of both the Māori and the English text of the Treaty" (Williams, 2001, p. 103).

The Tribunal's findings carry considerable weight and have helped to establish the *Treaty of Waitangi* as an important constitutional document.[43] However, the findings are not binding on the government. For example, in passing the Foreshore Seabed Act 2004, the Labour-led Coalition government acted against the advice of the Tribunal (Waitangi Tribunal, 2004). The Tribunals' powers and scope of practice have been discussed in reports from the United Nations. For example, the Committee to Eliminate Racial Discrimination (CERD) (2007, p. 4) have recommended that the New Zealand Government grants the Tribunal binding powers to adjudicate treaty matters. No action has been taken to date on these recommendations.

The practicalities of the Tribunal process are long and onerous with turn-around times on claims up to decades long, due in part to what M. Jackson (2000) identifies as chronic understaffing of the Tribunal. In historical cases, Tribunal processes are complicated by decades of haphazard Crown practices and policy including the return of land to Māori with no whakapapa connection to a particular piece of whenua. Successive governments have attempted to fast track the process by putting deadlines on Māori to lodge claims and have tried to establish a fiscal cap[44] on the total pool of settlement funding (Fleras & Spoonley, 1999, p. 132). These periodic hurry-ups are often motivated by conservative Pākehā concerned at the amount of resources going into settlement and reconciliation processes (Spoonley, 1993, p. 87).

In actuality, the settlements to date equate to approximately 2% of the value of the claims (Rumbles, 1999, p. 13).[45] The Crown retains and benefits from the remaining 98% of the resource base taken from Māori. Rumbles (1999, p. 13) argues that the Crown retains control throughout the settlement process, determining whether they accept the existence or the extent of treaty breaches or deciding "who will come to the negotiation table, what will be negotiated and how it will be negotiated". He argues that the process protects Crown unitary sovereignty and therefore fails to address the substance of fundamental Māori claims of tino rangatiratanga. At a consultation meeting around the fiscal envelope Anderson, (as cited in Gardner, 1996, p. 125) puts it succinctly:

> By whose law does a thief get to steal a car, admit later that he has stolen it, then decide when, how, and what part of the vehicle he will give back to the owner?

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[43] Bargh (2007, p. 26) contends the settlement process diverts attention from the wider issues of constitutional change.

[44] The fiscal envelope was a 1995 National government initiative that proposed limiting the total amount spent on *Treaty of Waitangi* settlements to one billion dollars.

[45] Take the particular instance of the Ngai Tahu settlement in 1998. Ngai Tahu accepted $170 million as full and final settlement and O'Regan their lead negotiator stated the full value of their South Island claim was about $16 billion (Consedine & Consedine, 2001, p. 204).

The transfer of resources and whenua through the Waitangi settlement process has enabled some economic development and independence for those participating hapū and some reconfiguring of relationships with the Crown.

Crown Invention of Treaty Principles

> The Special Rapporteur observed that the Treaty's principles appear to be vulnerable to political discretion, resulting in their perpetual insecurity and instability (Anaya, 2010a, p. 3).

Kelsey (1991, p. 123) maintains the judicial rewriting of New Zealand's founding document began in the 1987 with the Court of Appeal proposing 'Treaty principles' rather than the Māori text forming the basis of Crown-Māori engagement. Others cite the 1980s when the Labour government commenced "...a deliberate and cynical move to redefine the Treaty" (R. S. Hill & O'Malley, 2000, p. 23). Certainly, the Royal Commission on Social Policy in 1988 and the Labour government in 1989 both developed separate Treaty principles complimenting those developed by the Waitangi Tribunal (Te Puni Kōkiri, 2002).

Assorted legislation pertaining to education, energy, State-Owned Enterprises and the health sector all contain generic references to Crown-defined Treaty principles. This has created a snowball effect operationally across government, where departments "each in their own way, interpreted the Treaty principles in relation to their spheres of activity" (Hudson & Russell, 2009, p. 62)[46]. Appendix H, drawn from the work of Hayward (1997) writing for the Waitangi Tribunal and others, pulls together a complex web of the most widely utilised Crown-defined Treaty principles.

The Royal Commission on Social Policy's (1988) principles of partnership, participation and protection remain the most prominent and well known of the Crown-defined Treaty principles (Anderson et al., 2006). Partnership within this context often refers to the dynamic relationship between the Crown and Māori as treaty signatories. Participation relates to Māori engagement within a particular sector or activity, while protection relates to the Crown's article three responsibilities to guarantee Māori the same 'rights and privileges' as other New Zealanders.

Although the development of Crown-defined Treaty principles has opened up debate[47] about the application of the *Treaty of Waitangi* and provided a direction for Crown officials they remain problematic. This polemic emerges because as Kingi (2006, p. 10) correctly identifies that nowhere within either text are principles mentioned. So if the Treaty principles are a revitalisation or

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[46] C. Jones (1999, p. 52) during a sabbatical confirmed this observation noting, "Each agency I visited had its own interpretation of the Treaty, its own Treaty framework and its own commitment to understanding and addressing Treaty obligations".

[47] As recently as 2006, New Zealand First MP, Woolerton (2006) fronted an unsuccessful private members bill to have all references to treaty principles removed from New Zealand legislation.

refreshment of *Te Tiriti o Waitangi* why were both sovereign treaty partners not involved in this process? Durie (1994b, p. 85) notes that:

> Māori, placing greater emphasis on the actual words of the Treaty, have never been entirely comfortable with a focus on principles, sometimes because the definition of principles has been left to the Crown, acting on its own.

Building a Bicultural Public Service

According to Former Prime Minister, Right Hon. Geoffrey Palmer (1992, pp. 82-83), by 1986 the Labour Government had promised that all future legislation referred to it would consider the implications of the Crown-defined principles of the Treaty and departments should consult Māori on its application. This decision meant that despite incomplete understanding of the theory and practice of biculturalism, it became part of public service rhetoric and a goal for all government departments by the mid-late 1980s (Durie, 1994b, p. 104). This was reinforced with the introduction of the Royal Commission on Social Policy's (1987) Treaty principles.

Durie (1998, p. 11) argues that from the mid-1980s, Aotearoa embarked upon a radical process of societal change. He maintains that in the state sector an extensive series of state sector reforms reshaped the structures, institutions and processes of the public service. Durie (1993b, p. 4) upholds that "partnership became the catch-call" and there was a concerted effort to strengthen Māori participation and introduce a cultural element into the public service. Departments adopted various approaches to address biculturalism including kaumātua advisors, Māori advisory committees, Māori policy units, Māori sections, Māori managers and Māori designated positions (Durie, Fitzgerald, Kingi, McKinley, & Stevenson, 2002).

The health sector was amongst the first to take up the challenge of the *Treaty of Waitangi* and biculturalism. Durie (1994b) asserts Director General of Health Salmond's 1986 memo to all hospital boards in part motivated this focus and area health boards which recommending that the *Treaty of Waitangi* be integrated into health services. Salmond explained:

> For the Department of Health, the Treaty has special significance. Concepts of health are firmly based in Māori culture (which according to the Treaty has a right to official recognition and protection) and Māori people have a right to appropriate services-funded through our health system. (p. 86)

By 1987, the Standing Committee on Māori Health (1987) had recommended that a number of health services be taken over by Iwi Authorities, leading to the establishment of by Māori for Māori health services.

Spoonley (1993, p. 65) notes that these initiatives occur despite the Crown in its various forms having been a major factor in the alienation of Māori land and culture, and "...to expect a major reversal in this role would seem unduly optimistic". As detailed in chapter four, the release of the *Puao Te Ata Tu* (Ministerial Advisory Committee, 1988) and *He Whaipānga Hou* (M. Jackson, 1988) (on deficiencies in the criminal justice system) were a huge embarrassment, exposing the lack of bicultural change within the public service. Some remedial actions were subsequently initiated to address some of these failings.

The Limitations of Biculturalism

Many Māori, who have never wavered in their resolve to reclaim rangatiratanga, have often brought critical interpretations to Crown-Māori policy. Durie (1995) holds that Māori policy has been developed through different stages "with remarkably little input from Maori, except for the rubber-stamping of proposals already formulated on their behalf". Despite the gains of bicultural policy, Māori critics have raised a variety of concerns primarily focussed on the failure of biculturalism to deliver power-sharing between the Crown and Māori as treaty partners.

Some critics have seen biculturalism as reflected in Crown policy as a something of a ruse, a parlour trick of smoke and mirrors. Political commentator, O'Sullivan (2007, p. 18) contends biculturalism is "a tool of coercion developed to assist the state to retain colonial authority in a new political and legal environment where assimilation is no longer acceptable". He contends Māori hold only a minor role within Crown-defined bicultural power-sharing, in modifying state institutions to make them more palatable for Māori. M. Jackson (1995, April) argues that despite the appearance, the illusion of change, underlying power relationships have remained unchanged.

In a similar vein, other critics have seen biculturalism as tokenistic, window dressing with the inclusion of Māori advisors and policy analysts masking Crown resistance to power-sharing. Walker (1986, p. 5) clarifies that bicultural partnership to him implies "...more than Pākehā learning a few phrases of Māori language and how to behave on the marae... It means they will have to share what they have monopolised for so long, power, privilege and occupational security". [48] Historian Temm (as cited in D. O'Sullivan, 2003, p. 4) goes further to illustrate the point:

> A letter written by some civil servant that is culturally offensive is not cured by the fact that it appears under the letterhead of a department of state, which also describes itself by a Maori name.

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[48] A marae is the gathering place in front of the meeting house.

Assorted statements by Ministers of the Crown have confirmed Māori suspicions about the Crown's limited commitment to power-sharing based biculturalism. Correspondence from the then Minister of State Services (as cited in Fleras & Spoonley, 1999, p. 126) confirms:

> ...the government retains ultimate responsibility in respect to the welfare and development of the people, to the machinery of Government, and indeed the expenditure of public funds.

Former Minister of Treaty Settlements Hon. Doug Graham (1997, p. 41) concedes:

> ...that ultimately it is the government who must set limits and establish agendas...Maori-Crown relations can only be considered to be *like* a partnership, rather than a partnership per se, since a real partnership would imply some kind of joint sovereignty, with veto rights vested in each party as a matter of course.

A fundamental limitation of biculturalism to date lies in the unwillingness of the Crown to recognise Māori sovereignty. Likewise the "meanness' of resource distribution remains problematic with the Crown retaining substantial "...resources that lawfully belong to Tangata Whenua but which the government unlawfully usurped" (Fleras, 1991, pp. 186-187). Biculturalism also appears to have failed to address the substantive disparities between Māori and Pākehā revealed in the Hunn Report of the 1960s, which remain a reality into the twenty first century (Robson & Harris, 2007).

3.4 Neoliberalism

> When I was a child, I recall meeting these kuia (my nannies) in the street or at a marae. They would reach out and begin wailing quietly and tears falling from their eyes and saying '*Ka kite atu i a koe ko o matua tonu*' 'seeing you is seeing your forebears'. I was taught that no Maori is an individual
>
> (citing Tibble in Sharpe, 2002, p. 227).

The 1980s and 1990s were a period of significant global restructuring, with what activist scholar Kelsey (2004, p. 21) calls a paradigm shift from Keynesian interventionist approaches to neoliberal economics and government for many countries. The core of neoliberal philosophy is the belief that left to its own devices the market will allocate resources in the most efficient manner and will produce the outcome that is most beneficial for everyone. It assumes "the market" has special powers to be fair and wise and navigate the complexities of public good on behalf of us all, with minimal government intervention.

Cultural theorist Giroux (2003, p. 195) contends, that under neoliberal approaches capital is largely removed from state regulation, and social responsibility is minimised as market freedoms replace long-standing social contracts that provide

a safety net for vulnerable peoples. Neoliberal reforms often include privatisation and corporatisation of government departments, deregulation of markets, contracting out of services and introducing private sector management and accountancy practices (Fleras, 1991, p. 172). Justifications for reform are often grounded in the belief that the private sector is more efficient that the public sector.

Underlying neoliberal faith in the market is the belief that society is a meritocracy, if you work hard, you will succeed; it is merely a question of the strength of your character, your individual tenacity. Underlying this further is the colour-blind assumption that everybody operates from, a [mythological] level playing field with everyone having a fair chance to thrive (McCreanor, 2009). Giroux (2003, p. 194) argues this phenomenon is a kind of collective denial of history and structural discrimination. Critical theorist, Wilson (2007) purports in this ideological environment, social problems become problems of self-care. He explains this discourse in the context of Hurricane Katrina:

> Those left behind lack proper conduct - a "welfare state mentality" that erodes self-reliance, inducing them to wait for government help instead of saving themselves... It is the market that determines the rules of the game, waiting for the rising tide of economic prosperity to lift all boats.

A United Nations report, *State of the World's Indigenous Peoples* (Department of Economic and Social Affairs, 2009, p. 20) identifies neoliberalism as a threat to indigenous wellbeing. The authors argue that neoliberalism as a policy framework/ideology has been frequently imposed on indigenous peoples without their consent. They explain:

> ...under structural adjustment programmes, multinational corporations have extracted resources from indigenous territories without the free, prior and informed consent of the indigenous peoples involved, providing little or no compensation for the communities with adverse impacts on their livelihood and cultural/spiritual life (p. 20).

Aotearoa has been at the forefront of neoliberal reforms (particularly from 1984 through to the mid-1990s) in what Kelsey (1995) calls the 'New Zealand Experiment'. Much of this timeframe covered is overlapping and intertwined with the bicultural reforms already outlined.

'The New Zealand Experiment'
The zealous pursuit of neoliberal reform by successive governments shone international attention on New Zealand. Jesson (1999, p. 19) makes a disturbing comparison: "...New Zealand could be considered a freak among nations, the

Kampuchea of the free market, and 1984 could be considered Year Zero".[49] The blitzkrieg approach taken by the Labour government immediately after their election in 1984 saw multiple major reforms undertaken simultaneously, allowing limited public engagement and resistance.[50] Kelsey (1995, p. 2) notes:

> In rapid succession, the finance market was deregulated, exchange controls removed and the New Zealand dollar put on a free float. Controls on prices, wages, interest rates, rents and credit were replaced by a monetarist anti-inflationary regime, operating through a policy of high interest and exchange rates.

Bargh (2007, p. 1) contends that there are three main elements to the neoliberal policy as manifest within Aotearoa, free trade, free mobility of capital and reducing the size of government. The free trade elements of the reforms included the systematic reduction of trade barriers particularly within the manufacturing and agricultural sectors to open Aotearoa up to the global market. Free capital was about attracting foreign investment and the selling of State Owned enterprises such as the Bank of New Zealand, Telecom and Air New Zealand. Reducing the size of government was achieved through a combination of devolving traditionally core government services, streamlining what was left of the public service, and introducing increased managerial accountability (Fleras & Spoonley, 1999, p. 121).

The architects of the reforms expected to curb public debt and expenditure and achieve economic growth. These aspirations were unfulfilled. Rather as former New Zealand Prime Minister Right Hon. Helen Clark (2007, p. 1) now acknowledges neo-liberalism left New Zealand a "divided society where many had little hope of success". The economic position of Aotearoa was decidedly weakened by the mid-1990s with no economic growth for six years (Conway, 2002, September, p. 27). Between 1985 and 1992, the economy in fact shrank by one percent while other Organisation Economic Co-operation and Development (OECD) economies grew by an average of twenty percent (Kelsey, 1996). During the reform period foreign debt, quadrupled and New Zealand's credit rating was downgraded twice.

The impacts of the reforms on Māori were complex and contradictory. Political commentators, MacDonald and Muldoon (2006, p. 212) explain the "...changes released global forces that devastated the social and economic worlds of Māori, but, paradoxically, released a myriad of political possibilities that Māori grasped

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[49] Similarly Bargh (2007, p. 25) maintains commentators have likened New Zealand's engagement with neoliberal reforms as "Chile without a gun'.

[50] Minister of Finance, Hon. Roger Douglas who spearheaded the initial phase of the reforms explains (paraphrased in Asp, 2001, p. 9): "the fundamental idea was that the reforms be carried out as swiftly and drastically as possible, thus leaving no time for a response or opposition from any interested parties, his argument being that a fast moving target is more difficult to hit with any degree of precision".

with both hands". The following sections examine the implications of free trade and globalisation and explore the opportunities of devolution and the social impacts of the reforms in detail.

Pursuit of Free Trade and Overseas Investment

International trade has long been a part of economic life, but with new technology and the emergence of multi-national and trans-national corporations, the modern business-operating environment has been transformed. For instance, some corporations are now so vast that they have budgets and infrastructure larger than some countries (see De Grauwe & Camerman, 2003) and they can select where they operate from to maximise profit and minimise nation state interference. Trade negotiations between nations held under the auspices of the General Agreement on Trade and Tariffs (formed in 1947) and more recently led by the World Trade Organisation (WTO) (formed in 1995) are international mechanisms used to facilitate the free flow of trade between nations.[51]

At the heart of free trade philosophy is the removing of obstacles to the open flow of capital, goods and services. Domestic legislation around minimum employment conditions, protecting the environment and indigenous land claims are seen as potential barriers and can be considered negotiable terms within trade agreements. In Aotearoa, such agreements[52] are negotiated by the government, approved by Cabinet, and then endorsed. This process is then formalised by being tabled in Parliament and referred to a select committee and if necessary enabling legislation implemented (Ministry of Foreign Affairs and Trade, 2009). Agreements are not generally amended because of subsequent public or Select Committee input (Crown official, personal correspondence, January 29, 2010).

Attempts by the Crown to sell public assets to foreign companies or individuals during the reforms both in part to minimise debt and attract overseas investment were actively resisted by many Māori. This resistance emerged from the realisation that these assets would form the basis of resources the Crown would later need to honour treaty settlement claims (Bargh, 2007, p. 30). Māori advocacy led to the inclusion of a clause in the State Owned Enterprise Act 1986 prohibiting any actions that were contrary to the principles of the *Treaty of*

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[51] The ambitions of WTO to create a global marketplace are transparent, during the unsuccessful negotiations of the Multilateral Agreement on Trade, General Ruggiero, WTO Director was quoted as saying "we are writing the constitution of a single global economy" (as cited in Kelsey, 2004, p. 24). The WTO in particular Kelsey contends is dominated by superpowers that economically coerce and political bully member governments to aggressive pursue capitalist expansion. She cites Mike Moore "...asking one Southern delegate at the Doha ministerial whether he wanted to be 'consulted or terminated'" and a senior US trade official asking " Why shouldn't we use trade policy to reward our friends and hurt those who don't support us?".

[52] New Zealand has completed four trade agreements: Australia (1983), Singapore (2001), Thailand (2005) and Trans-Pacific–Brunei/Chile/Singapore (2006). Negotiations are also currently underway with China, Malaysia, Hong Kong, Bharain, Kuwait, Oman, Qatar, Saudi Arabia, India and United Arab Emirates (Ministry of Foreign Affairs and Trade, 2009).

Waitangi (Patete, 2008). Māori initiated multiple judicial actions in the decades that followed attempting to retain public assets in local control.

Free trade provides business opportunities for entrepreneurs, especially for those with the benefits of capital and education behind them. Bargh (2007, p. 36) contends Māori 'corporate warriors' believe that: "...Māori involvement in business can support social ends, without being solely about profit... a fusion of the social back into business ethics... providing a new perspective". These opportunities are mediated by the risk that free trade/globalisation poses to domestic commerce that often have a commitment to investing profits locally and providing employment. Kelsey (2004, p. 54) explains the impact of European and American subsidies to northern agribusiness: "...allows them to export food at below the real cost of production. Local food producers can't compete with that".

Combined Trade Union economist, Conway (2002, September, p. 16) notes through this period that overseas ownership in the New Zealand stock market rose from 19% (in 1989) to 61% (in 1997). By the end of the 1990s Kelsey (2004, p. 26) contends most Aotearoa infrastructure was in foreign ownership and the profits were going offshore. This included almost:

> ...all our transport, communication, energy, media and financial sectors and many of our [New Zealand's] natural resources are controlled by foreign investors. These investors have a history of siphoning off short term profits with minimal reinvestment, leaving behind a fragile infrastructure and a chronic deficit in the balance of payments (p. 26).

When the New Zealand government enters into free trade, agreements it values the prospect of making profit and economic growth over the protection of indigenous rights, employment conditions and environmental concerns. For Māori when the government diminishes its sovereignty with such pursuits it reduces its capability to honour its Te Tiriti o Waitangi obligations. Furthermore, Māori as sovereign treaty partners are not party to free trade negotiations yet are bound to these, as are all New Zealanders.

'Boutique Autonomy': Opportunities and Risks of Devolution

Central to the New Zealand experiment was the reinvention and downsizing of the public service, through corporatisation, privatisation and the contracting out of services. These neoliberal policy aspirations to transfer responsibilities into the community as a means to cut costs dovetailed neatly with Crown bicultural policy platforms around enhancing Māori autonomy. Given the Crown's complex and problematic historical relationship with Māori, iwi, hapū and whānau control was seen as a viable means of providing a range of services within Māori communities (Spoonley, 1993, p. 96).

Devolution also matched Māori aspirations as articulated at Hui Taumata (a government hosted Māori summit in 1984) at which participants advocated for the

redirection of negative social spending on Māori into positive development outcomes (Fleras, 1991, p. 176). Participants were interested in, full and active Māori participation in decision-making processes and agenda setting, the development of 'by Māori for Māori" service provision and Māori being responsible for resource allocation (Patete, 2008, p. 8).

Over the next fifteen years a plethora of Māori providers were developed within the health, education and social service sectors, with over 300 operating within the health sector. Fleras (1991, p. 179) describe these Māori providers as "...functionally independent of government yet answerable to the centre for the use of public resources and funds". The MANA Enterprise Development and Māori Access programme(s) are among a number of successful programmes of this time delivered to Māori whānau (Te Puni Kōkiri, 2000b).

MacDonald and Muldoon (2006, p. 213) describe this period of devolution as 'boutique autonomy' in that Crown agents' retained control over decision-making and only the appearance of autonomy was transferred. Thus, devolution as a strategy allowed the Crown to delegate responsibility, accountability and cost to the community but retain substantive control. Similarly Patete (2008, p. 1) holds devolution was more a case of decentralisation rather than power-sharing with treaty partners, and echoes of earlier critique of biculturalism.

Alongside the opportunities of choosing to accept government contracts, most obviously the injection of resources, the employment opportunities, the development experience and the opportunity to deliver effective programmes to Māori whānau were/are mitigating risks. Accepting the imposition of strict accountability procedures and 'eligibility criterion' in exchange for resources is seen by some to minimise the autonomy of Māori organisations (Fleras, 1991, p. 188). Patete (2008, p. 29) maintains the need to retain official relationships with Crown funders can affect how you choose to exercise rangatiratanga. Durie (1994a, p. 68) notes that the devolution process threatened kotahitanga among iwi through the creation of intensive competition between iwi for meagre resources, a rivalry, he suggests, "was more intensive and divisive than in the days of muskets".

Ethnic Disparities: Social Impact of the Reforms

Many individuals and families endured a decade of unrelenting hardship during the reforms (Kelsey, 1996, p. 2). The gap between rich and poor in Aotearoa grew exponentially with the top ten percent having a gross income level seventeen times higher than the poorest ten percent (Asp, 2001, p. 17). E. Pōmare et al. (1995) contend Māori were the 'shock absorbers' of the reforms due to the concentration of Māori in industries hardest hit with lay-offs and cut backs. Certainly Māori unemployment rates grew from 10.8% (in 1986) to 27% (in 1992) which in turn resulted in Māori disproportionately experiencing the impact of the 1991 benefit cuts (MacDonald & Muldoon, 2006). The ability of workers to

organise and respond to the changes was restricted by the Employment Contracts Act 1991, which abolished the legal privileges of trade unions. Conway (2002, September, p. 12) suggests this legislation altered the balance of power between employees and employers to such a degree it directly contravened several International Labour Organisation Conventions.

In what some called an "assault on the poor" social welfare benefits (excluding the old age pension) were reduced by up to twenty-seven percent during the reforms with eligibility criteria simultaneously tightened (Asp, 2001, p. 4). On the back of these changes market rates were introduced to state housing and user part charges initiated within the health, childcare, old age care and education sectors. State housing rentals for low-income earners and beneficiaries increased by 94% from 1991 to 1996 (Asp, 2001, p. 19). This led to overcrowding as families shared costs and transient families moved in search of lower housing and transport costs. Not unexpectedly, food bank usage rose dramatically with approximately seventy-five new food banks established in 1994 alone, in an attempt to address this crisis (Wynd, 2005).

Blakely, Tobias, Atkinson, Yeh and Huang (2007) observe that the life expectancy gap between Māori and non-Māori was closing from the 1950s through to the mid-1980s, but this trend abruptly reversed between 1980s and 2000. They suggest that this change in life expectancy was due to the structural changes in Aotearoa at this time. Robson (2007, p. 45) argues there is not enough evidence to describe it as a definite causal link but it needs to be considered at least as an exacerbating factor.

3.5 Summary

The Crown's failure to accept that Māori never ceded sovereignty remains the single most critical factor in Māori relations with the Crown since 1840. This denial led the Crown to establish kāwanatanga arrangements that have consistently denied Māori rangatiratanga and failed to protect Māori interests as guaranteed under *Te Tiriti o Waitangi*. Successive settler-dominated governments vigorously pursued policies of colonisation and assimilation and have been active agents in the alienation of Māori land and marginalisation of Māori communal cultural practices and ways of life.

Pākehā have been the beneficiaries of this transfer of economic assets and normalisation of Pākehā individualistic culture values and beliefs. By the 1960s, the significant socio-economic and health disparities between Māori and Pākehā were revealed through the Hunn Report. This, combined with decades of Māori resistance began a period of repositioning of Māori and Crown relations.

Biculturalism and neoliberalism have provided opportunities in terms of increased recognition of the *Treaty of Waitangi* and enabling 'boutique autonomy'. The appearance of change with the winding back of elements of the state's mono-

culturalism should not be mistaken for the substance of change, with rhetoric from Crown agents and politicians alike not matched with Māori involvement in decision-making and equitable resource distribution. Treaty settlement processes taking up to 149 years returning two percent of what was 'appropriated' does not seem reasonable redress against the reality of chronic racial disparities in health, education and employment and the indigenisation of poverty.

As established in decades of Waitangi Tribunal reports I contest that Crown policies of colonisation and assimilation are profoundly institutionally racist. The manifestation of this racism has been moderated through the rhetoric of policy platforms of biculturalism and neoliberalism but I argue through the remainder of this study that they have become normalised within Crown practice. This normalisation is typical of how institutional racism manifests contributing to why it is difficult to detect, prevent and eliminate.

Building from this historical analysis, in the following chapter I juxtapose structural analysis and libertarian theories of racism and privilege and introduces state acknowledgements of historic and contemporary manifestations of institutional racism.

CHAPTER FOUR: THEORISING RACISM AND PRIVILEGE

4.0 Introduction

> I refuse to accept the idea that man is mere flotsom and jetsom in the river of life, unable to influence the unfolding events, which surround him. I refuse to accept the view that mankind is so tragically bound to the starless midnight of racism and war that the bright daybreak of peace and brotherhood can never become a reality (M. L. King, 2002, p. 107).

Racism in its many forms [overt, covert, symbolic, socio-historical, structural, personally mediated, everyday, traditional, blatant, elite, systemic, reverse, cultural, inverse, intra-racial, internalised, laissez faire, tacit, indirect and scientific] has been debated, sometimes in very heated ways, in public and academic discourse for decades. Much of this discourse is outside the primary focus of this study on systemic and institutional manifestations of racism. My focus in this study is not with personally mediated racism or the psychological characteristics of those who perpetuate such violence. My interest lies in the ongoing intended and unintended actions of the Crown that embed structural disadvantage against indigenous peoples.

In light of this focus, in this chapter I introduce the terminology of racism and privilege used within this study. Building on the historical analysis of chapter three, I examine structural analysis perspectives. I contrast these with both discourses that deny the existence of institutional racism, and state recognition of historic and contemporary racism. These discussions establish a framework that lead into a more detailed examination of how institutional racism manifests within policymaking and funding practices.

Terminology

It is important that I outline my understanding of prejudice, discrimination, and racism, privilege, and institutional racism. These understandings have been influenced by the writings of C. Jones (2000, 2001, 2002, 2003) and Paradies (2005, 2006a, 2006b, 2007) who write from the United States and Australia respectively. C. Jones in particular is credited with popularising the concept of institutional racism within the public health sector in Aotearoa (Barnes-Josiah & Fitzgerald, 2004, p. 4).

Prejudice is a belief in the superiority of one race over another. When those prejudices are acted upon, they become discrimination. According to C. Jones (2000) prejudice and discrimination together constitute personally mediated racism, when there are differential assumptions and actions towards others

according to their race. This type of racism can be embodied in attitudes, beliefs, behaviours, norms and practices. C. Jones (2000, p. 1213) explains that racism:

> ...manifests as lack of respect (poor or no service, failure to communicate options), suspicion (shopkeepers' vigilance; everyday avoidance, including street crossing, purse clutching and standing when there are empty seats on public transportation), devaluation (surprise at competence, stifling of aspirations) scapegoating (the Rosewood incident[53], the Charles Stuart case[54], the Susan Smith case[55]) and dehumanization (police brutality, sterilization abuse, hate crimes).

As the focus of this study is on examining and attempting to transform institutional racism as a violent system, psychological discourses that identify racism as an individual character flaw are not central to this analysis. Indeed, they are only relevant in so much as people with beliefs and idiosyncrasies that influence their professional practice administrate systems. Institutional racism is having the power to have one's prejudices embedded in the institutions and systems of a society, thus disadvantaging one group and privileging another. In examining institutional racism the intent and motivations of those perpetuating it is not pertinent, the focus instead is on the outcomes achieved (McKenzie, 1999, p. 616).

To understand the contemporary dynamics of racism it can be useful to trace the historical trajectory of a particular society, as demonstrated in chapter three, to consider the specific nature of past relationships and issues of that particular society. Beyond these local specificities, racism can also be seen as a global phenomenon, as in the example of colonisation (Miles, 1989). Much western writing about racism specifically addresses the experiences of African Americans, Asian, and African immigrants in the context of Europe (Paradies & Cunningham, 2008). Within this study, where possible I utilise literature that addresses colonial contexts and the experiences of indigenous peoples.

C. Jones (2000) contends institutional racism has been codified into our institutions of custom, practice and law, making it hard to identify a perpetrator. Such racism reveals itself as differential access to both material conditions and power (access to information, resources and voice) by race. It can also be evident as inaction in the face of need. C. Jones argues this type of racism manifests itself as ethnic differences in income, education, occupation, housing and healthcare and can be inherited disadvantage. She notes (2000, p. 1212) the association

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[53] The Rosewood incident was a violent racially motivated conflict that took place in 1923 in Florida in which six blacks and two whites were killed and the town of Rosewood was abandoned and destroyed in what has been characterised as a race riot.
[54] In the Charles Stuart case, Charles murdered his pregnant wife and inflamed racial tensions in Boston in 1989 by concocting a fictitious African-American assailant.
[55] The Susan Smith case refers to a convicted child-murderer who gained attention in 1995 after claiming a black man stole her car and kidnapped her sons.

between socio-economic status and race in the United States "...has its origins in discrete historical events but persists because of contemporary structural factors that perpetuate those historical injustices".

Privilege refers to the unearned structural advantage that works in concert with systemic discrimination, to produce differential access to societal goods and services. Paradies (2007) holds that racism and its dialectic opposite privilege are intertwined concepts. They occur within a wider social system in which people are divided along socially constructed dimensions with power unevenly distributed (or produced) based on these dimensions. This analysis does not depend on the intentions of individuals as (2007, p. 67), "…oppression is systemic in society and is unwittingly and unconsciously (re)produced by many people who have no racist intentions whatsoever".

Thomas (2000) holds that the ideologically and structurally superior position of whites is the determining feature of race relations not prejudice. He explains:

> ...racism involves the ideas (i.e. legitimations) and practices (i.e. discrimination) that create and maintain a system of white racial privilege which is responsible for both past and present forms of racial inequality (p. 79).

In discussing white privilege, I wish to make the clarification that privilege is not evenly endowed on all. Rather as Moreton-Robinson (2004, p. 5) suggests, privilege is intersected with experiences of class, gender, sexuality and experiences of disability. Some white people are better positioned than others to utilise the full extent of their white privilege. Aspects of privilege can also be neutralised by choosing to become politically active and challenging the structures that convey privilege.

Institutional racism, thus, is the term I use to focus on a pattern of differential access to material resources and power by race, which privileges one sector of the population while disadvantaging another. As a founding member of the National Association of Black Social Workers, Better (2008, p. 11) contends this inequitable access is enabled through patterns, procedures, practices and policies of social institutions.

4.1 Structural Analysis

> White Anglo heterosexual, abled and middle class males are overly represented in government, legislatures, bureaucracies, the legal profession and the judiciary where they shape legislation, administration and judicial texts in their own image and to their own advantage
> (Moreton-Robinson, 2005, p. 67).

Since the 1970s, structural analysis has been utilised as an analytical approach and set of tools by activists to make sense of and make explicit uneven power relations within society (Kiro, 2000). Popularised through third world liberation movements, structural analysis has been championed by activists with goals of social and political transformation of the current hegemonic order. Influential within this field has been the enduring writings of Brazilian educationalist Freire (1998, 1970/2000; 1987) that have been applied worldwide. His teachings reveal an analysis of the historical-sociological, cultural and structural context behind a multitude of oppressions. For this reason, they are a useful lens for examining institutional racism.

A structural analysis viewpoint is achieved through asking critical strategic questions about who has power and who benefits from the current system. Through systems-level, analysis perspectives are reorientated from pathologising the failure of individuals and groups of people into examining the structural and institutional origins of disadvantage and advantage in society (Delahunty, 2001). This analysis process is used to conscientise and mobilise members of both oppressed groups and dominant/privileged groups to engage with processes that neutralise power differentials.

This section examines several perspectives grounded in the structural analysis tradition: the black power movement, decolonisation analysis, racism as violence and critical discourses of white privilege.

Black Power Movement

Black power was both the inspirational slogan of the civil rights movement popularised in the 1960s and an explicit critique of the white establishment in the United States (Wallach, 2008). It is from the black power movement that the concept of institutional racism emerged. Authorship is credited to activists Carmichael[56] and Hamilton (1967) from their book *Black Power: The Politics of Liberation in America*, which was written within the context of the militant black struggles to combat racism. They articulated the critical distinction between individual and institutional racism (1967, p. 2) when:

> ...white terrorists bomb a black church and kill five black children that is an act of individual racism… But when in the same city – Birmingham, Alabama- five hundred black babies die each year because of the lack of proper food, shelter and medical facilities, and thousands more are destroyed and maimed physically, emotionally and intellectually because of conditions of poverty and discrimination in the black community, that is a function of institutional racism.

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[56] Stokely Carmichael was later known as Kwame Ture.

Carmichael and Hamilton contend institutional racism results from a caste system that was established through slavery and then sustained by legally enforced racial segregation. They assert institutional racism can be seen as an internal form of colonisation where blacks are the de-facto colonial subjects. Key to their analysis is the belief institutional racism thrives when racist attitudes, have permeated society that hold (1967, p. 21) "...whites are better than blacks: therefore blacks should be subordinated to whites". Carmichael and Hamilton contend 'respectable' Americans who would not support overtly racist actions, will still support political institutions that perpetuate institutionally racist policies to actively protect their vested political, economic and social privileges.

In response to a series of race riots in the United States,[57] particularly one in Detroit Michigan, the Kerner Commission (1968) was charged with investigating, what happened, why it happened and how it could be prevented from happening again. Their widely distributed report reinforced and expanded Carmichael and Hamilton's analysis concluding that the primary cause of the riots were structural and institutional racism against African Americans. The authors argued this racism manifested itself in failed housing, education and social-service policies, which led to black frustration at lack of economic opportunity. They concluded "our nation is moving towards two societies, one black, one white – separate and unequal (Kerner as cited in Wickham & Zuberi, 2008, p. 3).[58]

The analysis of the Kerner report is further developed within the writings of radical feminist Lorde (1984; 2004). In her landmark critical essay *The Master's Tools Will Never Dismantle the Masters House*, (1984, p. 110), she holds that only temporary gains can be made by beating or competing with the master at his own game. Rather the master is controlling the agenda and diverting attention away from achieving transformative change. She names her anger and rage (1984, p. 124) in response to racism, and calls for collective not individual solutions to racism, and acknowledges the connectivity between racism, sexism and homophobia. She speculates the limited support from whites to address racism originate from our [white people's] fears of what we have to give up.

Critical race theorists, Coello, Casaňas and Rocco (2003, p. 18) assert that black power is a direct critique of the notion "...that racism is psychological or that it is simply about bad individuals". This insight opens up the political possibilities that racism can be transformed systematically.

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[57] Watts Riots of 1965 in Los Angeles, Division Street Riots of 1966 in Chicago and Newark riots of 1967.

[58] The recommendations of the report were rejected and ignored by President Johnson and within a month of the report being released upon the assassination of ML King Junior further rioting broke out in more than 100 cities.

Decolonisation Discourses

Within colonised countries, groups of people who remain colonised are engaged variously in decolonisation processes or enjoy the rare privilege of being 'never colonised' (Israe Paraone[59], personal correspondence, March 2, 2010). Decolonisation is both an individual and collective process of revealing and actively analysing the historic and contemporary impact of colonisation, mono-culturalism and institutional racism combined with political movement towards the recognition of sovereignty. This progression of dismantling colonisation can be peaceful, through violent revolt or a mixed approach. Throughout the twentieth century there has been a global decolonisation movement (Department of Economic and Social Affairs, 2009) led by indigenous peoples that has resulted in multiple peoples regaining self-governance and assorted measures of independence from colonial powers. This struggle has resulted in people being harassed, prosecuted and killed in their attempts to achieve social, cultural, political and economic transformation (Tutu, 1994).

The United Nations Charter (1945) within both article seventy-three and seventy-four, outline a principle of respect for the self-determination of all people, which continues to guide the United Nations' commitment to decolonisation. In 1960, the United Nations adopted the *Declaration on the Granting of Independence to Colonial Countries and Peoples* (United Nations, 1960) and subsequently in 1962 established a Special Committee on Decolonisation to facilitate self-government. Furthermore in 1990 and again in 2001 the General Assembly declared international decades to eradicate colonisation.

Writing of his experiences in Africa, Fanon (1961/2004, p. 27) asserts decolonisation is a process of changing the order of the world, creating new language and new humanity. Decolonisation is putting into practice the phrase 'The last shall be first and the first last'. State responses to 'uprising from the natives' he argues (1961/2004, p. 29) is to speak "...the language of pure force" for their purpose is to maintain control and protect the material privileges of the colonisers.

Māori activist, S. Jackson (1989, p. 49) upholds decolonisation involves the recognition that your mind has been enslaved. It then involves people being made aware of the behaviour of successive governments (1989, p. 52) "...to further entrench Pākehā political power and closing the door to any power for us [Māori]". He (1989, p. 50) asserts decolonisation is complete:

> ...when our people have done all those things and looked at the situation we [Māori] are faced with, they will [then] understand that we are completely capable of taking this country back and running it in a way that is based on our traditional beliefs.

[59] Israe Paraone is of the Iwi Ngati Awa, Tūhoe and his hapū is Tawera.

Racism as Violence

> I have laid down the law that there shall be no fighting and in the event of the two great tribes Māori and Europeans joining together to create a war it would be in vain, no fighting would ensure for my word has gone forth
>
> (Te Whiti as cited in Murphy, 1997, p. 31).

As outlined in chapter three, historically violence has been used by the state to assert and preserve Pākehā sovereignty. Indeed, it is well recognised that colonisation was/is a violent and racist process (see Awatere, 1984; Sherwood, 2009). Within their respective examinations of colonial indigenous state relations both Thomas and Nikora (1992) and legal scholar Rumbles (1999) describe racism as cultural violence.

The much-cited Duluth power and control model (see Shepard & Pence, 1999) which was developed in the 1980s as a tool to understand violence, against women assumes that women and children (and some men) are vulnerable to violence because of their unequal social, economic and political status. A similar analysis can be usefully applied to indigenous peoples and their experience with the state. Figure 7 specifically addresses cultural deficit theory, white privilege, land alienation, use of intimidation, coercion, isolation, children and force. This model has been used extensively in the context of structural analysis training as a tool to understand state violence against Māori.

In recent decades, Aotearoa has experienced some dramatic demonstrations of state violence practiced by the police against citizens exercising their tino rangatiratanga and challenging racism. The two most prominent cases being the response of the police against the occupation of Takaparawhau (Bastion Point) by Ngāti Whātua and allies in 1977 and violence directed at anti-apartheid protestors campaigning against the South African Springbok rugby tour in 1981.

The (re)occupation of Takaparawhau led by the Orakei Māori Action Committee in 1977 was the culmination of over a hundred years of lawful protest (Waitangi Tribunal, 1987). The peaceful 506 day action was a response to the immediate plans by the government to develop the area into high-cost housing and parks, and the long-term purchase and confiscation of whenua by the government for public works and development since the 1840s. During the occupation, a marae and housing were built and thousands of supporters visited the site to tautoko and learn more about Takaparawhau.

Figure 8: **Eviction Day Takaparawhau**
Photographer unknown: "Peace prevails as protest ends after 17 months" in *New Zealand Herald 1978, May 26 (sec1 pg.5). Reprinted with permission.*

As depicted in Figure 8, Ngāti Whātua and supporters were forcibly evicted by an unprecedented 800 strong force of police and army authorised by the government in May 1978. Over two hundred people were arrested overwhelming the local court system. The initial defendants took up so much court time cross examining arresting officers and reviewing Ngāti Whātua history that eventually most charges were dropped. Māori activist, Hawke (1998, p. 77) describes her arrest:

> One policeman grabbed me by the hair the other had me by my feet. They
> lifted me up and slammed me back onto the ground, probably to wind me.
> I was left breathless and my chest hurt. They probably cracked my rib, I
> heard my son and husband calling out "Leave my mother alone"... The
> arresting officer brutally flexed my wrist until I thought it would crack and
> forced me towards the paddy wagon.

Along with the arrests on eviction day, the police organised for non-unionised labour to bulldoze the wharenui (meeting house) and other buildings on the site and fenced off the area preventing access. Sometime later, after a Waitangi Tribunal hearing, legislation was passed which enabled the return of Takaparawhau to Ngāti Whātua.

Hundreds of thousands of New Zealanders, including many Māori were also involved in anti-apartheid protests throughout the 1981 Springbok rugby tour. The police with long batons repeatedly attacked unarmed and unprotected protestors and the notorious Red Squad was used to disrupt aggressively the right of protestors to engage in peaceful protest. During the height of the violence, police attacked three protestors dressed as clowns, giving out lollies and flowers. Paavonpera, an eyewitness interviewed by Bingham (2001, August 11) for the *New Zealand Herald* explains:

> They were vicious, raining blows all over them. The girl, she was on the
> ground and they just kept going. I ran over... and yelled out, 'Stop it, for
> fuck's sake, stop it'.

Halt All Racist Tours founder, Richards (1999, p. 4) holds the conflict fuelled by police violence was as close as New Zealand has come to civil war in modern times. The National government under the leadership of Prime Minister, Right Hon. Robert Muldoon committed to continue the tour despite significant popular protests. Stenning (2007, p. 230) through his investigation into Crown intervention in policing, has confirmed that police commissions met with the Crown Ministers during the tour to discuss arrangements for policing.

Discourses of White Privilege

> I exercised my white privilege by my silence. I exercised my privilege to opt out
> of engagement, even though this choice may not always be consciously made by
> someone with privilege (Wildman, 1997, p. 316).

Those that have experienced racism have been writing about white privilege for decades, as from this worldview it is self-evident that white people have benefitted directly and indirectly from historic and contemporary processes of colonisation and institutional racism. It has taken longer for white people to catch on, but there is an emerging critical literature (see Delgado & Stefancic, 1997) that names this systematic advantage of one race over another as 'unearned white privilege'. Cultural theorist, Ahmed (2004) argues that the emerging field of whiteness studies seeks to make whiteness visible, to displace it from the core

unmarked position of normality alongside other strategic efforts to systemically disrupt this privilege.

White feminist, McIntosh (1988) in her landmark essay on the subject, describes white privilege as a collection of unearned assets, an invisible weightless knapsack of white privilege that has special provisions such as: "...maps, passports, codebooks, visas, clothes, tools and blank checks" that can be cashed in at any time. She explains (1988, p. 1):

> ...whites are taught to think of their lives as morally neutral, normative and average and also ideal, so that when we work to benefit others, this is seen as work which will allow 'them' to be more like 'us'.

In examining privilege, she maintains it is necessary to confront the myth of meritocracy, the realisation that certain doors are opened and closed for people through no virtue of their own.

White privilege, contends activist educator Curry-Stevens (2007, p. 41) is often upheld by the unexamined acceptance of the long routine power relationships and dynamics in societies that maintain the status quo. Critical white theorist, Wildman (1996, p. 52) argues social and financial inheritance is a critical example of normalised white privilege. Due to slavery and widespread practices of colonisation, historically whites have had considerable opportunities to accumulate wealth not open to all. These advantages have been enhanced through the enactment of well-documented discriminatory legislation and practices (see Katznelson, 2005) that continue to be exacerbated through taxation policy and practices, which reward the elite.

In summary, just as institutional racism can be tracked to demonstrate structural disadvantage against indigenous peoples, so can white privilege be quantified across education, employment, access to housing to reveal white systemic advantage. This analysis is diametrically opposed to the race-free worldview of libertarian advocates.

4.2 Libertarian: Discourses of Denial

Rhetoric of formal equality and antiracism has been supported in principle, within western liberal-democracies for decades (Nakata, 2001, p. 11). Aspects of these views are embodied within United Nations (1965, 1976b) human rights instruments which have been widely ratified by nation states. Fundamental to the populist libertarian view is the notion of a meritocracy. That is, all citizens have equal opportunity to succeed and fail within society: it is down to an individual's resourcefulness and ability to engage in the market. Proponents of this position have been known to embrace Martin Luther King Juniors' (as cited in Awad, Cokley, & Ravitch, 2005, p. 1387) famous aspiration of wanting his "...children to be judged not by the color of their skin, but by the content of their character". This

appropriation conveniently overlooks King's consistent calls for the end of systemic discrimination by both the state and the dominant white population.

To understand libertarian discourses, Tuffin (2008, p. 5) contends it is useful to make a distinction between old-fashioned racism and more recent manifestations. The former is characterised by direct, explicit and blatant advocacy of white supremacy and physical violence, and the latter are typified by being more subtle, complex and socially acceptable. New, seemingly benign, libertarian standpoints (discussed in subsequent sections) are set against moral values such as the protestant work ethic, self-discipline and individual achievement, not biological or genetic superiority. Discourse theorists, Myers and Williamson (2002, p. 22) asserts:

> ...the public face of racism reflects the official rhetoric of formal equality and antiracism, but the deeply ingrained racism captured in private race talk reflects the racist ideology "deeply embedded in our social structures' and practices".

Denunciation of the relevance of history to contemporary racial inequities is, according to critical psychologist, Leach (2005, p. 434) a longstanding feature of libertarian denials of institutional racism. Although some libertarians acknowledge the problematic historic existence of racism, critical psychologist, McConahay (1986) holds they believe it has now 'been fixed' by the civil rights movement and assorted government sponsored anti-discrimination programmes, so everyone can now freely participate within the marketplace.

Sociologists, Zamudio and Rios (2006, p. 487) contend this standpoint allows "...white America to disconnect itself with this country's racial history, for them, history no longer matters, and color-blind[60] America, individuals rise and fall on their merit". It denies the existence of the structural disadvantage of indigenous peoples while simultaneously obscuring the structural advantage or racial privileges enjoyed by whites.

Within the next section, I examine critiques of Affirmative Action Programmes (AAP), denial of indigenous peoples' rights, cultural deficit theory, and discourses of political correctness as illustrations of libertarian standpoints in relation to institutional racism and privilege.

The Case against Affirmative Action

"If you give all the plants in the world the same amount of water, some will die". Equal treatment can increase rather than close the social and economic gaps between different groups, and appropriate specific measures are needed to ensure that everyone has equal opportunity
(Jonas as cited in De Bres, 2004, February, p. 7).

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[60] Colour blindness refers to a belief that race 'should not and does not matter'.

Across the planet, groups of people cannot gain access on anything like equal terms to social resources like higher education, employment and health services that are essential for human flourishing. Figure 9 below shows a well-known cartoon depicting the structural realities of equal treatment without affirmative action.
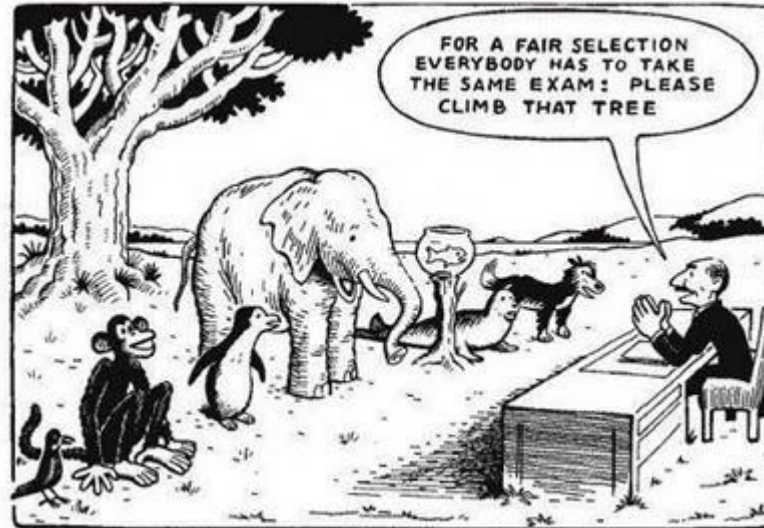
Figure 9: **Fair Selection Cartoon**[61]

Affirmative Action Programs (AAP)[62] are a widely used structural mechanism to facilitate equality of access to opportunities legitimated through international human rights instruments (see United Nations, 1976a, 2001). AAP can both act to redress the outcomes of socio-historical racism and promote diversity within employment and education. Moses (2010) maintains within different national contexts justifications for AAP need to be invoked strategically depending on the current (local) racial climate. She advocates a moral justification for AAP grounded in aspirations for greater social justice.

Critics hold that AAP is an intrinsically unfair form of reverse discrimination that disadvantages whites. Psychologists, Awad, Cokley and Ravitch (2005, p. 1386) hold this claim of unfairness centres around its violation of the merit principle, that individual's achievements should be proportional to input or effort. This is illustrated in Augoustinos, Tuffin and Every's (2005, p. 324) study on affirmative action discourse in education, which utilised viewpoints from tertiary students.

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[61] I was unable to identify the creator of this cartoon but it has been widely used by activists in New Zealand since the 1970s specifically by the EEO Trust, CORSO and it has been published variously in the *Treaty Times*, *Tiriohia* and the *PPPTA journal* without a complete reference. When and if the creator is identified future publications resulting from this thesis will include this information and relevant permissions will be sought.

[62] AAP within the context of universities Parker (2006, p. 18) maintains can involve initiatives such as: "...minority student and faculty recruitment, and minority retention through administration of special scholarships, diversity web sites, diversity centres, and ethnic study programs".

And I'm one against sort of holding places open for specific groups (*Mmm*) umm not because I'm racist or discriminating but because I think that merit is the most important thing you give a person the job because you think they are capable of doing it not because of who they are and I know that if I was put to that situation I probably would prefer not to take that job because I wouldn't have, I'd never know whether I got the job because I might be male or because I'm white so it's I think it's a really difficult line to walk.

Sociologists, Zamudio and Rios (2006, p. 487) hold white opposition to AAP is also predicated on concerns around breaches of the principle of equal opportunity, which was a central principle to the agenda of the civil rights movement. They contend affirmative action is 'preferential treatment' of certain groups, which is widely used to discredit indigenous peoples' rights claims. Management theorists, Harrison, Kravitz, Mayer, Leslie and Lev-Arey (2006, p. 1031) in their meta-analysis of AAP programmes concluded that attitudes to AAP stem from both the content of the programmes and critically how organisations communicate about the programs.

According to cultural theorists, Omni and Winnant (1994) opposition to AAP in the 1980s led the Reagan administration to redirect the Commission on Civil Rights[63], to make addressing "reverse discrimination" its' highest priority. Commenting on AAP at the University of Michigan, United States President, Bush (2003, January 15) stated:

> At the Law School, some minority students were admitted to meet percentage targets, while other applicants with higher grades and better scores are passed over. This means that students are being selected or rejected based primarily on the color of their skin. The motivation for such an admissions policy may be very good, but its result is discrimination and that discrimination is wrong.

Judicial and political debate about affirmative action remains active within the United States. Political commentator, Sherman (2009, February 7) contends the trend remains for increasingly conditional support for AAP with a clear movement away from blanket quota systems.

Indigenous Peoples' Rights as Unfair Privileges

> This Declaration [*United Nations Declaration of Rights of Indigenous Peoples*],
> far from affirming rights that place indigenous peoples in a privileged position,
> aims at repairing the ongoing consequences of the historical denial of the right to
> self-determination and other basic human rights
> (Anaya, 2010a, p. 2).

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[63] The Commission on Human Rights is a state watchdog group in the United States responsible for monitoring progress and problems in racial equality.

Indigenous peoples have exercised their sovereignty and asserted their rights for thousands of years. It is only in recent decades various forums within the United Nations have acknowledged these claims, including most recently with the adoption of the *United Nations Declaration on the Rights of Indigenous People*. Collective indigenous rights claims clash with libertarian views around the supremacy of both the individual and the market. Libertarian opposition to indigenous peoples' rights claims mirrors and extends arguments put forward to oppose AAP. Libertarians argue that ethnically targeting social spending and historical reparations are affirmative action. This targeted investment and mechanisms for ensuring indigenous representation in governance roles such as Māori seats within New Zealand parliament are dismissed within such discourses as special unfair privileges (Barber, 2008, p. 149).

Research undertaken within Aotearoa and Australia has identified similar themes across white discourse around indigenous peoples' rights through analysis of media, political and historical texts (Augoustinos et al., 1999; Barber, 2008; Van Dijk, 1992). Discourse theorists Wetherell and Potter (1992, p. 177) identify these themes as:

> Everybody should be treated equally.
> You cannot turn the clock backwards.
> Present generations cannot be blamed for the mistakes of past generations.
> Minority opinion should not carry more weight than majority opinion.
> We have to live in the twentieth (or twenty-first) century.

Implicit and explicit across these themes is firstly a denial of indigenous peoples' rights, and secondly an unwillingness to address the historical outcomes of colonisation, that have contributed to contemporary racial disparities.

These populist libertarian positions and fears about "getting a fair deal for whites" are manipulated and regularly played out by politicians to secure favour with voters prior to elections. Former Australian Member of Parliament, Hon. Pauline Hansen of the One Nation Party is a champion of this genre (Augoustinos et al., 1999). Her infamous maiden speech (1996, September) epitomises libertarian denial of institutional racism:

> I am fed up with being told, 'This is our land'. Well, where the hell do I go? I was born here, and so were my parents and children. I will work beside anyone and they will be my equal but I draw the line when told I must pay and continue paying for something that happened over 200 years ago. Like most Australians, I worked for my land; no-one gave it to me.

In Aotearoa former National Party leader, Hon. Don Brash got considerable political and media mileage from attacking 'special privileges' Māori were allegedly receiving from the Crown. Brash (2004, January, p. 13) stated:

> There can be no basis for special privileges for any race, no basis for government funding based on race, no basis for introducing Maori wards in local authority elections, and no obligation for local governments to consult Maori in preference to other New Zealanders.

Political commentator, Johansson (2004, p. 119) contends Brash articulated views held by many New Zealanders "...that Maori were receiving special privileges at the expense of others and that redistribution of the nation's resources to Maori for historical injustices had gone too far for too long".

Cultural Deficit Theory

> Many whites explain the gap between black and white earnings not by invoking inequality and prejudice, but by relying on "individualistic" explanations about thrift, hard work, and other factors-all of which tend to explain white success through white merit and equate whiteness with stability and employability (Mahoney, 1997, pp. 332-333).

Health researchers, Borell, Gregory, McCreanor, Jensen and Moewaka-Barnes (2009, p. 34) contend the framing of a problem is inherently political, as how problems are seen preclude some and privilege other solutions and resource allocation. Individual and race based explanations for racial disparities such as cultural deficit theory are often privileged by libertarian advocates. Indeed Pihama (2001, p. 139) upholds it is a dominant hegemonic discourse. From a cultural deficit standpoint, the overrepresentation of indigenous peoples and other minorities in negative social statistics is the function of systemic indigenous failure. This deficit analysis credits these failings to a lack in an individual or grouping (L. Black & Stone, 2005; M. Thomas, 2000). Valencia (1997) contends these purported failings are represented as laziness, lack of motivation and/or a welfare mentality, while Māori health advocates, Reid and Robson (2007, p. 5) maintain the failings are wrongly credited to a mix of inferior indigenous genes, intellect, education, aptitude, ability or effort.

Pihama and Gardiner (2005, p. 21) contend deficit theory has had significant influence on social policy and has become entrenched in everyday language of many New Zealanders. They argue that within deficit theorising the home environment and family background have become the focus by which to explain differences in school achievement, involvement in crime and health behaviours. Health researchers Subban, Terwood and Schuster (2008, p. 770S) assert that those that prescribe to the deficit model tend to treat minorities as if they are deficient and need fixing. The solution to racial disparities from this standpoint is

more cultural assimilation, as to succeed one must be assimilated and be more 'white-like' (Solorzano & Yosso, 2002, p. 31).

Deficit theorist, McWhorter quoted in the *Los Angeles Times* (George, 2000, p. E3) articulates bluntly what critical race theorists name as a majoritarian viewpoint:

> The sad but simple fact is that while there are some excellent Black students... "on average, black students do not try as hard as other students. The reason they do not try as hard is not because they are inherently lazy, nor is it because they are stupid... these students belong to a culture infected with an anti-intellectual strain, which subtly but decisively teaches them from birth not to embrace school-work too whole-heartedly".

Moderated by social norms about acceptability of public expressions of blatant racism, deficit theorists usually use indirect language such as 'at risk' and 'disadvantaged' communities rather than name particular ethnic groups (Van Dijk, 1992, p. 89). The effect and meaning of the discourse however remains intact.

Critics observe that deficit theory clearly positions the problem of racial disparities with minority groups, ignoring system and structural bias. This approach, according to critical whiteness scholars, Fine, Weis, Powell and Burns (1997) therefore ensures that the behaviours of dominant groups are never closely examined and white privilege is never exposed. Reid and Robson (2007, p. 5) claim there is extensive evidence that indigenous peoples receive lower levels and poorer quality service than non-indigenous peoples. They hold therefore that:

> [a]ny discussion on equity and rights must be informed by acknowledging this preferential benefit accrued by Pākehā from the systems they introduced and built, and continue to redefine and control.

Dismissed as Political Correctness

Progressive attempts to combat sexism, racism and other forms of discrimination are characterised by some libertarians as attacks on the rights and freedoms of individuals to say, feel and behave as they please (Sanson et al., 1998). These objections since the 1990s have often been framed as political correctness. Related terms include the phrase the 'nanny state', and assert that the state exerts excessive control over people's lives. The implicit assumption behind political correctness is that [white] individual autonomy and freedom are more valuable than [minority] group rights to be free from discrimination. Within this discourse, van Dijk (1992) maintains the white majority present themselves as being victimised by political correctness, as being discriminated against and being disadvantaged by unfair privileges bestowed on minorities.

In the aftermath of the Lawrence inquiry, activist scholar, Bourne (2001, p. 18) documented assorted claims of 'political correctness gone mad' from critics opposed to substantive reforms instigated by the Macpherson report (1999). The populist circular arguments have been used to powerful effect in shutting down informed policy debate in favour of recycled rhetoric about individual rights. Critical theorist, Wilson (1996, p. 6) explains:

> The genius of using a term like *political correctness* was that people would never declare themselves politically correct, so it was virtually impossible to counter the conservative attacks when a culture of soundbites defied the kind of analysis needed to refute the presumption that political correctness existed.

Claims of political correctness, he suggests, are an attempt to silence dissent and block progressive reform.

In summary, discourses with their roots in western libertarian ideas favour the rights of the individual over collective interests and rights-based discourses. Racism within this standpoint is the outcome of "wayward individuals" and not the product of systemic inherited disadvantage as a result of colonisation and/or slavery. Efforts to address racial disparities from this standpoint should therefore not compromise white privilege but instead, there is a need to focus on the purported endemic failure of minorities to take responsibility for themselves and their children.

4.3 State Acknowledgment of Institutional Racism

The state has a duty to act in the best interests of all its citizens. As outlined in chapter three, there is strong evidence that many governments have historically disregarded the best interests of indigenous peoples through their pursuit of colonisation and/or assimilationist policies (Department of Economic and Social Affairs, 2009).

In his landmark essay *Race, Class and the State*, Sivanandan (1981) holds racism is entrenched within the apparatuses of the state, which provides the context for a range of discriminatory practices. Kuznicki (2009, p. 419) writing in the context of the United States around Jim Crow segregation laws, contends the state cannot be considered neutral in regard to racism, as it has mandated discrimination in public life and therefore condones discrimination in private life too. He explains:

> [t]he federal government and many state and local governments sent a powerful message in both word and deed that discrimination was not simply a private taste or proclivity. Instead, discrimination was a matter worthy of local, state and federal government support (p. 419).

Bourne (2001, p. 19) concurs, arguing that it is the state – the legislature, the Executive, the judiciary - through their administration of public services that sets the tone and tenor of race relations in society. This tenor setting is complex, balancing out historical injustices while attempting to honour public commitments made within the international community to human rights agreements that seek to minimise racism and enhance race relations.

Within this section, I examine the legacy of colonial racism, contemporary inquiry based findings of institutional racism and the challenge of addressing ethnic inequalities as key themes of state discourse associated with institutional racism.

Legacy of Colonial Racism

In recent years, there has been increasing attempts by nation states to reposition their relationships with indigenous peoples. These developments are in response to both domestic and international pressure and highlight the increasing lack of acceptability for historic colonial engagement with indigenous peoples. A reconciliation agenda driven by indigenous and non-indigenous peoples lies at the heart of these attempts at healing and transforming relationships.

State defined reconciliation processes however typically do not address the substance of indigenous sovereignty claims. MacLennan (1995, p. 2) quoted former New Zealand Prime Minister, Right Hon. Jim Bolger in *The Dominion* saying, "We cannot negotiate the division of sovereignty between various groups of New Zealanders. That is not possible and won't happen". This unwillingness to address issues surrounding sovereignty has also been reflected in the public statements of the Australian, Canadian, New Zealand and the United States governments when they voted against the adoption of the *United Nations Declaration on the Rights of Indigenous Peoples* (Banks, 2007).

Despite these pragmatic denials of the contested nature of unitary parliamentary sovereignty various reconciliation processes are underway that acknowledge historic colonial racism. Within this subsection, I examine Waitangi Tribunal processes in Aotearoa and the stolen generation reconciliation process in Australia.

Waitangi Tribunal Processes

> The treaty settlement process is clearly one of the most important examples in the world of an effort to address historical and ongoing grievances of indigenous peoples, and that settlements already achieved have provided significant benefits in several cases (Anaya, 2010b, p. 2).

Attempts at reconciliation within Aotearoa remain centred around Waitangi Tribunal processes. The Tribunal is appointed by the government of the day to provide advice to the Crown as an independent part of the judiciary. Tribunal process entails formulating the extent of breaches of either treaty text and

recommendations are made to the Crown around the scope of the settlements. Crown negotiators working with Māori claimants determine the final settlement, which usually involves an official apology.

Waitangi reports are revealing in that they are independent commentary on the historic and contemporary behaviour of successive governments. The following excerpt from the report into the Taranaki claim (Waitangi Tribunal, 1996, p. 309) powerfully demonstrates this:

> The protests of the landless were protests of desperation, but for their actions they were imprisoned in their hundreds, at will, without trial, and with all civil rights suspended. The ultimate consequence, the invasion and sacking of Parihaka, must rank with the most heinous action of any government, in any country, in the last century.

The following is from the Te Reo claim (Waitangi Tribunal, 1986, p. 20):

> The evidence and argument has made it clear to us that by the Treaty the Crown did promise to recognise and protect the language and that that promise has not been kept... But educational policy over many years and the effect of the media in using almost nothing but English has swamped the Maori language and done it great harm.

Cumulatively the thousands of pages of Waitangi Tribunal reports provide a comprehensive picture of the harmful effects of colonial racism.

Stolen Generation
The Australian government has been slow in accepting the harm of their historic colonial policies and practices on indigenous peoples. Augoustinos, et al. (1999, p. 355) contend the myth of terra nullius was embodied in Australian law for 200 years. This doctrine was rejected by the High Court in the Mabo v State of Queensland (No. 2) decision in June 1992 which "…found that indigenous people who have a continued connection with their land may hold native title" (Pedersen, Dudgeon, Watt, & Griffiths, 2006, p. 90).

Soon after this ruling, a national inquiry was called into the separation of Aboriginal and Torres Strait Islander children from their families, resulting in the *Bringing Them Home* report (Lavarch, 1997). The report focussed on a seventy-year period when Australia had active laws, policies and practices that separated indigenous children from their families. As part of this process Van Krieken (2004, p. 127) asserts:

> [t]he state was made the legal guardian of all children of Aboriginal descent, overriding Aboriginal parents common-law rights over their children, who were to be removed at official will and sent to a mission or a

child welfare institutions, or to be fostered with a white family if sufficiently light-skinned.

The justification for the forcible removal of children of mixed blood from their families and their placement with non-indigenous people, was on the basis that the successful integration of the races in the best interests of the child (Lavarch, 1997). The children at the heart of this policy have become known as the stolen generation.

The *Bring Them Home* report (Lavarch, 1997) is populated with detailed first-person accounts of Aboriginal and Torres Strait Islander families' experiences of this policy. It includes strong recommendations from the judiciary to the Australian government. Among the recommendations was a commitment to funding the recording of indigenous testimonies, reparations guided by the van Boven principles (United Nations, 2005), and called for an official apology from the Australian parliament. The report concluded by noting that the gross violations of human rights indigenous communities had endured were acts of genocide. Tom Calma, Aboriginal and Torres Strait Islander Social Justice Commissioner (2008) contends implementation of many of the recommendations remains unfinished business. However on 13th February 2008 the Prime Minister of Australia, Right Hon. Kevin Rudd (2008, February 13), offered a much anticipated public apology to indigenous communities.

These acknowledgments of historic racism and apologies by the state in both Australia and New Zealand were not casually offered, rather are the outcome of sustained activism. They are part of a wider process of reconciliation between state parties and indigenous peoples.

Inquiry Based Findings of Institutional Racism

For politicians and senior public servants acknowledging colonial racism as a "dark chapter" of the past is fundamentally different from recognising it within current state practices. In recent times, when institutional racism is acknowledged it is often within the context of a crisis in a specific area that needs to be investigated and risk managed through an inquiry process. Over the past forty years, particularly within both England and the United States, there has been a series of inquiries into the incidents within the health and education sector and actions of the police and military that have identified institutional racism as a cause and/or a contributing factor (Blofeld, Sallah, Sashidharan, Stone, & Struthers, 2003; Kerner Commission, 1968; Macpherson, 1999).

Within this section I focus on two landmark inquiries that address institutional racism and had a wide impact on policy development within their specific localities. I examine *Puao Te Ata Tu* (Ministerial Advisory Committee, 1988), the investigation led by kaumātua John Rangihau into racism within the provision of

social welfare in Aotearoa, and the Lawrence inquiry led by Sir William Macpherson (1999) into police practices in England.

Puao Te Ata Tu

In 1986[64] the then Minister of Social Welfare, Hon. Ann Hercus commissioned an inquiry into the Department of Social Welfare (DSW) responsiveness to Māori, following a series of complaints from Māori. *Puao Te Ata Tu* (Ministerial Advisory Committee, 1988) the subsequent report identified endemic inadequacies around policy, planning and service delivery for Māori and proved a wake-up call for many government agencies working in the arena of social policy. Evidence showed that the Department did not serve Māori well (p.78); rather they systematically addressed the interests of Pākehā. The authors named these failings institutional racism, as:

> …the outcomes of mono-cultural institutions which simply ignore and freeze out the cultures of those who do not belong to the majority. National structures are evolved which are rooted in the values, systems and viewpoints of one culture only. Participation by minorities is conditional on their subjugating their own values and systems to those of "the system" of the power culture (p. 19).

The primary recommendation of the report was to establish an overarching policy objective around eliminating cultural racism (p. 9) by incorporating the values, cultures and beliefs of Māori in all future policy development. Spoonley (1993, p. 67) contends the authors were unequivocal in their expectations that effective bicultural policies were to be adopted by government departments to provide Māori communities with "the power to direct and allocate resources that the State [currently] has at its command".

Walker (1990, p. 280) and Huygens (2007, p. 65) hold that *Puao Te Ata Tu* linked the roots of Māori socio-economic hardship to the history of colonisation and its contemporary outcomes in institutional and cultural racism. Furthermore, it suggested the rigid functioning of the DSW had fed a cycle of dependency and located Māori as end-users of government services rather than treaty partners. Many of the recommendations for action were an attempt to curtail the very mono-culturalism that had been nurtured through Crown's historical policy platform of assimilation as outlined in chapter three.

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[64] An earlier report by the Women's Antiracism Group (Berridge et al., 1984) in response to Māori claims of systemic racism also undertook a systematic analysis of perceived institutional racism within the Department. It did not reach such a wide audience, but helped pave the way for the Māori advisory groups' work.

Stephen Lawrence Inquiry

In 1993 Stephen Lawrence, a black teenager, was stabbed to death by five or six white young men in what was likely to have been a racially motivated crime.[65] Those that were put on trial were acquitted due to lack of evidence and could not be retried under English law because of extensive publicity around the case that could prejudice another trial. Macpherson (1999) who was commissioned to oversee the inquiry into this unsolved murder concluded police failed to prosecute the alleged killers due to institutional racism. By this, he meant it was a collective system failure. He found no evidence of racist policies as such and maintained the intentions of the individual police involved were not important, but the issue was the racist outcomes of the policing interventions.

The inquiry acknowledged that for institutional racism to be addressed it needed to be openly recognised and its causes addressed by policy, example and leadership. If this were not done, institutional racism became embedded in the ethos or culture of an organisation. Macpherson argued his findings were potentially applicable across public institutions throughout England. He maintained (1999, p. 46) that:

> It is incumbent on every institution to examine their policies and the outcomes of their policies and practices to guard against disadvantaging any section of our communities. ...there must be an unequivocal acceptance of the problem of institutionalised racism and its nature before it can be addressed, as it needs to be, in full partnership with members of minority ethnic communities.

Critics of the report findings, particularly amongst the police, argued that using the term institutional racism implied all police had racist intentions, which they argued was not the case or particularly helpful (Murji, 2008, p. 843). In their evaluation of the impact of the Macpherson report on the police force Foster, Newburn and Souhami (2009, p. 33) found many police argued that police involved in the case were not racist. Rather they were incompetent and their incompetence was colour-blind. Media critic, Daley (1999, February 23) asserted that the claim of institutional racism was vague and dangerous and it had invented a form of 'thought crime', while political commentator, McKinstry (1999) likened Macpherson's analysis to a 'indulging in a series of sweeping generalisations'.

The then Labour government however endorsed Macpherson's analysis, which marked a significant turnaround in official policy from complete denial of racism "...as a trait in British society to official acceptance of it as a matter that was embedded in all the institutions of government and society" (Murji, 2008, p. 850). A series of substantive policy and legislative changes were subsequently launched.

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[65] That being one of 200,000 racist incidents involving attacks, abuse and harassment in Britain every year (Bennetto, 2009, p. 39).

Both *Puao Te Ata Tu* and the Stephen Lawrence inquiry involved recognition of embedded systemic racist bias within public institutions. The contrasting impact of these inquiries on public policy development and implementation are examined in more detail in chapter eleven.

Addressing Ethnic Inequalities

> ...despite the many efforts of communities and successive governments, social and economic inequalities, accentuated by the economic recession, remain unacceptably high. An unrelenting focus on the elimination of racial inequalities is needed, so that future generations of New Zealanders are free from this blight. It is also time to examine whether there are still systemic or institutional barriers to racial equality that need to be addressed to make other interventions more effective (Human Rights Commission, 2011b, p. 4).

Since the release of the Hunn Report (1961) across public policy, discourse within New Zealand there has been a commitment to reducing ethnic inequalities between Māori and non-Māori. This focus has been heightened by the consistently expressed concerns of United Nations monitoring bodies about racial inequalities in Aotearoa. In the late 1990s, these efforts were championed under the umbrella of 'Closing the Gaps' (Te Puni Kōkiri, 2000c) and were by the early 2000s rebranded as programs to 'Reducing Inequalities' (Ministry of Health, 2002g). These programs have aimed to generate greater equality of opportunity, so ethnicity is not a major determinant of life chances and wellbeing.

Considerable effort has been invested in describing ethnic disparities within health, education the criminal justice system and elsewhere as compiled in the Human Rights Commission (HRC) (2011a) report on structural discrimination. Within their report (2011a, p. 37) the HRC identify that even when culturally responsiveness programs are in place that practitioners across the spectrum including public sector managers can continue to exhibit biased practice, a notion that is explored more deeply in the context of this research in chapter eight. They argue that a focus on universal provision of public services assumes everyone has equal access to services thus entrenching inequalities.

Through their research with informants from across the public sector, the HRC isolated a range of initiatives they consider best practice in relation to tackling ethnic inequalities. They include cultural competency work within the health sector, Te Kotahitanga program (Bishop, Berryman, Cavanagh, & Teddy, 2009) within the education sector, neighbourhood policing programs in Counties Manukau and youth courts and Māori focus units within the criminal justice system. Common elements across these programs are collaboration and a consistent approach, building understanding of structural racism, meaningful partnership and consultation with Māori, targeted interventions to address inequalities and building evidence through the strategic use of evaluation.

The results from the Ministry of Social Development's (2010) latest *Social Report* indicate that the piecemeal approach currently being pursued to addressing ethnic inequalities has yet to produce substantive change. Alternative strategies to address structural racism are discussed in depth in chapter eleven.

4.4 Summary

Racism and privilege are interlinked concepts, for when one group of people are being structurally disadvantaged and another is being privileged. The intentions and motivations of those involved are not the defining characteristic of the racism rather the resulting racial disparities.

Emerging from structural analysis traditions institutional racism has been used within the ideological left in the context of both black power and indigenous decolonisation struggles to describe systemic oppression and the privileging of the dominant white population. Such analyses have proven a powerful lens to gain a deeper understanding of racial power dynamics. Indeed this study of institutional racism draws heavily on structural analysis traditions.

Libertarian discourse in contrast holds firm to the values of individualism, democracy and meritocracy and largely rejects the notion of institutional racism. Within this paradigm, individual rights are emphasised and policy is developed for everyone rather than tailored to meet the needs of minorities. From this viewpoint racism is practiced by isolated 'bad apples' and remedial action to address past atrocities are considered reverse discrimination and represented as unfair to the white majority/minority. Racial disparities in turn are explained away by cultural deficit theory.

It is well established that historically many states have engaged in racist policies and practices whether it is slavery, colonisation and/or assimilation as outlined in chapter three. As state's attempt to reconcile with these complex histories, many are acknowledging the legacy of this colonial racism. Recognition of the state's role in racism has also entered contemporary public policy discourse through reactive inquiries into the administration of components of the public sector. These inquires have generated a range of remedial actions. I maintain efforts to date within Aotearoa to address ethnic inequalities and systemic institutional racism have yet to produce substantive results.

Within the next chapter, I outline the controls on state parties and Crown officials in Aotearoa to prevent institutional racism.

CHAPTER FIVE: CONTROLS TO PREVENT STATE RACISM

5.0 Introduction

Within the international community, there is a range of controls on state parties to govern acceptable behaviour. Treaties for instance are a mechanism by which one independent nation or sovereign entity agrees to engage with another independent nation or nation(s) or sovereign entity/entities (Orange, 1987). Historically treaties have been variously negotiated between colonial nations and indigenous peoples and are utilised within peacemaking processes to forge alliances after conflict. Human rights agreements administered by the United Nations are also voluntary controls on the behaviour of state parties. These agreements delineate acceptable behaviour and bind governments to protect the interests of their citizens from among other things systemic discrimination (Human Rights Commission, 2010).

Governments in turn have a range of controls to define ethical conduct of their office bearers in relation to these commitments. These controls consist of accountability mechanisms including policy and procedures to guide professional practice, pathways for the public to request information, and to appeal Crown decisions (Palmer & Palmer, 2004). These international and domestic controls together serve to reassure many, that the decisions of their politicians and Crown officials are open to scrutiny and are therefore rigorous and fair. New Zealand has more than 3000 Crown entities to support its commitment to such treaties and agreements.

Within this chapter, based primarily on a desktop review of a range of Crown documents I outline a range of accountability mechanisms as they pertain to Crown officials and state parties in the context of systemic racism in New Zealand. I also review the government's performance in this regard in relation to the commitments understood to be made in *Te Tiriti o Waitangi* and various human rights agreements.

5.1 Public Sector Accountability

> The public service is the machinery of government...because they generally have more information, expertise and time to think than ministers, public servants have power
>
> (Palmer & Palmer, 1997, p. 78).

In jurisdictions where democratic principles are foundational but where neoliberal ideas prevail, there has been significant change in the shape and practice of the public sector. A substantial amount of what was built up as core government activity devised to protect citizens and enhance collective wellbeing is now, contracted out as services to a mix of market and community sector providers

leaving, in principle, a leaner more efficient sector (Kelsey, 1993). In New Zealand this transitional process has resulted in perpetual restructuring and what the State Services Commission (SSC) (2002) view as a considerable loss of knowledge and expertise. However, Crown officials remain at the core of the public service and the efficient functioning of government is dependent on their ethical conduct. Crown officials and their Ministers are expected to abide by a plethora of legislation[66] and regulation. The ultimate political accountability of governments however lies with the electorate.

In their ethical framework for the state sector in New Zealand, the SSC (2002, p. 2) holds there are three key dimensions necessary to sustain ethical conduct: control, guidance and structure. The details of these dimensions are outlined within the *Cabinet Manual* (Department of Prime Minister and Cabinet, 2008) and related guidelines administered from assorted sites across government (see Ministry of Health, 2002c; Ministry of Justice, 2010; State Services Commission, 2007). They are outlined below in preparation for later discussion on the level of Crown official compliance with these directives and the effectiveness of these controls in preventing and minimising systemic racism.

Control Dimension

> Under this system "...any conduct they [independent Crown monitoring agencies i.e. Privacy Commissioner] put under the spotlight must be explained and justified, with adequate reasons, unless it is to be found wanting"
>
> (Palmer & Palmer, 2004, p. 263).

The control dimension refers to the informal, formal and institutionalised controls (see Table 4), which enables independent investigation of the activities of Crown officials and Ministers. This framework ensures government activities are subject to both external and independent review. Some of these controls are available to members of the public others must be initiated by a Member of Parliament (MP).

Table 4: Control Framework to Scrutinise Government Activities

Informal Controls	Write or visit a Member of Parliament.
	Writing media releases and letters to the editor.
Formal Controls	Petition parliament.
	Utilise the protected disclosure legislation.
	Utilise the official information legislation.
	Complaint to the Office of the Ombudsman.
	Judicial Review.
Institutionalised Controls	Written or oral parliamentary question.
	The select committee process.
	Routine activities of the Controller, Auditor-General and Audit Offices.
	Royal Commission of Inquiry.

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[66] For instance the Crimes Act 1961 covers corruption and bribery of a Minister of the Crown, a MP, an official and the corrupt use of official information (State Services Commission, 2002, p. 4).

A traditional method of control in relation to addressing concerns about the workings of Crown agencies open to the public is writing to or visiting a MP. Such a visit can result in correspondence to relevant Crown Minister(s), further investigation and clarification of an issue. It can also lead to a parliamentary question, which offers MPs an opportunity to question Ministers of the Crown about the administration of their departments and policies. Thousands of questions are tabled and responded to annually; these take the form of both written and oral questions and frequently originate with constituents.[67] These answers then become part of the public record of parliament through the *Hansard* system.

The public individually or through interest groups are also able to write letters to the editor and generate media releases raising concerns in relation to government activity. Under a Mixed Member Proportional (MMP), electoral system public opinion can act as a potentially powerful informal control on the conduct of government. Palmer and Palmer (2004, p. 228) contend opinion polls are frequent and are often used by politicians to frame their activities to secure favourable outcomes. The media therefore is a vital resource as it is through this source that most people get their information about public affairs.

New Zealand's governance arrangements enable the right to petition parliament. Petitions can be instigated by private citizens to seek policy and/or legislative change (Office of the Clerk of the House of Representatives, 2000). They are usually referred for consideration to select committees, whom are required to respond with recommendations within ninety days. Hundreds are initiated each year on a wide range of topics, recommending the government take a variety of actions. Parliamentary standing orders place a number of limitations on petitions, so for instance if other legal remedies have not been exhausted or if it could be subject to an Ombudsmen complaint, the House will not receive the petition.

Many of the controls on government are reliant on the publics' access to information. The Official Information Act 1982 creates a legal requirement that official information be made available to anyone who seeks it, thereby opening up the conduct of government to scrutiny (State Services Commission, 2002). The core principle of the Act is information must be released unless there is a good reason to withhold it. The Act enables the public to scrutinise the workings of government and promotes public sector accountability. It applies to all government departments, Ministers, and most Crown entities including DHBs.

The Protected Disclosure Act 2000 (also known colloquially as the 'whistle blower legislation') was developed to protect employees who expose some form of serious wrongdoing within their organisation. Serious wrongdoing includes matters such as the unlawful use of public funds, actions that might endanger

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[67] In 2009 for instance there were 1,100 oral questions and some 20,000 written questions tabled (Prebble, 2010, p. 175).

public health and/or gross mismanagement. The legislation protects employees who have made disclosures (in accordance with internal procedures) from disciplinary action.

The Ombudsmen are responsible for investigating complaints and making recommendations in relation into administrative decisions and practices of central government. The mandate of Ombudsmen focuses on both the resolution of individual complaints and an examination of their underlying causes.[68] The Ombudsmen owe no allegiances to the Executive and are appointed for five-year terms. They have particular responsibilities in relation to investigating official information complaints and process thousands annually. Public law specialists Palmer and Palmer (2004, p. 268) explain that the Ombudsmen has no power to alter decisions but they can investigate and report to both parliament and the Prime Minister. The resulting publicity can exerts some influence on efforts to right administrative injustices.

Legislation grants the Executive a plethora of discretionary powers across a range of areas. A judicial review is a control on the behaviour of Ministers and Crown officials who act in a manner outside their mandate or according to processes that are illegal, unreasonable and/or unfair and their decision can be quashed by a court (Department of Prime Minister and Cabinet, 2008, p. 50). Judicial review is concerned with decision-making process rather than the merits of the decision. It is a procedural remedy so the points of process can be remedied but the decision may still stand.

Select committees[69] are a mechanism designed to facilitate systematic and comprehensive scrutiny of government activity. They usually examine bills after their second reading, (unless they are under urgency) which often enables the public to provide written and/or oral submissions on the content of the proposed bill. This process both provides for public discussion and the refinement of legislation. Select committees can also initiate an inquiry as in the example of the Māori Affairs select committee inquiry (2010, September 23) into the impact of tobacco companies on Māori. An inquiry can be conducted into virtually any aspect of government policy, expenditure and administration. Standing orders require the government to make a formal response to the select committee report within ninety days. The proceedings of select committees are often open to the public and the media during the hearing of evidence and the committee can call for persons and papers to be placed before them.

The Controller, the Auditor-General and the Audit Office are parliament's routine watchdogs over financial expenditure, ensuring public monies are used in an appropriate manner. They oversee a regular auditing program to assure parliament

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[68] Periodically the Ombudsmen office produce a compendium of case notes giving details of their findings.
[69] There is a designated select committee with a focus on matters related to heath.

that departments are performing and accounting for their performance in a manner consistent with parliament's intentions. They cast light on particular government policies and are a check against financial corruption and inefficiency in government (Palmer & Palmer, 2004, p. 128). Their routine independent reports and their special investigations are tabled in parliament periodically so are thereby open to political, media and public scrutiny.

Royal Commissions of Inquiry also investigate concerns relating to the administration of government. Specifically they examine the workings of any existing law, the necessity or expediency of any legislation, the conduct of any Crown official, any disaster or accident involving members of the public and any other matter of public importance (Department of Prime Minister and Cabinet, 2008, p. 58). Royal Commissions, set up by the Governor-General on behalf of the Sovereign, can summon witnesses, hear evidence, conduct investigations and award costs.

There are a range of informal, formal and institutionalised controls in place to moderate the behaviour of Crown officials and Ministers. In order for these controls to prevent, obstruct, transform institutional racism they first must be able to detect racism. Therefore, access to information and the monitoring of Crown behaviour is essential to their effective operation.

Guidance Dimension

The guidance dimension of controls refers to administrative, legislative and Māori specific guidance (see . 5) that in this context could prevent racism. This guidance framework provides advice and direction to enable Crown officials and Ministers to administer efficiently and effectively the public sector.

Table 5: Guidance Framework for Crown Officials and Ministers

Administrative guidance	Code of Integrity and Conduct (legally binding)
	Letter of expectation to CEOs.
	Cabinet Manual.
Legislative guidance	New Zealand Bill of Rights.
	New Zealand Public Health and Disability Act.
Māori specific guidance	Te Puni Kōkiri.
	Waitangi Tribunal.

Central to the guidance dimension is the SSC's role in monitoring the performance of the public service to ensure both the quality of service delivery and to uphold appropriate standards of integrity and conduct. This is primarily achieved through their oversight of the *Code of Integrity and Conduct* (2007) which outlines the expected behaviour of officials in relation to the core elements of impartiality, fairness, responsibility and trustworthiness. The public service is expected to remain politically neutral thereby being able to serve Ministers from across the political spectrum. Although Crown officials must have regard to the policies and priorities of the government of the day, they are expected:

> ...to give free and frank advice to Ministers and others in authority, and when decisions have been taken, to give effect to those decisions in accordance with their responsibility to the Ministers or others (Department of Prime Minister and Cabinet, 2008, p. 4).

Since 1997, in addition to the code of conduct the SSC (2002, p. 6), issue a letter of expectations to all new public sector Chief Executives, broadly defining their duty of care. It outlines the SSC expectation that Chief Executives must:

> ...conform to the highest standards of integrity and probity, and ensure that they have systems and procedures in place to maintain and enhance public trust and confidence in the integrity of their departments, the Public Service as a whole, good government and representative democracy (p. 6).

The *Cabinet Manual* (Department of Prime Minister and Cabinet, 2008, p. 2) is the authoritative guide to central government decision-making and the primary source of information on constitutional arrangements as seen from the perspective of the Executive branch of government. It clarifies that the *Treaty of Waitangi* puts limits on majoritarian decision-making and accords a special recognition to Māori rights and interests through article two and three. It recognises that autonomous Māori institutions have a role within the constitutional and political system and a model of two parties negotiating and agreeing with one another is appropriate in circumstances.

The New Zealand Bill of Rights Act 1990 is a key element of New Zealand's constitutional arrangements and is designed to protect a number of fundamental rights and liberties from intrusion by government. The Act provides guidance by defining discriminatory conduct in the context of legislation, regulations, policy development and service delivery. The Ministry of Justice (2010) have developed a mandatory non-discrimination standard (see Appendix I) to support the implementation of the Bill of Rights Act[70] Through the application of this standard the Attorney-General is obliged to notify parliament when a bill is in breach of the Act, thereby opening it up for parliamentary scrutiny.

The NZPHDA (as discussed later in chapter six) outlines the functions and responsibilities of various parts of the health system. The Act contains clear statements about the role of the health sector in reducing inequalities, improving

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[70] A recent report by the HRC (2011a, pp. 31-32) made the distinction that this standard does not consider the implications of policy advice for Māori, rather relates to the Crown-defined treaty principles. The HRC argued even if the policy implications for Māori were negative, such an analysis would provide Ministers with more complete information to enabled better informed policy making.

health outcomes for Māori and the relevance of Crown-defined Treaty principles[71] to the workings of the sector. Central to the treaty relationship is the understanding that Māori have an important role in developing and implementing health strategies for Māori (Ministry of Health, 2002c, p. 4). DHBs are therefore issued with a responsibility to establish and uphold processes to enable Māori to contribute to strategies to strengthen Māori health and provide relevant information to Māori for that purpose. The Act also enables dedicated Crown-appointed Māori representation at the governance level of DHBs to ensure Māori voice in health decision-making.

The NZPHDA requires both Ministry and DHB to consult about matters related to the provision of health and disability services. For DHBs, this specifically includes requirements to consult on District Strategic Plans (DSP), District Annual Plans (DAP) and significant changes to policies, proposed changes in methods of contracting and in a variety of circumstances on other issues. The standard of consultation required is that defined within the Local Government Act 2002. This entails issuing a public notice, specifying a consultation period, providing an opportunity for written submissions to be heard and all submissions are to be made publicly available. To support the consultation requirements, guidelines[72] (see Ministry of Health, 2002c) have been developed to support the work of Crown agencies in this area.

As introduced in chapter three the Waitangi Tribunal is a permanent Commission of Inquiry charged with investigating and making recommendations related to policies, practices actions or omissions of the Crown that are alleged to breach either *Te Tiriti o Waitangi* or the *Treaty of Waitangi*. The findings of the Tribunal carry considerable weight and offer directions for Crown officials and Ministers but are not binding on the government. Their focus has primarily been on historical breaches but contemporary claims such as the claim of Te Whānau o Waipareira (Waitangi Tribunal, 1998) relate to perceived discriminatory practices against urban Māori by the Crown have also been activated.

Enabled through the Ministry of Māori Development Act 1991, Te Puni Kōkiri (TPK) has a role in monitoring and liaising with each department and agency that provides services to Māori. The department aims to build an evidence base through research and statistical monitoring to understand and focus the state sector on improving its effectiveness for Māori (Te Puni Kōkiri, 2009a). It has particular interests in promoting Māori achievement across education, employment, health and economic spheres and monitors relevant Crown agencies

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[71] Critically the NZPHDA was the first time the treaty was included in a piece of social legislation, and the first time, Boulton (2005, p. 37) there has been explicit requirements to include Māori input into decision-making on health and disability services.
[72] Ministry (2002c, p. 16) guidelines emphasis that the decisions and reasons for them should be conveyed back to those that participated in the consultation as part of a robust process. These include that the proposal is not yet fully decided on, sufficient time must be allowed and sufficient information should be supplied.

to ensure the adequacy of those services. As an integrated policy Ministry, it conducts research, policy development, community level investment, evaluation and monitoring and manages Crown-Māori relationships on behalf of government. A key focus is also "…to ensure that Government decision making and processes are informed by treaty considerations and are reflective of the aims, aspirations and realities of Māori communities" (Te Puni Kōkiri, 2009b).

There are a range of administrative, Māori specific and legislative controls in place to guide the behaviour of Crown officials and Ministers. These controls rely on Crown officials and Ministers having the professional commitment and competencies necessary to enact this guidance.

Structural Dimension

Structural controls are realised through sound human resource management practices. Devolved management is fundamental to how the New Zealand public service works. The underlying principle is that public sector managers work best under conditions of clear performance requirements, with managers having sufficient authority and discretion to meet the requirements. Employment arrangements and incentives are linked to specified performance, and good information flows are encouraged to keep the system in balance and to enable risks to be managed as close as possible to their source (State Services Commission, 2002, p. 15).

Crown Ministers such as the Minister of Health are responsible to parliament for their own activities and those of staff administrating their ministerial portfolios. Chief Executives through their delegations under law and performance agreements are in turn responsible for the advice given to the Minister and the conduct of their staff. Despite the centrality of Chief Executives to the activities of government departments, Palmer and Palmer (1997, p. 71) argue Crown officials are ultimately the Minister's agents "...in everything they do, as they act in his or her name". Politicians are affected by substantial failures in their department, for which the public expects them to be politically accountable, as unfolded in the resignation of the Minister of Conservation over the Cave Creek disaster.[73]

The introduction of both the State Sector Act 1988 and the Public Finance Act 1989 streamlined the public sector giving state sector managers freedom to manage, while holding them accountable for their actions. Emphasis was placed on strengthened financial controls and departments demonstrating their efficiency. The utilisation of performance agreements and strategic and key result areas with specified targets have became embedded across the public sector. These accountability requirements apply from Chief Executives through senior management teams to grass roots Crown officials in layers of level-specific

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[73] The Cave Creek disaster occurred when a viewing platform maintained by the Department of Conservation in Paparoa National Park collapsed killing fourteen people in 1995.

performance targets. Often requirements are detailed in job descriptions, employment contracts and annual performance review targets.

A historic control specific to the health sector has been Māori Co-Purchasing Organisations (MAPOs) which were established under the Northern Regional Health Authority (RHA) in the mid-1990s as a structural response to racism. The MAPO strategy was a mechanism to enable a 'treaty relationship' with iwi, so Māori could be involved in funding and planning decision-making and service and policy development at all levels. North Health established MAPO with Tainui, Ngāti Whātua and the iwi of Te Tai Tokerau. Kiro (2000, pp. 221-222) quoted Shea (former North Health manager) described MAPO as being:

> Responsible for prioritising Maori health within the RHA's core business activity for all Maori within the North Health region… [and] The MAPO share joint responsibility for the selection and development of services and providers who are deemed safe, necessary, appropriate, effective and capable of efficient service delivery.

These Treaty relationships forged by North Health operated at both governance and operational levels were later transferred to the HFA and then the Ministry of Health and local DHBs (Minister of Health, 2000). A formal memorandum of understanding defined the treaty partnership with operational protocols to define the mechanics of the working relationship. The practicalities of the partnership meant MAPO staff work alongside Crown colleagues and were involved in all strategic policy-making and planning, funding decision-making, contract negotiations and monitoring.

In summary, there are a plethora of controls on the behaviour of Crown officials and Ministers. These checks and balances address the dimensions of control, guidance and structure. The effective functioning is reliant on access to information to detect racism and professional commitment to compliance.

5.2 Domestic Human Rights Frameworks

> With more than thirty years of active public policy to dismantle legal barriers to equality and equity, how is it possible for racism not to wither and die under the bright lights of the civil rights movement?
>
> (Better, 2008, pp. 23-24).

Domestic human rights frameworks are often both aligned to international instruments and are complaint-centric. Legislation is central to these frameworks and defines acceptable social behaviour, act as a deterrent, and serve as an educational device (Gaze, 2002; M. Jones, 1997). Meikle, (2011, p. 55) contends a comprehensive human rights approach includes elements of awareness raising and education, the integration of rights into policy making, enhancing political

accountability and transparency through the enactment of legislation and is focussed on promoting civil society participation.

Paradies (2005) and Sanson, et al. (1998) assert that an effective domestic human rights framework requires an independent agency to administer the legislation and related portfolios free of political interference. They concur that such an agency needs to be well resourced and have a mandate to take a whole of government approach. Capacity needs to be sufficient to allow timely responses to complaints and relationships to be formed with communities targeted by racism. Paradies (2005, pp. 18-19) also emphasises the importance of that central agency taking strategic responsibility to collect and publish data about the how and when racism is manifested so anti-racism interventions can be effectively evaluated and progress monitored. This work can be extended and strengthened by an engaged civil society.

In the context of racism practiced by state parties, an independent agency to oversee human rights is important. Historically various governments have endorsed what are now considered racist legislation, such as the Jim Crow laws in the United States which denied Afro-Americans suffrage, political and economic equity (Better, 2008, p. 26). This caution aside, Psychologist Aronson (1999), argues the most critical factor in the reduction of blatant discrimination in the United States has been the civil rights legislation of the 1960s.

In order for anti-discrimination legislation to be effective, the scope of the legislation needs to include institutional discrimination as practiced by local, regional, state and/or federal governments. This is not always the case as governments grant themselves exemptions and exclusions. Bourne (2001, p. 21) writing in the context of England notes initial drafts of the Race Relations (Amendment) Act 2000 (UK) exempted public bodies from over half of the Acts powers related to both direct and indirect racism.[74] Moreton-Robinson (2004, p. 4), notes the failure of Australian anti-discrimination laws to provide legal redress for the extinguishment of native title as an illustration that systemic discrimination against indigenous peoples can and does fall outside legislative jurisdictions.

Sanson, et al. (1998, p. 174) claim that legislation can invoke controversy and disapproval from parts of society, as some feel it curtails their individual freedom. Paradies (2005, p. 13) asserts it is difficult to definitively gauge the impact of anti-discriminatory legislation. He maintains however, that there is no doubt that similar legislation around seat belt usage and drink driving, has brought about significant changes in expressed attitudes and observable behaviour.

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[74] The final version of this legislation still gave the immigration service grounds to contravene the Act.

New Zealand Experience

> Inaction is a form of structural discrimination.[75] Where governments do not respond to the needs of ethnic groups, the absence of initiatives perpetuates barriers (Human Rights Commission, 2011a, p. 40).

New Zealand's domestic human rights framework is administered by the Human Rights Commission (HRC),[76] who holds a range of powers as outlined in the Human Rights Act 1993. These powers include a broad mandate to provide technical and policy advice in achieving compliance with human rights instruments, the capacity to receive and mediate complaints, to undertake research to investigate patterns of discrimination and identify solutions, and the ability to conduct public inquires. The Commission also have a responsibility for the provision of information to create an environment that supports the progressive improvement of human rights.

The HRA is broadly aligned to New Zealand's obligation under ICERD (United Nations, 1965). The HRA does not empower the Human Rights Commission to overturn a discriminatory Act of parliament, or government regulations, nor a discriminatory action or policy that has authorised or required by an Act or regulation. Complaints not resolved through mediation may be taken to the Human Rights Review Tribunal. The Tribunal can determine whether that particular law, action or policy is discriminatory. When government legislation or regulations are found to be discriminatory, Wilson (2001, August 13, p. 3) explains:

> …the remedy will be a declaration of inconsistency, which the responsible Minister will be required to bring to the attention of the house, along with the Executive's response to that declaration.

However, there is no requirement for discriminatory policy or legislation to be overturned.

The 2001 revisions of HRAA enabled the Commission to receive complaints about the public sector in relation to employment, public access, the provisions of goods and services in similar footing to that of the private sector. These alterations were developed after the partial completion of Consistency 2000[77], a major project reviewing all domestic acts, regulations, government policies and administrative practices with a view to assessing their consistency with anti-discrimination legislation (Butler, 2004, p. 51). Despite these revisions, the core

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[75] The Human Rights Commission (2011, p. 4) use the term structural racism interchangeably with institutional racism to refer to "…practices, norms and behaviours within institutions and social structures which have the effect of denying rights or opportunities to members of minority groups, keeping them from achieving the same opportunities available to the majority group".

[76] The Human Rights Commission was established in 1978 and the Race Relations Office was subsumed within it in 2002.

[77] Consistency 2000 as a project was later abandoned by the government.

conduct of the public sector is primarily judged against the standards of the New Zealand Bill of Rights Act 1990. [78]

Since 2004, the Human Rights Commission has released annual reports reviewing progress and areas of development in race relations. These reports (Human Rights Commission, 2005b, 2006, 2007, 2008, 2009, 2010b, 2011b) confirm the ongoing existence of racial discrimination with an average of 572 complaints annually and 23% of those complaints being related the actions and non-actions of Crown agencies. The reports flag an ongoing lack of public knowledge on how to make a complaint, the ongoing existence of entrenched ethnic disparities and the lack of a consistent framework for race relations research.

For the first time in 2010, structural racism as a barrier to racial equality in the enjoyment of civil, political, social and economic rights was selected as a priority area by the HRC (2011b, p. 5). A major research project is currently being undertaken to investigate to what extent structural racism is present within key government agencies and what strategies have proven effective to transform such racism. Their initial discussion document (Human Rights Commission, 2011a) informed by interviews with senior officials, focuses on what initiatives have proven successful to improve embedded ethnic inequities.

The strength of a domestic human rights framework is dependent on the resources invested in it and its political independence. Addressing ethnic inequalities and responding to complaints are important tasks for human rights agencies but efforts also need to be focussed on addressing the contribution of Crown agencies to such inequities. An engaged civil society could help extend and strengthen domestic human rights efforts.

5.3 International Human Rights Instruments

> Human rights deal with relationships among and between individuals, groups and the State. They are about how we live together: about our responsibilities to each other. In particular [they are about relationship] between the governed and those who govern (Human Rights Commission, 2005a, p. 20).

The United Nations is an international forum made up of nation states, to maintain world peace and security and is the primary global body to define and monitor human rights (Nakata, 2001, p. 11). Negotiated at the end of World War Two the *Universal Declaration of Human Rights* (United Nations, 1948) is an underpinning human rights document. It affirms human beings are born free and equal in dignity, rights, and that everyone is entitled to these rights and freedoms without distinction of any kind. Alongside this core document are various instruments and mechanisms to address civil and political rights, economic, social and cultural rights, indigenous peoples' rights and freedom from racial

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[78] The Bill of Rights Act pertains only to the public sector specifically the legislature, executive and judiciary branches of government.

discrimination (see United Nations, 1965, 1976a, 1976b, 2007). Collectively these instruments provide a safety net and attempt to protect and promote the fundamental freedoms and human rights of all people.

The United Nations structure consists of various committees and bodies with specific designated areas of responsibility. Issues related to racial discrimination and indigenous peoples' rights cut across several departments within the United Nations. The implementation of human rights treaties is in part monitored through state parties providing regular progress reports to the relevant committee. NGOs from the state party, also often provide parallel reports, commenting and critiquing government accounts. Both sets of information are analysed and help shape the relevant United Nation committee monitoring report.

Litigator, Meikle (2011, p. 42) warns that the United Nations lacks the capacity and resources to review state party reporting in any depth, thereby compromising the rigour of their monitoring. She maintains the United Nations reporting process is predicated on the good will and honesty of state parties. In contrast, legal scholar, Meron (1985) argues this process is the strongest tool the international community has to combat discrimination in that it is comprehensive in scope, legally binding in character, and equipped with built-in measures of implementation. Either way, as demonstrated in various United Nations committee reports over time (see Choules, 2006, p. 278; Jonas, 2001, p. 41) state parties across the political spectrum persist in breaching human rights conventions.

Racial Discrimination

> Paper rights cannot achieve self-determination nor can they promote state accountability to moral precepts and international law
> (Alfred & Corntassel, 2004, p. 3).

The development of ICERD and CERD to monitor progress on its implementation is a major platform of the United Nations' response to racism. The Convention calls for the speedy elimination of racial discrimination and rejects all justifications for discrimination in theory and practice. There are currently over 180 signatories to the Convention who have committed to eliminating racism within their jurisdiction. As part of these commitments, states such as New Zealand agreed to embed key elements of the Convention into domestic legislation.[79]

Through the 1950s and 1960s, anti-racism efforts also focus on supporting the decolonising efforts of non-self-governing territories (Nakata, 2001, p. 12). Since

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[79] In Aotearoa this was initially addressed through the 1971 then the 1977 Race Relations Act but is currently administered under the Human Rights Act 1993.

1945 this contributed to over eighty former colonies gaining independence,[80] and only sixteen non-self-governing territories containing fewer than two million people still working towards independence of some kind.[81]

Other key United Nations activity to address racism includes three consecutive decades of action to combat racism commencing in 1973 and three major global conferences on racism. The 2000 World Conference on Racism in Durban (United Nations, 2001) developed both a Declaration and Programme of Action focussing on the root causes of racism. The Declaration called for the adoption of stronger domestic anti-discrimination laws and policies in an attempt to empower civil society to demand greater accountability for abuses and strengthen targets' grounds for recourse.[82]

The United Nations has also pursued decades of combined diplomatic and political efforts to facilitate the end of the racist apartheid regime in South Africa. The United Nations involvement was initially in response to concerns raised by the Indian government about the situation of Indian citizens living in South Africa (Reddy, 2004, October). Through the course of their involvement the General Assembly: passed multiple resolutions on apartheid, established a centre against apartheid, passed both anti-apartheid conventions (see United Nations, 1973, 1986) and declarations (see United Nations, 1989), and organised sanctions and boycotts. These actions ultimately contributed to the marginalisation of South Africa within the international community. In 1994, a democratic non-racial government was elected and willingly endorsed United Nations human rights instruments.

CERD Monitoring
Under the requirements of ICERD state parties, submit periodic reports to CERD detailing legal, judicial, administrative and other steps taken to fulfil their obligations to eliminate racism. These reports are examined by eighteen independent experts alongside parallel reports from NGOs. Both state party and NGO representatives provide verbal and written reports to the committee and CERD provides feedback on positive action achieved and lists recommendations for remedial action.

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[80] These included Puerto Rico, Soloman Islands, Sierra Leone, Uganda and Zanzibar (United Nations, 2010).

[81] Although others such as West Papua have been taken off the United Nations decolonisation agenda even though they are not independent or self-governing.

[82] Unfortunately much of this discussion, maintains Human Rights expert, Petrova (2010, pp. 131-132), was overshadowed by debate about the Israeli-Palestinian conflict which resulted in walkouts and heated discussion about remedies for historical injustices including the slave trade and colonisation. The 2009 Durban Review Conference in Geneva was beset with similar concerns resulted in a number of state parties choosing to stay away and withdraw from the process (Human Rights Commission, 2010b, p. 6).

The New Zealand government ratified ICERD in 1972[83] and has submitted reports to CERD since 1974, often in the form of consolidated reports. New Zealand (as with other state parties) has only partially implemented the Convention due to the constitutional arrangements and the government's assumption of unitary parliamentary sovereignty. Additionally there is currently no effective constitutional or legislative mechanism in place to prevent parliament, from passing legislation that is racially discriminatory, or to overturn such legislation once it is practiced.

Table 6 summarises CERD's recommendations arising from ICERD reporting and monitoring processes. The recommendations can be grouped in relation to a series of reoccurring themes. These themes pertain to omissions and problems with legislation, compliance with international obligations, and sector specific recommendations to address ethnic disparities. They also cover efforts at reconciliation to alleviate historical injustices, developments in racial climate, technical human rights matters pertaining to implementing the clauses of ICERD, inclusive of the use of special measures.

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[83] This obligation was addressed through the passing of the Race Relations Act 1971.

Table 6: CERD's Concluding Remarks/Recommendations for New Zealand

	1974-1995	1995	2002	2007
Legislation	Recommend: The *Treaty of Waitangi* incorporated into domestic law. Concerned: Consultation with Māori regarding the Treaty principles. Treaty of Waitangi (Fisheries Claim) Settlement Act 1992.	Concern: Treaty of Waitangi (Fisheries Claim) Settlement Act 1992 Implementation Waitangi Tribunal recommendations.	Recommend: Treaty provisions ICERD respected in domestic law.	Recommend: provisions ICERD in domestic law. Treaty into domestic law. Re-engage Foreshore & Seabed legislation.
International	Recommended NZ Active support United Nations anti-apartheid measures. Concerned NZ Sporting contact South Africa breached Gleneagles Agreement.	Recommend adopt optional ICERD article 14.	Recommend: adopt optional ICERD article 14. Implement Durban Program on Racism.	Recommend ratify International Labour Organization Convention No. 169. Implement Durban Program.
Disparities	Concerned social & economic disparities. Employment discrimination & channeling Māori into unskilled occupations. Negative impact of economic reforms on Māori.	Concern: ongoing social & economic disparities & impact economic reforms.	Concern: rights to employment, housing, social welfare and health care. Vulnerability to domestic violence	Concern: administration criminal justice system. Recommend: track racially motivated crime.
Sector Specific	Recommended: Te Reo as an official language, and promote its use in broadcasting & publications. Concern: Number & proportion Māori in parliament and Cabinet. Appropriation Māori land. Ill treatment Māori youth in "at risk" programs and rejection of parallel criminal justice system.	Recommend: Independent complaint authority for prisons.	Concern: Low representation of Māori women across some sectors. High levels of incarceration Māori.	Recommend: *Treaty of Waitangi* in school curriculum.
Historical	Concern with compatibility "fiscal envelope" policy with provisions of the *Treaty of Waitangi*.	Concern:"Fiscal envelope" Consultation with Māori and sale of Crown-owned assets.		Recommend: resource Waitangi Tribunal & expand powers. Ensure cut-off date historical claims not unfair.
Human Rights	NZ non-complaint through not declaring racist organisations illegal. Lack prosecutions. Concern: Independence of Race Relations Conciliator.	NZ non-compliant: prohibit organisations incite racial hatred.	Recommend: remove barriers to prosecuting those inciting racial hatred.	Recommend: NZ government adopts an action plan for human rights. Make complaints processes more accessible.
Racial Climate	Ill advised decision to precede Springbok Tour against HRC advice.			Recommend: facilitate an informed public discussion status of *Treaty of Waitangi.*
Special Measures	Concern: Māori educational attainment, vocational training & housing. Representation Māori in senior roles within public sector. Proportional voting system. Māori artifacts and works of art.	Concern: educational attainment.	Concern: complaints review Tribunal narrow interpretation of special measures.	Concern: lack of distinction special measures versus permanent indigenous peoples' rights. Review special measures in public.

Note. Adapted from *Concluding observations of the CERD on New Zealand* (No.18A/9816(1974); (A/31/18+Corr.1(1976); (A/34/18(1979); (A/36/18(1981); (A/39/18(1984); (A/42/18(1987); (A/45/18(1990); (A/57/18(2002); (C/NZL/CO/17) 1974-2007, New York, NY: United Nations.

Over the last thirty-year reporting period, CERD has consistently offered recommendations related to the implementation and the resolution of breaches of

the Treaty of Waitangi. These recommendations include the need to incorporate the Treaty into domestic law, queries around the fairness of treaty settlement processes and the plethora of ethnic disparities across a range of government activities. New Zealand continues to be non-compliant to components of the ICERD regarding the prosecution and prohibition of organisations that incite racial hatred. Additionally New Zealand has not adopted the mechanism to enable people detrimentally affected by actions or the intended actions of a state party to contact directly the committee. Other historical matters have however been resolved.

CERD concluding observations have consistently identified remedial actions for New Zealand to minimise racial discrimination. These remedies are both structural in nature calling for elevation of the Treaty within constitutional arrangements and systemic in nature calling for action to address ethnic disparities. The extent, scope and persistence of these recommendations raise questions as to the ability of the New Zealand government to abide by its ICERD commitments.

Indigenous Peoples' Rights

> We must all be cognisant of the fact that the United Nations is an international organization controlled by existing nation-states, who are largely controlled by the same colonial attitudes that have repeatedly ignored, devalued or otherwise violated our [indigenous people's] fundamental human rights (Dorough, 2001, p. 110).

Indigenous people's advocacy for collective rights utilising global forums predates the development of the United Nations system, with indigenous deputations raising concerns through its predecessor the League of Nations (Durie, 2004). The formative stages of the United Nations were silent on the experiences of indigenous peoples as Charters and Stavenhagen (2009, p. 10) contend in their history of indigenous peoples' rights:

> ...the situation of indigenous people was [considered] solely the concern of states and that, as long as governments adhered to the general principles of universal individual human rights, there was no role or responsibility for the United Nations.

Increasing international awareness of indigenous issues in the 1970s and expressed concerns about racism led the United Nations to commission a substantive decade-long study (Cobo, 1983) into discrimination against indigenous peoples. The study catalogued a wide variety of state actions that were unfair and concluded that continuous racism against indigenous peoples threatened indigenous survival. The Cobo study led directly to the establishment of a United Nations Working Group on Indigenous Peoples. Prior to this forum Willemsen-Dias (2009, p. 25), a United Nations insider asserts indigenous issues received 20-40 minutes of attention annually. The working group, in a significant

and unprecedented move for the United Nations, accredited indigenous representation to attend, prepare papers and proposals at this forum.[84]

The mandate of the group was to review developments pertaining to promotion and protection of indigenous peoples' rights and develop standards to address these. By the 1990s, membership in this forum swelled to approximately a thousand participants, and a global indigenous peoples' rights movement has developed (Willemsen-Dias, 2009, p. 27). The working group was responsible for the preliminary work on the draft *International Declaration on Rights of Indigenous Peoples*. They also initiated several substantive studies on areas of concern to indigenous peoples on issues ranging from health, land and sustainable development, to language, education and treaties.[85]

Other actions by the United Nations to address the aspirations of indigenous people include the dedication of 1995-2004 as an international decade for the world's indigenous peoples.[86] The culmination of this decade saw the establishment of a permanent forum on indigenous issues to ensure the systematic exchange of information between governments, United Nations bodies and indigenous peoples. This forum has a contested mandate to support research and policy-making in relation to indigenous peoples for nation states. Briefings at the inaugural meeting, according to attendees, Alfred and Corntassel (2004, p. 3), made it clear the forum was not a place to 'complain', that is table human rights abuses, nor engage in political debate such as issues of indigenous sovereignty. The structure of the forum means:

> ...delegates attending the Permanent Forum have approximately three minutes to convey the needs of their communities within pre-determined topic headings such as "Health", "Environment", and, "Economic Development" (p. 3).

Alfred and Corntassel assert that even as a permanent organ within the United Nations system the forum "...provides no formal recourse for Indigenous delegates to remedy human rights violations occurring within their communities".

Declaration on Indigenous Peoples' Rights

> As someone involved in this process [the development of the United Nations Declaration on the Rights of Indigenous People], I found myself before a half closed door, one that did not wish to exclude anyone but which, however, prevented passage. I gave it a gentle nudge, and with some difficulty opened it a little. I will forever be thankful for that nudge because it opened up the possibility

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[84] A travel fund was also developed to enable indigenous participation.
[85] Willemsen-Dias (2009, p. 25), who worked on the document, forty years on recently confirmed that the issues raised then still have relevancy and currency in the lives of indigenous peoples now.
[86] Disappointingly only limited funding was made available to finance indigenous activities and programmes to mark the decade. Alfred and Corntassel (2004, p. 2) quote the figure of US $185,162 by 2003.

of thousands of people crossing that threshold, people representing the more than 300 million human beings whose rights were being violated and who needed to act to overcome this situation (Willemsen-Dias, 2009, p. 30).

The first chair of the Working Group on Indigenous Populations, Eide (2009, p. 41) upheld that indigenous peoples historic experience of governments has been problematic, with changing policy and even constitutions. International recognition of the right to self-determination within the Declaration he argues provides flexibility and bargaining power to mediate complex relationships between indigenous peoples and states. Negotiated over a twenty-year period, the Declaration[87] outlines a comprehensive platform of civil, political, economic, social, cultural and environmental rights (see Table 7). It justifies indigenous peoples' claims to far-reaching autonomy and control over lands, affirms the power of veto over development projects, and upholds claims for restitution and/or compensation.

Table 7 Overview of Declaration of Indigenous Rights

All human rights	Self-determination & autonomy	Maintenance indigenous instiutions	Collective right to live in freedom, peace & security	Not to be subjected to forced assimilaton or relocation
Redress cultural, intellectual, religous & spiritual property taken	Cultural, spiritual & lingusitic identities	Participate in decision-making & States consult in good faith	Traditional medicines & own media	Land, territories & resource rights
	Enforcement of treaties	UN and its bodies promote application of Declaration	These are minimum standards	

Note. Adapted from *United Nations Declaration on the Rights of Indigenous People s* by United Nations, 2007, New York NY: Author.

The majority of the opposition through the negotiation of the Declaration came from the New Zealand, the United States and Australian and to some extent the Canadian governments. Their opposition related to the inclusion of the right to self-determination (article 3), the right of veto (article 19) and concerns about possible land claims relating to lands 'lawfully' owned by other citizens (article 26) (Australian, New Zealand, & United States delegations, 2006). During the negotiations, indigenous advocate, Henricksen (2009, p. 80) contends, many governments viewed collective indigenous peoples' rights, in particular the right of self-determination, as challenging existing unitary political and legal structures based on the notion of individual human rights. This tension remains under active debate within the objecting states despite those governments formerly opposed now offering their qualified support of the Declaration.

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[87] Within the context of the UN system a declaration is an aspirational statement by the General Assembly about a significant matter and is not legally binding.

According to Carmen (2009, p. 94) the Declaration has already been used to good effect by the Yagui indigenous people in Mexico in their fight against the use of pesticides.[88] Reports from Australia are less promising with the Aboriginal and Torres Strait Islander Social Justice Commissioner (2009, p. 137) raising significant concerns about the slowness of the Australian government in implementing the Declaration. Likewise the New Zealand Prime Minister, Right Hon. John Key has publicly stated (see Watkins, 2010, April 20) New Zealand's endorsement of the Declaration is both conditional and symbolic. The potential impact of the declaration remains unclear at this time.

5.4 Treaty Obligations

> The Treaty of Waitangi is New Zealand's own unique statement of human rights.
> It includes both universal human rights and indigenous rights. It belongs to and is
> a source of rights for all New Zealanders
> (Human Rights Commission, 2010a, p. 40).

Te Tiriti o Waitangi (as introduced in chapter one) is the primary treaty relevant to institutional racism against Māori in Aotearoa. To recapitulate, it established the terms and conditions of non-Māori settlement, the Māori text affirmed Māori tino rangatiratanga, provided Māori with the same rights and privileges as British citizens, promised to protect Māori taonga and clarified kāwanatanga arrangements. The New Zealand government therefore had, and has, the responsibility to mind the interests of all New Zealanders while simultaneously having particular obligations to address the interests of Māori. I contend that if such commitments had been upheld institutional racism would not be detectable within Crown practice. Within the context of Aotearoa, this makes Te Tiriti potentially a significant control on state racism.

Up until May 2011, there were 2,239 claims lodged with the Waitangi Tribunal (Crown official, personal correspondence, May 17, 2011). These claims outline how the claimants allege they have been prejudicially affected by the policies, practices, actions and omissions of the Crown. Statements of claims must pertain specifically to the actions of a Crown Minister or a Crown official acting on their behalf. Broadly, all of these claims are allegations of institutional racism against the Crown. The following subsection examines the major themes of health related Waitangi Tribunal statements of claim.

Health Related Waitangi Tribunal Claims

> Mainstream public health services run by the Crown have systematically failed to
> address this health inequality and thus have breached our article iii rights to enjoy
> the same health status as non-Māori
> (Hodges & MacDonald, 2008, August, p. 1).

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[88] They have successfully cited article 29 which requires states to secure the free, prior and informed consent in the storage or disposal of hazardous waste on indigenous lands.

An enquiry to the Waitangi Tribunal confirmed that as of April 2011, there are eighty-nine deeds of claim related to health (Crown official, personal conversation, April 15, 2011).[89] Whānau, hapū and iwi and Māori communities lodged these claims from 1984 through to the most recently in 2008. Some of these claims substantially relate to health sector activity, others having more indirect links.[90] These are claims are either predominately historical or more contemporary in their focus. The following sub-section outlines the major themes of these health related Waitangi Tribunal claims.

Historic Claims
Many of the identified claims were comprehensive in nature, and related to the historical alienation of whenua from whānau and hapū, and the disruptions of customary practices of land tenure. Several claimants explicitly noted the acts of war initiated by the Crown in pursuit of land and the resulting loss of life.

The decimation of the Māori population through the introduction of alcohol, tobacco and new diseases was identified as a direct negative health impact of Crown practices. Mihinui (2000) in her claim cited the contribution of the Crown to the spread of tobacco amongst Māori communities. Maniapoto, Maniapoto and Haereroa (2008) cited the breach of Te Rohe Potae compact by the Crown, which for some time had kept alcohol out of the King Country. Within their claim (2008, p. 6) they suggest Crown practices both impaired and damaged "...the spirit, wairua, mana and ihi (essential force) of the hapū and its members".

Within the health-related claims, many represented the Crown as being an active agent in the undermining of Māori rangatiratanga and traditional practices. Within the Whanganui Mana Wahine (Waitokia, 2008, p. 2) deed of claim they describe how the Crown forced "...cultural, political and social, and economic systems [over Māori women] which effectively alienated their authority over their properties and resources and diminished their way of life".

Claimants also outlined the Crown's failure to uphold and recognise traditional holistic health and healing practices. A low-point of this approach was seen as the criminalisation of traditional healers through the Tohunga Suppression Act 1907. Tangiahua (2008) in her deed of claim on behalf of Ngāti Hauiti argued traditional Māori practices of health and healing were subsumed by mono-cultural western traditions. Wolfgramm et al. (2008, p. 5) explain:

> The new settlers denigrated Māori knowledge and understanding of the world and the natural, spiritual and social environment to the dimension of myth, legend and superstition, dehumanizing Māori and promoting a belief

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[89] See appendix J for a log of the health related claims logged with the Waitangi Tribunal.
[90] In reviewing, the correspondence related to the claims a number of claimants have died without their cases being resolved.

they (Pākehā) are superior and therefore have greater rights to resources and services.

A range of claimants expressed concerns about the inadequacies of the Crown's health service delivery to Māori. Echoing the concerns raised by Tangiahua, many were troubled about the failure of the generic health system to address the wairua, tinana, whānau and hinengaro (emotional) health needs of Māori. Others felt the Crown had failed to provide health services consistent with Māori culture and tikanga. The marginalised of Te Reo within the public health system and beyond was also considered problematic.

In his deed of claim, General Practitioner, O'Sullivan (2008) noted the lower hospitalisation and treatment rates of Māori (compared with non-Māori) in accessing health services. Wolfgramm et al. (2008) reiterated this in relation to each point of the continuum of care from accessing screening, screening to diagnosis, diagnosis to treatment and treatment completion to rehabilitation and care. Others specifically named the lack of access to preventative education and programs experienced by whānau and hapū.

Te Rarawa (Piripi, 2008) in their deed of claim identified poverty and high unemployment as barriers to Māori accessing services available to the general population not addressed by the Crown. Others noted the prevalence of personally mediated racism within the [generic] health system that was likely to impact on clinical decision-making. The influenza epidemic, and subsequent tuberculosis and typhoid outbreaks reinforced for some the failure of the Crown to provide adequate health services.

Contemporary Claims

Many of the contemporary health related claims cited the compromised socio-economic position of hapū resulting from Crown practices of colonisation, assimilation and neo-liberalism. Several claimants alleged that the Crown created an environment of deprivation, which increased the exposure of Māori to the determinants of ill health. O'Sullivan (2008) maintains that access to education, employment, income, housing, income support and health literacy are often compromised for Māori. Others uphold that particularly rural Māori live in the absence of the most basic of resources such as clean running water and appropriate sanitary arrangements. Exposure to addictive substances such as nicotine and alcohol were also highlighted. Hodges and MacDonald (2008, August) claim that the economic reforms and the subsequent welfare policies of the 1980s and 1990s exacerbated this deprivation.

Inequities in health outcomes between Māori and non-Māori are well recognised within health literature (see Pōmare, 1980; Pōmare & De Boer, 1988; Pōmare et al., 1995; Robson & Harris, 2007) and were included in many contemporary deeds of claims. Some claimants included morbidity and mortality rates, while

others cited infectious diseases, cardiovascular and coronary heart disease, dental health, mental illness, injury, cancer and diabetes rates.

Many claimants did not see health policy as reflecting Māori worldviews or Māori health needs. Cotter, Emery and Hemopo (1998) assert health policy has simply failed to address worsening Māori health status. Where pertinent policy does exist, both McLean (2003) and Hemopo (1994) within their claims allege Crown practice is not consistent with its own policy directions. They cite deviations from both *He Korowai Oranga* (A. King & Turia, 2002) and *Whai Te Ora Mo Te Iwi* (Department of Health, 1993) respectively.

Claimants also included both broad references to flawed Crown consultation and governance arrangements and outlined concerns that are more specific. Several deeds of claims were lodged in relation to the closure of the Gisborne Hospital (see Cotter et al., 1998) and by urban Māori groups (see W. S. Kingi, Tawhai, & Kingi, 2008) who maintain they were excluded from decision-making. Concerns were also expressed about lack of Māori representation in health governance and senior management across a succession of Crown agencies administrating the health sector.

Some claimants allege a systemic pattern of the Crown under-funding Māori health services. Paki (2008, p. 2) in his deed of claim argues "the Crown has continued to cut and under fund health services to Māori and in areas which Māori are highly represented, the evidence of which includes lack of diabetes screening, management, and screening for and treatment of heart disease". Both Mihinui (2000) and Hohepa-Birks (1994) allege the Crown has ignored kaupapa Māori evidence while making funding decisions. Other deeds of claims raise concerns about the failure of the Crown to monitor mainstream service delivery to Māori.

Some claimants made explicit but more often implicit allegations of institutional racism against the Crown (see Mullen-Mack, 2002; Paki, 2008; Waitokia, 2008). Wolfgramm et al. (2008, p. 9) explain:

> Systemic and institutional prejudice is evident through most components of the health system in Aotearoa and is evidenced daily throughout the country.

Within chapters eight and nine those claims that directly relate to health policy and funding practices will be outlined and woven through counter narratives and related evidence.

5.5 Summary
According to a desktop review of Crown documents, New Zealand appears to have a plethora of controls to sustain ethical conduct of Crown officials and theoretically to prevent systemic discrimination. Grounded in the principles of

control, guidance and structure these controls range from intricate procedures, legislation and regulation guiding officials' practice, to pathways for the public to scrutinise Crown activity and lodge complaints and concerns about institutional racism in assorted fora. These controls on Crown officials are overlaid with a domestic human rights framework and an independent human rights agency which is currently prioritising addressing structural racism.

To date these controls have not been effective in preventing institutional racism within the New Zealand as demonstrated in *Puao Te Ata Tu* (Ministry Advisory Committee, 1988) and *He Whāipanga Hou* (Jackson, 1988) and I assert from the findings of this study. Despite the sanctions available within the public service through the course of this study I found no evidence of there being any negative consequences for any Crown official for their involvement in perpetuating institutional racism.

Unique to New Zealand is the obligations on the New Zealand government to uphold *Te Tiriti o Waitangi*. Decades of independent Waitangi Tribunal reports demonstrate a colonial legacy of racism that remain ongoing through the lodgement of contemporary claims around the administration of the health system, institutional racism and entrenched inequitable health outcomes.

Beyond Te Tiriti there is an intricate web of international controls in place developed to moderate the behaviour of state parties to minimise and/or prevent systemic racism. Amongst the most ambitious controls has been both the ICERD and *Declaration on the Rights of Indigenous Peoples* developed within the United Nations. A review of state party reporting against the ICERD shows consistent breaches of the Declaration and the need for remedial actions to achieve compliance by many governments, including New Zealand.

Within the next chapter I draw attention to traditions of public health as a platform for exposing the dominance of western bio-medical analysis within health policy.

CHAPTER SIX: TRADITIONS OF PUBLIC HEALTH

6.0 Introduction

> Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health (Commission on the Social Determinants of Health, 2007, p. iv).

In her much-utilised public health textbook, *The New Public Health*, Baum (2008) argues that the term 'health' carries with it much cultural, social and professional baggage. She argues discourses of health are crucial in that they inform the shape of health systems, policy directions and ultimately the funding and delivery of health services. However, until the mid-twentieth century, western discourses about health were overwhelmingly dominated by bio-medical discourses, equating health with the absence of disease (Foucault, 1994; Pōmare, 1986). These views contrast sharply with eastern constructs about the role of energy, and the nature of disease transmission and wellbeing. Indigenous definitions such as those espoused by Durie (1994b) and C. Cunningham (2009) are broader still, inclusive of spirituality, collective notions of wellbeing and emphasise the inter-connectedness of all things.

Among the most widely cited definitions of health is that of the World Health Organization (WHO). Their constitution (1948, p. 1) states: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Collectively these competing discourses, and the multiplicity of responses to perceived deviations from what is considered normal or healthy according to the prevailing wisdom about the human body and mind, make for complex personal[91] and public health[92] systems.

In this chapter I introduce the field of public health, as a backdrop to enable a more specific analysis of how racism manifests within public health policymaking and funding practices. Firstly I describe indigenous traditions of health and wellbeing and then provide an overview of the development and the commonly accepted characteristics of generic global public health purportedly to be universally valued. This overview provides a backdrop to an exploration of contemporary traditions of public health as practiced in Aotearoa.

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[91] Personal health in this context is referring to primary, secondary and tertiary treatment services whether publicly or privately owned.
[92] Public health within this context refers to programmes and interventions designed to protect and promote good health within populations of people not at an individual treatment level.

6.1 Indigenous Public Health

> Indigenous Peoples' concept of health and survival is both a collective and an individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are spiritual, the intellectual, physical and emotional. Linking these four dimensions, health and survival manifests itself in multiple levels where the past; present and future co-exist simultaneously
> (Committee on Indigenous Health, 1999, p. 3).

Indigenous models of public health generally recognise that health is intimately linked to indigenous world views and development (Durie, 2004). M. Cunningham (2009, p. 155) in her review for the United Nations, contends customary practices are based on indigenous communities seeking to maintain interior and exterior equilibrium and harmony between community members and the cosmos around them in a combination of practices and knowledge based about the human body, nature and spirituality. In a statement to the United Nations the Osiligi peoples from Kenya (1998), p. 1) explain:

> Indigenous people's health issues and other problems cannot be separated from the critical and related problem of continued dispossession and alienation from their traditional lands and land resources. Indigenous health relates to our spiritual and cultural expression.

The North American "medicine wheel" reflects indigenous holistic, spiritual philosophies and beliefs (Dapice, 2006). There are many variations in medicine wheels (see Figure 10) but they often have distinct coloured quadrants which pertain to the four dimensions of life. Medicine wheels continue to be used for various astronomical, ritual, healing and teaching purposes, including as the basis of individual and community level health interventions (Eaton, 1994; M. King et al., 2009).
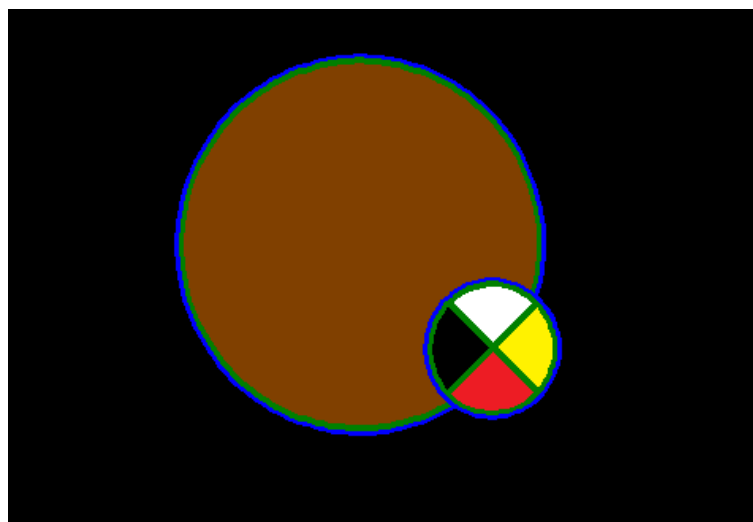
Figure 10: **Creation Story**

This representation of the medicine wheel, entitled the creation story, was developed by Don Lemieux[93] which shows the relationship of the Anishinaabe people with the earth the larger orb and the creator, - black background and the need to live in harmony with other races, - four colours of the medicine wheel, and spirits, - various colours, that exist in this realm. Used with permission.

The relatively strong health status of indigenous peoples prior to European contact, the impact of colonisation and the resulting collapse in indigenous health status brought on by infectious diseases, warfare and urbanisation and land alienation are well documented (see Bird, 2002; M. Cunningham, 2009; Durie, 1994b; Gracey & King, 2009). The legacies of these common experiences across indigenous health, particularly for those, that are a minority population within their own lands, are being increasingly linked by health researchers such as Anderson et al. (2006) and Cohen and Northridge (1999) who offer contemporary examples of life expectancy and quality of life discrepancies between indigenous and non-indigenous peoples.

Around the world, indigenous peoples are at various stages in terms of reclaiming political power and rebuilding infrastructure and capacity to lead their own development (Department of Economic and Social Affairs, 2009). There remain considerable ongoing challenges in terms of revitalising indigenous languages and securing the return of misappropriated lands. Cunningham (2009, p. 181) and King, Smith and Gracey (2009, p. 76) contend that the restoration of indigenous wellbeing is inextricably linked to decolonisation processes, and the enactment of indigenous self determination.

Indigenous responses to health and wellbeing challenges are diverse. The advent of globalisation there is increasing cohesion within the indigenous peoples' rights movements as demonstrated with the collaboration over the *Geneva Declaration on the Health and Survival of Indigenous Peoples* (Committee on Indigenous Health, 1999) and more recently the *United Nations Declaration on the Rights of Indigenous People*. Through the Geneva Declaration indigenous peoples called for increased investment in indigenous health, advocating for indigenous led and controlled services delivered from an indigenous epistemology. Alongside this call are demands for constitutional and legislative reforms by state parties and a commitment to reduce the inequities accompanying globalisation.

Indigenous researchers have raised a number of high-level concerns related to indigenous health planning. Nettleton, Napolitano and Stephens (2007), Te Rōpū Hauora o Eru Pōmare (2002) supported by departments within the United Nations (Department of Economic and Social Affairs, 2009) have all tabled concerns around the lack of robust processes in the collection of ethnicity data pertaining to indigenous peoples rendering the experiences of indigenous people invisible within much state level analysis of morbidity and mortality. This distorts the evidence base upon which health planning is based. Similarly indigenous health

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[93] Don Lemieux is a member the Bad River band of the Lake Superior Chippewa.

researchers Chino and De Bruyn (2006, p. 596), Reid (2002b) and E. Pōmare (1986, p. 411) question the effectiveness of generic health models and interventions in meeting the needs of indigenous peoples. They call for greater state accountability about effective service delivery to indigenous peoples, and assert their right to monitor the Crown. Considerable intellectual energy has also been invested in isolated holistic indigenous measures of health status to convert mono-cultural bio-medical measures of indigenous wellbeing into more culturally responsive practice (see Durie, 2005, April; Durie et al., 2002; Durie, Fitzgerald, Kingi, McKinley, & Stevenson, 2003).

Māori Public Health

Durie (2001) holds that there are diverse Māori realities and different whānau, hapū and iwi have distinct traditions and approaches to health and indeed Reid (2002b) argues that there is much still to be written about Māori health. Based primarily on the writings of Durie (1994, 1999, 2001, 2004) and Ratima (2001), in this section I contend that there are two distinct manifestations of public health practice - customary and Māori health development. The former predominated in the period prior to colonisation and into the early nineteenth century with an emphasis on the interconnectedness of all things and maintaining balance. The latter is influenced by affirmations of Māori sovereignty, modern traditions of hapū development, and the evolution of western public health traditions.

Māori Customary Approaches

Māori have long traditions in public health grounded in collective whānau lifestyles and intimate spiritual and practical connections with the natural environment. The application of tikanga minimised disease and injury. Codes of behaviour governed by tapu, noa and rāhui (restrictions) were used to ensure survival, by protecting water supplies, food sources and the safety of whānau (Durie, 1994b; Ratima & Ratima, 2003). In the absence of written laws, the conferment of tapu was a powerful public sanction to limit personal and community activities. Durie (1994b, p. 10) explains:

> The balance between tapu and noa was a dynamic one, moving to accommodate seasonal, human and physical needs within a value system that was sufficiently holistic to accommodate health interests.

Pā (village) sites were selected based on consideration of drainage, dampness and military advantage while the use of pātaka [raised food storage] kept food rodent free.

Recognising the importance of water for survival, Durie (1994b, p. 13) notes, Māori developed different classifications[94] of water, which helped prevent water-borne disease. A range of traditional healing practices were also developed, from

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[94] These types include waiora (rainwater), waipuna (hillside spring), waimāori (running streams), waikino (stagnant pools), waimate (downstream sites) and waitai (saltwater).

ritenga (customs) and karakia (incantations and rituals), rongoā (physical remedies), mirimiri (massage), wai (use of water to heal) and surgical interventions (Ahuriri-Driscoll et al., 2009; Durie, 1994b). Early Pākehā commentators were unanimous in their praise of the Māori health system (Reid, 2002b, p. 52). Captain Cooks' chief science officer, Banks (as cited in A. Salmond, 1991, p. 279) recorded at the time: "such health drawn from so sound principles must make physicians almost useless". Reid (2002b, p. 61) cites the example of the development of a recipe that transforms highly toxic karaka berries into a safe food source as evidence Māori conducted some forms of 'clinical trials'. The writings of Māori health pioneer Hon. Te Rangi Hiroa[95] (1950) outlined elaborate indigenous systems, overlapped with contemporary western ideas of infection control and disease prevention. Demographer, Pool (1991) asserts that for hundreds of year's tikanga based systems proved effective public health measures.

By the beginning of the twentieth century, Māori wellbeing was compromised through the profound health impacts of colonisation. Kunitz (1994), from his examination of the impact of Europeans on several Polynesian peoples, noted that the alienation of land by making Māori poor also made them susceptible to diseases that flourish under conditions of poverty, overcrowding, and malnutrition. Land alienation disrupted social networks that provided practical and emotional support. These circumstances presented complex challenges to both customary Māori and generic health systems.

At the turn of the twentieth century, within the newly formed Department of Health and through Māori leaders like Hon. Maui Pōmare, an innovative ecological approach to health was embraced. M. Pōmare championed using Māori community leaders as sanitary inspectors, influencing positively on rebuilding and strengthening Māori health infrastructure (Lange, 1999). Customary codes of tapu and noa were however being replaced[96] with health regulations and statutes of the new settler government. Critically, M. Pōmare also linked poor health with socio-economic adversity and advocated for a political commitment to health at the highest level. He championed targeted and cultural relevant programs and emphasised the need to develop a skilled health workforce. Durie (1999) argues this approach still holds relevance within Māori public health a century later.

Māori Health Development

> The starting points for Māori health promotion are Māori responsive frameworks, with Māori needs, preferences, and aspirations at the centre
> (Ratima, 2001, p. 228).

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[95] Te Rangi Hiroa is also known as Sir Peter Buck.
[96] Tapu was retained as a means of environmental management of wāhi tapu (burial grounds) and at the marae.

Contemporary Māori public health contains elements that are uniquely based on mātauranga Māori but also draws on the traditions of Māori development and generic public health (Pōmare, 1986). In keeping with a kaupapa Māori approach, E. Pōmare (1986, p. 410) asserts, the observation of Māori protocols and engagement with kaumātua and kuia for support, guidance and sanction is common across much Māori public health practice. This tradition is frequently delivered by Māori practitioners from Māori organisations and is assumed inseparable from wider Māori social, economic, political and cultural realities.

Reid (2002b, p. 59) suggests a contemporary turning point in Māori health came with the consolidated political push for pro-active Māori development in the 1970s and 1980s. At a key national Māori health hui, Hui Whakaoranga (Department of Health, 1984, March), Reid maintains, Māori commentators noted the inadequacies of western concepts of health and advocated for greater recognition of culture as an integral part of wellbeing. This increased awareness led to the development of a series of influential Māori health models most notably, *Te Whare Tapa Whā*[97] (Durie, 1994b) and *Te Wheke*[98] (Pere, 1991), which emphasised the importance of culture, the interconnectedness of emotional and physical health and the importance of whānau and spirituality.

Currently the most widely used Māori public health framework is *Te Pae Mahutonga* (Durie, 1999). Developed by Durie, it builds on the contributions of Pōmare (see Cody, 1953) and the Ottawa Charter (World Health Organization, 1986, November). Using an indigenous icon (see Figure 11), the model represents the key elements of health and the key capacities needed to strengthen them. Durie (2004, p. 16) describes it as a "…schema to identify the parameters of practice, and to signpost strategic directions to be pursued by states, the health and education sectors, and indigenous peoples themselves". He emphasises the need for deeper discussions to occur around Māori health, as part of wider debate about culture, the environment, constitutional arrangements, socio-economic realities and indigenous leadership.

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[97] *Te Whare Tapa Whā* articulates an ideal concept of health emphasising the balance between wairua, hinengaro (mental and emotional aspects), whānau and tinana (physical realm).
[98] Te Wheke is holistic in nature and inclusive of elements of *Te Whare Tapa Whā* also raises notions of diversity, vitality, and continuity between the past and present.

Figure 11: **Te Pae Mahutonga**
Adapted from "Te Pae Mahutonga: A model for Māori health promotion" by M.H Durie, 1999, *Health Promotion Forum Newsletter*, p.2-5.

Ratima (2001, p. 239) argues Māori public health is characterised by being both committed to emancipatory goals and being ideologically motivated. She suggests its core values focus on strengthening Māori identity, collective autonomy, social justice and equity. She isolated six principles (see Table 8) which exemplify Māori public health. She concludes her study (2001, p. 234) by defining Māori public health as "...the process of enabling Māori to increase control over the determinants of health and strengthening their identity as Māori and thereby improve their health and position in society".

Table 8: Principles of Māori Public Health

Principle	Description
Holism	Recognises the interconnections of the past, present and future. Emphasises importance of intergenerational connections. Continuity between spiritual and material realms.
Self-determination	Māori right to control their own future in all domains and at all levels. Formal accountability to Māori communities. Māori initiation, ownership, management and delivery.
Cultural Integrity	Interventions that affirm and strengthen Māori identity and reinforce Māori cultural values and practices. Developing a culturally competent workforce.
Diversity	Mindful of diverse and dynamic Māori realities.
Sustainability	Durability of solutions not quick-fix solutions. Welfare of future generations not compromised by the interests of the current generation.
Quality	Meet high technical and cultural standards. Credible in Māori terms and meet Māori expectations. Systematic collection of accurate and relevant information for planning and evaluation.

Note. Adapted from *Kia urūru mai a hauora: Being healthy, being Maori: Conceptualising Maori health promotion,* (doctoral dissertation) by M. Ratima, 2001, Wellington, New Zealand: Otago University. Reprinted with permission.

Ratima (2001) and Durie (1994b, 2004) concur that Māori public health is strongly linked to whānau, hapū and iwi development. Ratima argues the links are

present in the shared purpose, value-base, processes, principles and strategies utilised across both disciplines. The drive of both is to achieve Māori potential. The point of difference, asserts Ratima, is the breadth of their focus. Durie (1994b, p. 1) emphasises the importance of Māori control and agency across both disciplines, i.e. defining one's own priorities and then weaving a collective pathway to achieve those aspirations. Puketapu (2000, pp. 126-127) reinforces that Māori development is the prerogative of Māori and "…there is no compelling reason for Māori to depend exclusively on the Treaty partnership as the basis for Māori development planning, policy and programmes".

The emergence of Māori providers within the public health system from the 1990s has been central to Māori health development. Rather than focus exclusively on health, providers often deal holistically with social, economic and cultural areas of life, sourcing funding from various Crown agents and through entrepreneurial activity. Cram and Pipi (2001, p. 25) in their study of Māori providers success recognised consistency, trustworthiness and accountability as key success factors. Provider credibility was achieved through ongoing engagement with communities, a strong cultural base and the commitment of skilled staff to the kaupapa (purpose) of the organisation. One of the participants in their study (2001, p. 28) explains:

> It's about serving the people. The critical failure is about not losing sight of why you're there. The only thing that makes you strong is the number of people that stands behind you, the number of people that you've served well. If you lose sight of that, you're just an individual, waiting to be plucked off.

There is a plethora of emerging evidence to demonstrate the effectiveness of Māori public health interventions engaging Māori whānau. One of the most prominent successes has been the national aukati kaipaipa tobacco cessation programme, delivered by Māori providers. It has achieved some of the highest quit rates in the world (Dowden & Taite, 2001). Māori health researcher, Henwood's (2007, p. 7) review of the five Te Tai Tokerau based korikori a iwi exercise and nutrition programs found alongside anticipated attributable health outcomes, "…spin-offs were identified in education, community and whānau/hapū wellbeing and development, and longer-term economic development and tourism opportunities". Tipene-Leach, Abel, Haretuku and Everard (2000) have linked the development of a national Māori Sudden Infant Death Syndrome (SIDS) programme to improved awareness levels of SIDS within Māori communities, enhanced research and evidence base and reduced SIDS rates.

In summary, Māori public health is about Māori control and interventions developed with whānau and hapū that are relevant and embedded within Māori cultural, political, spiritual, economic and social realities.

6.2 Generic Global Public Health

> Public health is a political activity because it is about change, and its history shows that public health actions are expressions of prevailing political ideologies, the beliefs of those in government and the extent to which formal power holders are influenced by interest groups
>
> (Baum, 2002, p. 61).

Within western traditions, public health pioneer, Winslow (1920, p. 23) defines public health as: "...the science and art of preventing disease, prolonging life, and promoting health through the organized efforts of and informed choices of society, organizations, public and private, communities and individuals". This widely used definition captures the contribution of public health to the key realms of communicable disease prevention, policy development and its engagement with local communities.

Epidemiologists Beaglehole and Bonita (2004) contend [generic] public health is a primary function and responsibility of the state. Public health, they argue, has a prevention orientation. It is concerned with minimising risk factors, addresses the determinants of health, and has a multi-disciplinary base and emphasises both collective responsibility and partnerships with communities. Laverack (2005), Labonte (1997), Raeburn and Rootman's (1998) all argue that the elements of empowerment and social justice are also key to contemporary manifestations of public health practice.

The WHO (2008, p. 3) through an analysis of forty-one countries have defined a collection of essential public health functions. These functions (see Table 9) are a set of actions, that state parties should provide which are fundamental to improving, promoting, protecting and restoring the health of the population. The functions provide useful insight into what state parties consider core [generic] public health activity. From a New Zealand public health perspective, notably absent in their analysis is an explicit commitment to prioritising indigenous health.

Table 9: Essential Functions of Public Health

1.	Monitoring, evaluation and analysis of health status.
2.	Surveillance, research and control of the risks and threats to public health.
3.	Health promotion.
4.	Social participation in health.
5.	Development of policies and institutional capacity for public health planning and management.
6.	Strengthening of public health regulation and enforcement capacity.
7.	Evaluation and promotion of equitable access to necessary health services.
8.	Human resources development and training in public health.
9.	Quality assurance in personal and population-based health services.
10.	Research in public health.
11.	Reduction of the impact of emergencies and disasters on health.

Note. Adapted from *The essential public health functions as a strategy for improving overall health systems performance: Trends and challenges since the public health in the Americas*

Within this section I examine the origins of generic public health and influenced by Baum's (2008) conceptualisation, I outline the origins of generic public health. I then examine medical, behavioural and socio-environmental traditions of public health.[99]

Origins of Generic Public Health

Early public health decision-makers were concerned with where and how to bury the dead, isolating people with leprosy and quarantining ships suspected of carrying diseases (Rothstein et al., 2003). There were two rival theories as to how disease was spread. Miasma theory suggested disease resulted from inhaling bad smells from filth. The germ or contagion theory held that pathogens caused disease. These different understandings impacted on approaches taken to public health interventions. Experiences in early nineteenth century Europe, combating the waterborne sanitation diseases of cholera and typhoid brought on by rapid industrialisation and urbanisation led to the development of more systemic approaches.

Baum (2008, pp. 18-19) identifies several distinct stages within the early development of generic public health: the colonial, nation-building, affluent and medicine eras. The emergence of epidemiology, the study of disease patterns across populations, rapidly became a dominant consideration in public health decision-making. The ability to quantify mortality and morbidity, identify disease and isolate injury enabled a plethora of insight into how to prevent and manage disease.

Environmental reforms and learning to manage the threats of epidemics and pandemics was the primary focus of the colonial era. Reynolds (1989) argues legislation became the main instrument in enabling these reforms. For instance Snow, a London physician utilised the Public Health Act (UK) 1848 to remove the handle from a water pump on Broad Street as he believed it was a source of cholera infection. During this era the poor were often constructed as the cause of diseases. The writings of political theorists, Engels and Virchow as early as the 1840s challenged this discourse, speculating changes to working and living conditions were likely to be influential in preventing disease (Waitzkin, 1981).

Baum's nation-building era refers to the beginning of last century when British colonies such as Australia and New Zealand were establishing their public health bureaucracies. This was a zealous time of assimilation with compromised health outcomes for indigenous populations, in the wake of the assumption of white

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[99] Note this broad brush précis does not attempt to address the complexities of public health delivery within third world contexts, but rather privileges public health as delivered within the affluent west.

sovereignty. Baum (2002, p. 24) contends maintaining health for white people was seen as part of a citizens duty and encouraged by state health checks and the encouragement of open-air exercise. Being healthy contributed to a nation's efficiency and was therefore considered a legitimate concern of governments. The health of indigenous peoples was a lesser priority.

The affluence and medicine era focussed around the post-war abundance when significant medical break-throughs occurred. At this time it was expected that clinical medicine, during this its "golden age", would conquer disease through more and more sophisticated medical technology, including organ transplants (McKinlay & Marceau, 2002). There was little attention and/or investment in public health through this period. Baum (2002, p. 26) maintains, public health resources were focussed on policing standards for clean air, water and food. Major emphasis was also on immunisation campaigns and the screening of populations.

Medical Traditions

Practice nurses and general practitioners are the cornerstones and first point of contact for most people engaging with the wider health sector. Medical approaches to public health focus on the prevention of disease and interventions usually occur within primary care settings. These interventions often focus on individual level behaviour change through lifestyle advice and health education programmes. Health screening and immunisation are also areas where medical interventions have influenced public health through population-based interventions. Table 10 below illustrates the relative position of primary care led interventions in a wider continuum of core generic public health activities.

Table 10: Public Health Continuum

Individual focus	←				→ Population focus
Screening & immunisation	Lifestyle advice	Health education	Social marketing	Community development /action	Economic & regulatory activities
Primary care ←				→	Public Health

Note: Reproduced from *Integrated health promotion: A practice guide for service providers* by Department of Human Services, 2003, p.44. Melbourne, Australia: Vic Health. Reprinted with permission.

A key marker in the intersection of primary healthcare with public health is the *Alma Ata Declaration* (World Health Organization, 1978, September), which introduced the notion of health as a community asset and identified access to health as a social justice issue. The ultimately unsuccessful challenge to mobilise attending state parties to achieve health for all by the year 2000 was embraced by both public and primary health practitioners.[100] The Declaration emphasised global co-operation through the involvement of other sectors and community participation. It also championed health education as a formal measure to enhance

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[100] In much the same way the millennium development goals continue to inspire some (United Nations, 2000).

knowledge, raise consciousness around health and thereby enable behaviour change around lifestyle factors (Ritchie & Short, 2000).

In the wake of the Declaration, Tannahill (1997, p. 169) argues health education become a cornerstone of primary and generic public health practice. Bonevski, Sanson-Fisher and Campbell (1996) in their review of international evidence around the effectiveness of lifestyle advice delivered within primary health care settings concluded there "...was unrealised potential for disease prevention in primary healthcare". Structural barriers to general practice participation in public health are considerable. Baum (2002, pp. 314-315) identifies the fee-for-service structures within practices, short consultation times, a significant focus on curative interventions and lack of public health expertise generally within primary healthcare as obstacles to effective practice.

Population based screening programs involves the early detection of whether an individual is at risk of a particular disease through testing for risk factors and early physiological indications. Successful detection particularly within national breast and cervical cancer screening programmes, for example, can enable often life-saving early treatment. Screening programmes for cardiovascular disease that address behaviour risk factors are more complex and require more intensive follow up and ongoing engagement. Baum (2002) and Goel et al. (2003) suggest there is strong empirical evidence that uptake of screening opportunities is most prevalent with the healthiest section of the population and those most vulnerable do not engage at the same rates.

Since the discovery of the smallpox vaccine, immunisation has also been a key public health tool. Successful immunisation programmes achieve 'herd' immunity.[101] On a global level, immunisation has seen the eradication of smallpox and reduced polio, measles and diphtheria down to manageable levels across much of the developed west. As with screening, analysis by indigenous and non-indigenous health researchers such as Crengle, Pink and Pitama (2009) and Grant, Turner and R. Jones (2009) suggest there is evidence that the uptake of immunisation is most prevalent within the healthiest section of the population.

Lifestyle/Behavioural Approaches

By the 1970s, emerging understanding of the impact of lifestyle choices on health considerably influenced public health activities. These insight entered the public discourse through what became known as the Lalonde Report (Lalonde, 1974) commissioned by Health Canada. Baum (2002, p. 32) maintains, healthy lifestyle traditions focused on individuals taking responsibility for their health, were awakened by both health professionals and social marketing campaigns. Significant amounts of public health activity at this time focussed on how to reduce disease risk factors through changes in diet, exercise and tobacco use.

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[101] Herd immunity occurs when the vaccination of a significant proportion of a population provides some protection for those few whom have not developed immunity.

During this period behavioural change models, such as the health belief (see Becker, 1974) and the stages of change models (see Prochaska & DiClemente, 1984), based on social learning and reasoned action theory were widely utilised within the sector.

The first international conference on health promotion, held in 1986, saw the development of the influential *Ottawa Charter for Health Promotion* (World Health Organization, 1986, November). It became a template for generic public health, building from a base of health education and behaviour change, it emphasised the importance of community action, creating supportive social environments, building healthy public policy, and included the bold ambition of re-orientating the health sector. The Charter presented an ecological approach to strengthening health status that recognises the validity of advocacy as a public health tool and within its preamble recognises everyone's entitlement to the core prerequisites of health. These fundamental conditions and resources for health include peace, shelter, education, food, income, a stable eco-system, social justice and equity (World Health Organization, 1986, November, p. 1).

The Charter also consolidated a shift in emphasis in public health practice to community participation, policy change, strengthening social capital and the importance of equity. Intersectoral approaches were favoured with medicine being only one of many contributing professions. Activity often occurred in specific settings or domains as in school-based and/or healthy city programmes, moving beyond disease specific interventions. The Ottawa Charter remains widely used across Australasia as a planning and evaluation tool for public health interventions.

Critics of behavioural traditions such as Syme (1996) assert that there is too much emphasis on individual responsibility within the tradition and structural systemic impacts on health are ignored. In his 1996 review of a multi risk factor intervention on coronary heart disease Syme is adamant that context is critical to the efficacy of behaviour interventions. Wilkinson (1996, p. 64) concurs from his review of the evidence that health behaviour is clearly related to the social context in which people live, and that to change behaviour it may be necessary to change more than lifestyle.

Baum (2002, p. 338) concurs that interventions which focus on the provision of information and resources to facilitate behaviour change, tend to ignore the structural circumstances which put people's health at risk in the first place. The Australian Minister of Health, Hon. John Cornwell (as cited in Raftery, 1995, p. 35) explains some of the challenges of looking beyond the individual:

> At a political level, the public policy approach lacks support because it produces results in the long term and less visibly than the short-term crisis intervention of heroic medicine. Coronary bypass surgery and level-three

intensive care for very low birth weight babies are newsworthy. Addressing questions of poverty, education, housing, nutrition and income maintenance to overcome the problem of very low birth weight babies is not possible in a 60-second television news segment.

Socio-Environmental Approaches

Labonte (1992) explains that socio-environmental approaches describe the broad social, environmental and economic strategies to promote health beyond medical and behavioural traditions. They emphasises the interwoven relationship between individuals and communities and their social, cultural and physical environments. Lifestyle choices within this approach remain the responsibility of an individual but it recognises that largely the wider social environment determines these choices, by community norms and values, harmful and healthful regulations and policies.

Connections between environment and health were introduced to a wider audience through the landmark British Black Report[102] on social inequalities (D. Black, Townsend, & Davidson, 1982). Determinants of health authorities, Marmot (2004), Wilkinson, (2003) and Whitehead (2007) have since identified the existence of a social gradient in health; in that the lower an individual's socioeconomic, position is the worse their health. Chaudhuri (1998, p. 27) explains how environmental factors can influence child health:

> Poor children often live in social and low rent housing located very close to industrial areas, high-density traffic corridors and interchanges and sites previously used for toxic waste disposal. Housing is often inadequate due to its age, chronic poor maintenance and faulty design leading to a variety of indoor air quality hazards including mould growth or the presence of toxic substances such as lead paint or asbestos.

Research into the determinants of health has had a profound impact on generic public health practice, confirming that both societal and lifestyle factors influence health status. Figure 12 developed by Labonte (1990a) diagrammatically depicts how physiological, behavioural and psychosocial risk factors in combination with risk conditions such as poverty can intersect and influence health status.

The core of a socio-environmental approach is to mobilise communities to affect change on both risk factors and conditions that threaten and strengthen health. This approach opens up a variety of spheres for public health activity both within and outside the core health sector such as working with local government, education, employment, economic development and welfare sectors on policy and collaborative programmes.

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[102] Which was subsequently ignored by the Thatcher government.

⇧ Health Status

Physiological Risk Factors
- hypertension
- hypercholesterolemia
- genetic (inherited) factors

Behavioural Risk Factors
- smoking
- poor nutrition
- physical inactivity

Psychosocial Risk Factors
- isolation
- lack of social support
- poor social network
- low self-esteem
- high self-blame
- low perceived power

Risk Conditions
- poverty
- low education/occupation status
- dangerous, stressful work
- dangerous, polluted environment
- discrimination (sexism, agism, racism, etc.)
- low political-economic power
- large gaps in income/power within a community, state, nation
- unaffordable housing
- inadequate access to food

Figure 12: **Social Environmental Approach to Health**
Adapted from "Heart health inequalities in Canada: Models, theory and planning" by R. Labonte, 1992, Health Promotion International, 7(2), p.122. Reprinted with permission.

The socio-environmental tradition also emphasises the importance of active participation in public decision-making and what political commentator, Cox (1995) calls "social capital" and Muukkonen (2009) calls "an engaged civil society". Baum (2002, p. 343) contends that the existence of trust and reciprocity in relationships are key indicators of the existence of social capital and the ability to cooperate to achieve common goals. She maintains that the active engagement of people in the planning of health initiatives improves their quality, relevance and effectiveness. Participation also helps communities overcome powerlessness and leads to people being healthier. An inter-related concept is the notion of empowerment. Israel, Checkoway, Schultz and Zimmerman (1994, p. 153) defines empowerment as "…the ability of people to gain understanding and control over personal, social, economic and political forces in order to take action to improve their life situations".

Within the next sub-section, I examine two elements of the socio-environmental tradition community development/action and social, economic and cultural determinants of health approaches.

Community Development/Action

> People need the basic material prerequisites for a decent life, they need to have control over their lives, and they need political voice and participation in decision-making processes. Although individuals are at the heart of empowerment, achieving a better distribution of power requires collective social action – the empowerment of nations, institutions, and communities (Commission on the Social Determinants of Health, 2007, p. 15).

Community development advocates (see Green & Raeburn, 1988; Raeburn & Rootman, 1998) hold that community lies at the core of public health interventions. A community is often defined as a geographic neighbourhood or a sub-population or social grouping (Goodman et al., 1998). Communities, assert medical anthropologists, Wayland and Croder (2002), are made up of various competing interests vying for attention and resources. The strengths and potential weaknesses of a community influence its ability to respond to challenges and environments that compromise health. Labonte (1990b, p. 69) argues that not all communities are equal, and that a social justice approach demands prioritising working with communities whose circumstance place them at the greatest risk.

Community development/action is a process of community empowerment. Community development the broader of the two terms refers to an open-ended approach where communities identify and prioritise issues that they wish to address. Bryar and Fisk (1994, p. 203) define community development as a "…radical process which seeks to redistribute knowledge and skills through active involvement of those usually excluded from such participation". Minkler, Wallerstein and Wilson (2008) identify several elements they hold as critical to this approach, empowerment, community competence, starting from where people are at, participation, how issues are selected, and creating critical consciousness. Raeburn and Rootman's (1998) model of community development, the PEOPLE[103] system is similar but includes the additional elements of people-centeredness, organisational development, life quality and evaluation.

Community action is more specifically focused on affecting change within a specific area. Greenaway, Milne, Henwood, Asiasiga and Witten (2004) in their meta-analysis of community action projects identified empowerment, equity, collaboration and consensus as key elements of such an approach. Laverack (2004, p. 64) in his health promotion text, criticises community action approaches, noting that such top down programmes in both their design and delivery can be disempowering to the intended beneficiaries. He explains:

> Such programmes can reinforce people's feelings of powerlessness by ignoring their concerns, over-riding their needs and by giving out the message that their problems are not relevant to those who hold power, the outside agents and health promotion 'experts' (p. 64).

Oakley (1991, pp. 17-18) in his study of rural development identified a variety of advantages of a development approach including, efficiency, effectiveness, self-reliance, coverage and sustainability. An 'evidence of effectiveness' review commissioned by the WHO (Wallerstein, 2006, p. 14) found development approaches consistently achieved outcomes at psychological, organisational and community levels, and across populations. The specificity of those outcomes

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[103] The mnemonic stands for Planning and Evaluation of People Led Endeavours.

varied based on what public health issues were being addressed and the social and cultural contexts where the program took place. These outcomes were achieved after long-term investment Baum (2002) contends such an approach is not a quick fix to improving health status.

Social, Economic and Cultural Determinants

> The devastating health inequities we see globally are man-made. The causes are social – so must be the solutions. A global society in which millions of children and adults are unable to lead flourishing lives is not sustainable (Commission on the Social Determinants of Health, 2007, p. 3).

A determinants approach to public health recognises that a range of influences from age, sex and ethnicity determines health and hereditary factors, through individual behaviours to the social, cultural and economic context in which people live (see Figure 13). The Commission on the Social Determinant of Health (2007, p. 14) argue that social hierarchies in which economic and social resources including power and prestige are distributed unequally, impacts on people's freedom to lead lives they have reason to value. This inequity in turn has a powerful impact on health and its distribution. Health inequities, maintains Whitehead (1992), are differences in health that are unnecessary, avoidable and unjust.
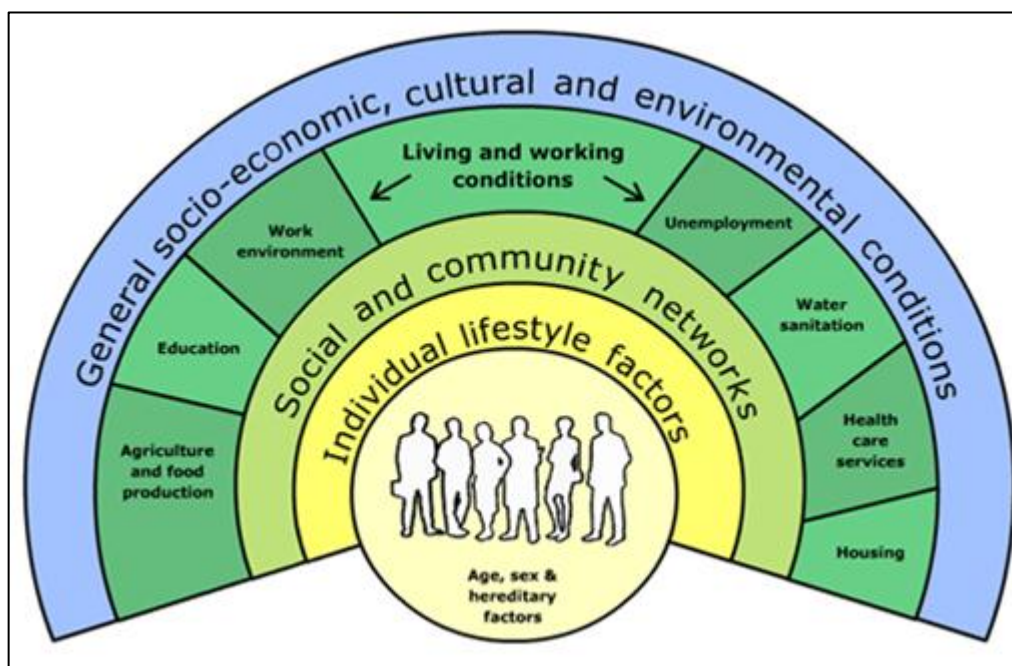
Figure 13: **The Determinants of Health**
Reproduced from *Policies and strategies to promote social equity in health: Background document to WHO strategy paper for Europe* by G. Dahlgren & M. Whitehead, 1991, p.11. Copenhagen, Denmark: World Health Organization. Reprinted with permission.

Whilst some determinants of health can be modified, others cannot. In their review of the international evidence the New Zealand National Advisory Committee on Health and Disability (NACHD) (1998, p. 8) argue that income, primarily influenced by participation in paid employment, is deemed the most

important and modifiable determinant. The primary driver of a determinants approach is promoting equity and reducing power differentials and inequities between population groups. Advocates for this approach argue the right to the highest attainable level of health is enshrined in human rights conventions and in the constitution of the WHO (United Nations, 1976b; World Health Organization, 1948).

Action on the determinants occurs both within the health sector and outside it, through local networks and national advocacy coalitions. The Ministry of Health (2002g) commissioned a reducing inequalities framework to advance work on the determinants of health, which identifies several key sites for interventions. These include i) structural approaches to tackling the root causes of health inequities; ii) intermediary pathways focussing on targeting material, psychosocial and behavioural factors that mediate the impact of structural factors and iii) interventions within health and disability services to minimise the impact of disability and illness. A substantive review undertaken by the NACHD (1998, p. 61) of ninety-eight publications into interventions to reduce health inequalities found structural measures to be most effective.

One of the emerging tools of the determinants tradition is also the use of social and health impact assessment tools (see Ministry of Health, 2007e; Public Health Advisory Committee, 2005). Health impact assessment "...is a combination of procedures, methods and tools by which a policy may be assessed and judged for its health effects across a population" (World Health Organization, 1999, p. 4). This process of critical review identifies both potential intended and unintended impacts of policies, plans and regulation and the distribution of those impacts on communities. It can be used at project level to decide about a new skate park or at a strategic policy level about public transport policy. It can be used by policy-makers and affected communities together or separately to provide evidence to inform policy development, implementation and/or evaluation.

In summary, generic approaches to public health have been shaped and adapted to changing political environments and to new evidence about what influences health status. Early emphasis was placed on using legislation to address poor water, sanitation and housing, to tracking disease patterns through epidemiology, to medical break-throughs enabling health screening and immunisation. The 1970s brought emphasis on healthy lifestyles and behavioural models. New insights about the impact of social and physical environments on health lead to interventions addressing psychosocial risk factors and emphasis on the importance of equity, community engagement and empowerment. Emerging determinants approaches highlight the role of healthy public policy and multi sector collaboration to achieving health gain.

6.3 Current Practices in Aotearoa

> Health promotion is an inherently political enterprise. Not only is it largely funded by government but the very nature of its activity suggests shifts in power. Its recognition that peace, shelter, food, income, a stable ecosystem, sustainable resources, social justice and equity are basic prerequisites for health implies a major redistribution of power and wealth
>
> (Signal, 1998, p. 257).

One significant point of difference between public health practice in Aotearoa and the rest of the world is the obligations and opportunities of *Te Tiriti o Waitangi*. This creates an imperative for public health practitioners, managers, policy-makers, funders and decision-makers to ensure that programs address the needs of Māori. Government policy directions and funding practices are also key drivers of practice as they define what interventions are funded and, increasingly, the detail of those interventions. Access to public health training and qualifications and high staff-turnover within the sector (see Ministry of Health, 2007d) also shape what kind of public health practice occurs, as does the strength of public health leadership within academic and managerial roles.

The majority of public health activity in Aotearoa is funded through the Ministry of Health. DHBs, Accident Compensation Corporation, Territorial Local Authorities, New Zealand Food Safety Authority and Alcohol Liquor Advisory Board also fund a range of public health services. Since the early 1990s public health services have primarily been funded through a set of service specifications *Public Health Service Handbook* (Ministry of Health, n.d.). Late into this study the specifications were revamped and transferred into the Ministry of Health National Service Framework Library. The specifications outline a range of public health funding streams which have a strong behavioural and bio-medical orientation.

The following section examines Te Tiriti o Waitangi and public health legislation and competencies as key markers of public health practice in Aotearoa.

Te Tiriti o Waitangi

> It is little wonder, therefore, that Māori have come to view the Treaty as an ideal framework for Māori health development… it is clear that above all else it is concerned with equity and the promise that Māori can enjoy – at the very least – the same health and well-being as non-Māori
>
> (T. K. Kingi, 2006, p. 8).

Variously Te Tiriti, the Treaty and Crown-defined Treaty principles are embedded within local public health sector discourses (See Durie, 1994b; Kiro, 2000; Ratima, 2001; Wise & Signal, 2000). Emphasis within government health legislation and policy documents is heavily orientated towards the Treaty principles derived from the Royal Commission on Social Policy (1988) but also acknowledges the 'special relationship' between Māori and the Crown (see A.

King, 2000; A. King & Turia, 2002). For instance the NZPHDA (part 1 section 4) states:

> In order to recognise and respect the principles of the *Treaty of Waitangi*, and with a view to improving health outcomes for Maori, Part 3 provides for mechanisms to enable Maori to contribute to decision-making on, and to participate in the delivery of, health and disability services.

Within the health sector a variety of cultural and treaty audit tools have been developed to assess and maximise responsiveness to Māori, influenced by the contributions of Ramsden (2002) and Durie (1994b). *The CHI Model: Culturally Appropriate Auditing Model* (Durie, 1993a) developed for the Public Health Commission, enables service delivery to be audited against Māori development, health gain, cultural beliefs and values. *He Taura Tieke* (C. Cunningham, 1995) developed for the Ministry of Health, is a comprehensive checklist to access effectiveness of service delivery to Māori. This assessment is done through examining technical and clinical competence, structural and systemic responsiveness and consumer satisfaction. TUHA-NZ (Treaty Understanding of Hauora in Aotearoa New Zealand) (Health Promotion Forum, 2000) emphasises the text of Te Tiriti and advocates that Te Tiriti should be used as the basis of all local health promotion practice.

The *Whānau Ora Health Impact Assessment* (Ministry of Health, 2007e) establishes a process to assess the impact of policy on whānau health and wellbeing. In turn, the *Health Equity Assessment Tool* (HEAT[104] tool) (Signal et al., 2008) is a framework designed to help practitioners and decision-makers assess whether a particular policy or intervention will increase or decrease health inequities. Despite stated commitments to the Treaty and/or Te Tiriti within legislation, policy and competency documents, Signal and Egan (2009, p. 130) maintain that levels of engagement with these documents are variable. They call for urgent action to reinvigorate engagement with Treaty based practice to address inequities in health outcomes.

Public Health Legislation

There are two key pieces of local public health legislation: i) NZPHDA which establishes the structures and accountabilities of the sector, ii) Health Act 1956 which primarily focuses on risk management and communicable disease control. NZPHDA is the legislation which established DHBs and sets out the roles of the Minister of Health, Ministerial committees and health providers. It also defines the strategic direction and goals for health and disability services emphasising the importance of reducing disparities, respecting and recognising the Crown defined principle of the *Treaty of Waitangi*, improving Māori health and ensuring community voice in health service planning. It required the development of both

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[104] The HEAT tool was designed to aid Crown officials undertake funding and planning activity to minimise health inequalities through their decision making.

national health and disability strategies as the overarching strategic framework for the sector. DHBs were given responsibility for undertaking needs assessments within their geographic boundaries and service planning. The Ministry of Health retain an overview of the sectors activities, and responsibility for most public health services and a key role in monitoring the funding and provisions of services by DHBs.

The Health Act 1956 outlines the specific responsibilities of the Director-General of Public Health and other senior public health officials and the statutory scope of practice for Medical Officers of Health (Ministry of Health, 2008d). The Act outlines the power and duties of local authorities, specifically addresses issues around the quality of drinking water, infectious and notifiable diseases, trading in human blood, quarantine, the national cervical screening programme and air pollution. The draft Public Health Bill[105] is likely to modernise this legislation to address new public health threats such as Severe Acute Respiratory Syndrome (SARS) and the influenza A (subtype H1N1) and incorporate New Zealand's obligations under international health regulations. Other public health legislation defines responsibilities and sets standards in relation to water and air quality, food safety and communicable disease control. It also governs access and use of alcohol, access and advertising of tobacco, use of seat belts and speed and safety of cars.

Public Health Competencies

An examination of competency documents provides some insights into the scope and nature of local public health practice. Competencies can be defined as "...the ability to apply particular knowledge, skills, attitudes, and values to the standard of performance required in specified contexts" (Bowen-Clewley, Farley, & Clewley, 2005, p. 59). Within Aotearoa there are a variety of competency documents relevant to public health most notably, generic public health competencies developed by the Public Health Association (2007), and both health promotion (see Health Promotion Forum, 2011), and public health medicine specific competencies (see New Zealand College of Public Health Medicine, 2008).

Commonalities across these sets of competencies include understanding health policy, *Te Tiriti o Waitangi*, the importance of community, cultural competency, commitment to professional development and planning. Differences include divergent emphasis on advocacy, and chronic and infectious disease prevention. When benchmarked against Canadian (see Health Canada, 2008) and Australian (see National Public Health Partnership, 2000) competency documents New Zealand places greater emphasis on indigenous health. Debates in New Zealand

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[105] The Public Health Bill (No. 177-2) was introduced to parliament in 2007 intended to "… update existing public health legislation in order to improve, promote and protect public health and help optimal and equitable health outcomes for all population groups in New Zealand" (New Zealand parliament n.d). It remains unclear when and if this bill will proceed beyond its first reading.

continue about the merits of developing Māori specific public health competencies and work is currently being undertaken to develop an overarching public health ethical framework for the sector (Public Health Association, 2011).

In general both Māori and generic public health traditions are both in active use within Aotearoa. There is both a professional obligation to work with Te Tiriti and legislative requirement to work with the Treaty principles and overarching imperative to prioritise Māori health gain. Current practice is strongly influenced by how the Ministry of Health develops health policy and funds public health services.

6.4 Summary

There is a range of approaches to public health. These approaches are based on divergent ontological understandings about both the nature of what health and wellbeing is and how disease is spread and/or acquired.

Indigenous public health systems and practices aim to sustain balance between indigenous communities and their environments and are driven by a focus on collective wellbeing. Indigenous health remains dominated by the challenge of how to rebuild and recover from the destruction outcomes of state policies of colonisation and assimilation.

Historically generic public health has been strongly influenced by bio-medical understandings of disease prevention and has adapted to reflect new scientific breakthroughs whether that be the development of vaccines or screening programmes. More recently, the notions of community development/action popularised by the Ottawa Charter (World Health Organization, 1986, November) and insights into the social determinants of health have expanded this tradition.

In the New Zealand context, both generic and Māori public health traditions coexist. These practices are influenced by various commitments to Te Tiriti and/or the Treaty within legislation, local competencies requirements and professional commitments to achieving equitable health outcomes. The reach and impact of these public health traditions are shaped and influenced by what is taught and published about these traditions and how they are incorporated or not into policy and funding practices.

In the following chapters, I illustrate how Māori public health traditions and knowledge are marginalised within Crown policy making and funding practices in favour of generic traditions.

CHAPTER SEVEN: MASTER HEALTH POLICY NARRATIVES

7.0 Introduction

Crown officials, as core policy makers (and funders); wield considerable influence over the public health sector. Their authority is actualised through legislation, strategic policy documents, and operational protocols. The discretion of Crown officials is manifested in both their actions and inaction. Alongside these powers and responsibilities are a range of controls discussed in chapter five that guide, direct and restrict the activities of Crown officials and to promote ethical conduct (State Services Commission, 2007).

This chapter and chapter nine represent what critical race theorists call the 'master narratives' of the Crown. Both chapters are deliberately presented using phraseology taken directly from a desktop review of policy documents, to stand as the Crown's position without critique. This chapter is also contextualised by some relevant literature and informed by OIR responses from Northland DHB. In direct contrast chapters eight and ten address what critical race theorists call counter narratives, in this instance the experiences of those targeted by institutional racism supported by supplementary data.

Within this chapter, I introduce the structure of the New Zealand health sector. I examine macro health policy as defined by the Labour-led coalition (1999-2008) policy writers and the subsequent National-led coalition government who have retained power in the recent 2011 elections. I outline how the macro policy is operationalised through an overview of meso level health planning through the work of several Crown agencies.

7.1 Structure of the Health Sector

Despite pre-existing indigenous health systems, a Department of Health was formally constituted as a government department in New Zealand in 1900. For several decades now, the health system has been a political 'hot potato' in elections with successive governments seemingly perpetually tinkering and reforming the system (Ashton, 2005). Each restructuring has brought new sets of organisations to fund and deliver health services, 1983-1993 Area Health Boards, 1993-1997 Regional Health Authorities and Crown Health Enterprises, 1998-2001 HFA and Hospital and Health Services, 2001 onwards DHBs and the addition of a NHB in 2009. Quinn (2009, p. 2) in his assessment of fifty years of health reforms, contends the rationale of the reforms was to improve health outcomes, increase accountability and efficiency and to reduce escalating health expenditure.

The focus of this study is on the health system as reshaped by the Labour-led coalition government (1999-2008) through the NZPHDA and more recent adaptations by the National-led coalition (2008-ongoing). The 2000 reforms re-established the Ministry of Health[106] as the primary agent in the health and disability sector. Ministry officials have the overall responsibility for the management and development of the health system and are the primary means of driving performance improvements with the system (Ministry of Health, 2010g). They act as the Minister's principal advisor on health policy, as a funder and regulator of health and disability services and oversee the collection and distribution of health information. Within the Ministry, He Kete Hauora (the Māori health directorate) holds responsibilities for the development of strategic Māori policy advice.

The most recent reforms in November 2009 ensured, a variety of functions, such as monitoring of DHB performance, were transferred from Ministry to the NHB. Internal to the Ministry, the NHB and its associated business unit, co-ordinates the planning, funding and monitoring of DHBs and national services, arbitrates regional service disputes and leads national capacity planning for workforce, information technology and capital. The intention is that the:

> ...National Health Board and the Ministry of Health will work together to consolidate planning, funding, workforce planning and capital investment, as well as better supervise the billions of dollars in public funding spent on hospitals, primary health services and important national health services (Ministry of Health, 2010g, p. 4).

DHBs as Crown entities are a step removed from central government. As a Crown entity, a DHB has a measure of independence. Palmer and Palmer (1997, p. 92) argue they are set up to avoid political control and having a Minister directly responsible for those organisations. DHB officials and board members are responsible for the purchase and provision of health services within a designated geographic area. DHBs are required to focus on reducing inequalities among their populations, prioritise health services within budget and provide access to a range of core health services. Under the NZPHDA, DHBs must improve, promote and protect the health of communities, promote integration of services and the independence and inclusion for people with disabilities (Ministry of Health, 2008d). They must also demonstrate their contribution to the improvement of mainstream services delivery to Māori (Ministry of Health, 2011b, p. 36).

Figure 14 below lays out the contracted health providers who have service agreements with a DHB for delivering a range of health services. DHBs have formal accountability arrangements with the Ministry of Health, whom in turn have specific delegations and obligations to the Minister of Health. The DHB

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[106] Also referred to as the Ministry within this thesis

accountability mechanisms include requirements to submit a statement of intent, district strategic and annual plans and an annual report to the Minister of Health for approval. Accountability is also actualised through the Crown funding agreement between the DHB and the Minister, which requires DHBs to abide by the business rules, and policy guidelines outlined in the Ministry's (2011b) operational policy framework.
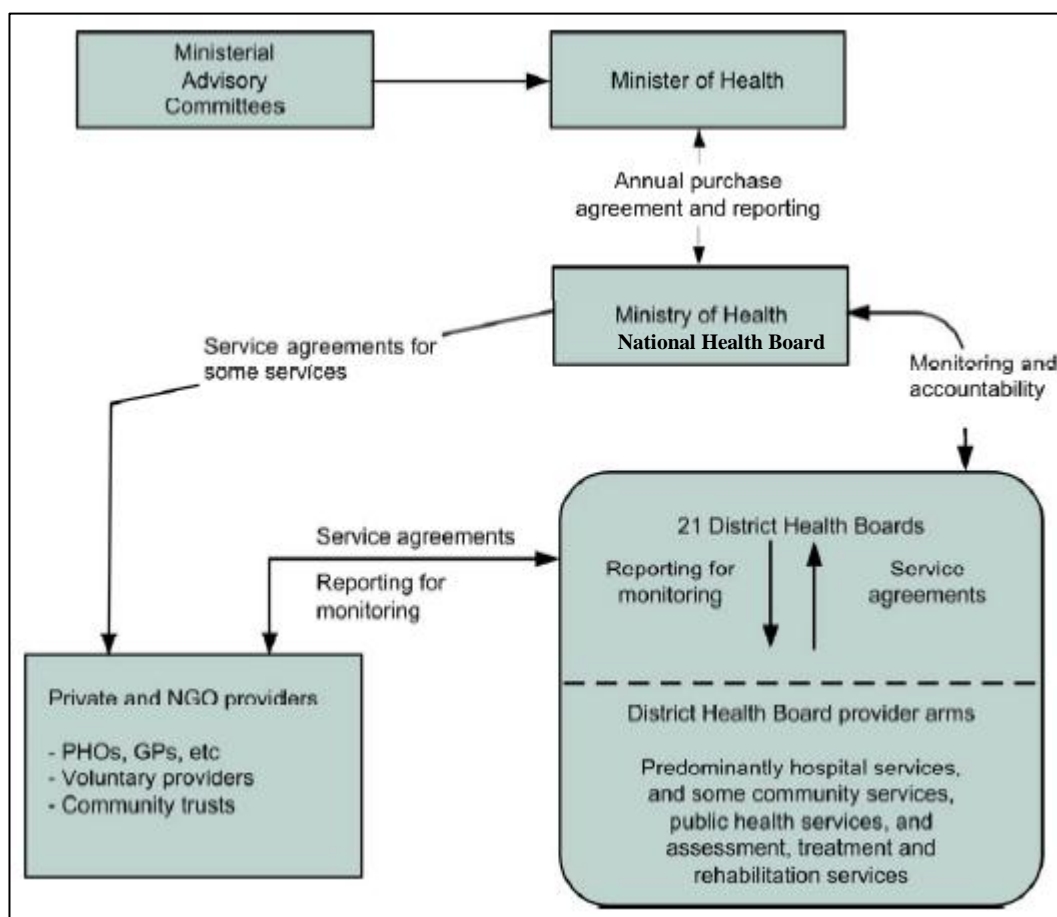
Figure 14: **Structure of the New Zealand Health Sector**
Reproduced (and adapted) from *New Zealand health system reforms (Research paper 09/03)*, P. Quinn, 2009, p.20. Wellington, New Zealand: Parliamentary Library Research Unit. Reprinted with permission.

Ministerial advisory committees support the Minister of Health to tap into expert and independent advice. As part of their sector-wide review, the National-led coalition government streamlined and consolidated such committees.[107] Similarly, decision-making in DHBs are supported by advice through three statutory advisory committees, Community and Public Health, Disability Support and the Hospital Advisory Committees.

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[107] The remaining committees focus on; assisted reproduction technology, ethics, cancer control, family violence, pharmacology and therapeutics and assorted mortality review committees.

7.2 Macro Health Policy

> Policies are most obviously political phenomena, yet it is a feature of policies that their political nature is disguised by the objective, neutral, legal-rational idioms in which they are portrayed
> (Shore & Wright, 1997, p. 8).

Public policy involves a complex array of vested political interests, values and beliefs and diverse stakeholders vying for influence. Policy is used by a government to outline a course of action to fulfil a political agenda and as a mechanism for prioritising the distribution of public resources. More specifically, Davis and Ashton (2001) argue that health policy determines who gets health services, what those services are, when they will get them and who will provide them. Decision-makers wield considerable influence over policy development, but Fischer (1995) contends so do policy makers. For it is policy makers who often determine what policy issues will be taken seriously, the solutions generated and whose values and beliefs will be used to evaluate them.

Tenbensel and Gauld (2001, p. 25) identify four policy-making processes: the rationalist, stakeholder, participatory and neo-liberal. Rationalist approaches are led by politicians and expert groups and focus on problem defining and solution identification. Within this tradition, knowledge and information are sifted according to rigorous scientific standards. The stakeholder approach utilises a complicated process of negotiation to manage diverse interests and values to maximise stakeholder investment in policy implementation. This approach requires an understanding of power relationships between policy stakeholders and the skills of political brokerage.

Participatory approaches attempt to maximise citizen participation to gain informed democratic consent and participation in both policy development and implementation. This type of approach is often adopted when policy makers judge that public acceptance and support is significant. Neo-liberal approaches, Tenbensel and Gauld (2001, p. 39) argue, entrust the market to be the most effective means to allocate resources. They contest that neo-liberal models driven by economic imperatives, dominate current policymaking. In contrast, Stone (2001) argues policy can arise from a continuous bustle of activity in which people do not perceive themselves as making policy, but over time, a number of small acts set the direction and limits of government policy. In relation to policymaking, the Chief Ombudsman has ruled that participation in policymaking requires that individuals have the right to, know what options are being considered, and that sufficient information must be provided to allow a proper judgment to be formed. Furthermore, sufficient time must be allocated to enable individuals and groups to express views before the government is committed to a particular policy (State Services Commission, 2002, p. 10).

However, it is formulated; policy has the potential to be either inclusive of multiple perspectives or steadfastly mono-cultural affirming the worldview of one grouping only. Davis and Ashton (2001) suggest even when public consultation processes occur; government control is absolute, regarding their retention of decision-making as to which policy solutions or priorities will be funded. As outlined in chapter three, within the context of Aotearoa, and particularly during the era of colonisation and assimilation, government policy has been used for decades as a powerful mechanism to subjugate Māori.

Labour-Led Coalition Government (1999-2008)

> Labour started its life as a party of change – a voice for the working classes who believed that a fairer future was possible. Many of those first involved just wanted the basics – adequate food, clothing and shelter; a job with reasonable conditions and regular wages; support in illness or old age; and a hope for an even brighter future for their children
> (Labour Party, n.d.).

The Labour party has gone through various transformations since its formation, the most significant being it is championing of radical free market theories and reforms during the 1980s. The fifth labour-led government (1999-2008) under the leadership of Right Hon. Helen Clark took a more moderate line with an assortment of coalition partners and supply agreements with the Alliance Party, the Progressive Coalition, New Zealand First, the United Future Party and often working with the Green Party. Labour campaigned on a platform of a more planned and community-orientated health system, under revamped health legislative and sector structure. Labour articulated their ideological opposition to a healthcare model, which promoted competitive tendering for contracts (New Zealand Labour Party, 1999).

Their coalition partners' health policies ranged from commitments to free healthcare, greater investment in public health initiatives, prioritising child health (see Alliance Party, n.d.), investment in the public health system, extending oral health services, endorsement of particular public health initiatives around suicide and alcohol and other drugs (see Progressive Party, n.d.), increased investment in health services and eldercare (see New Zealand First, n.d.) and emphasis on healthy lifestyles choices (see United Futures, n.d.). These competing priorities formed elements of the Labour party's web of coalition commitments.

Critical to the Labour-led health sector reforms was the development of a number of high-profile sector-wide strategies. These included the *New Zealand Health Strategy* (NZHS) (A. King, 2000), the *New Zealand Disability Strategy* (Dalziel, 2001) the *Primary Healthcare Strategy* (A. King, 2001) and were followed by the Māori health strategy, *He Korowai Oranga* (A. King & Turia, 2002). Underneath these core strategic documents lay assorted population specific and disease-based strategies, supported by operational level evidence-based toolkits, action plans

and guidelines to enable policy implementation within the sector (Ministry of Health, 2002d).

Within the following section, I examined NZHS, *Achieving Health for All* and *He Korowai Oranga* as the key macro level public health strategy documents.

New Zealand Health Strategy

> Behind the statistical comparisons lies the unacceptable reality that some New Zealanders live in unhealthy housing, some have poor nutrition and, in rural areas, some have limited access to clean water and sewerage systems
>
> (A. King, 2000, p. 3).

The NZHS (A. King, 2000) was designed as the foundation document for health and disability service planning. Its overarching goal was to improve the health of the entire population while simultaneously reducing inequalities in health. Then Health Minister, Hon. Annette King, isolated specific areas where she believed the greatest population-level health gain could be achieved to benefit all New Zealanders. The NZHS acknowledged the Royal Commission on Social Policy's (1988) Treaty principles and the importance of both treaty parties relating to one another in good faith with mutual respect, co-operation and trust.

The NZHS had an explicit commitment to the further development of Māori providers and the continuation of the two-pronged Māori health strategy of mainstream enhancement and the development for Māori and by Māori services. Māori were positioned within the strategy both as treaty partners and as a community with disproportionately high health needs. The detail of the strategic approach to addressing Māori health was outlined in the then forthcoming document, *He Korowai Oranga* (A. King & Turia, 2002).

Based on epidemiological analysis and consultation with the public, the NZHS identified a set of key objectives that covered risk factors such as smoking, lack of exercise and prevention of chronic diseases such as diabetes (see Table 11). Underneath these objectives were detailed performance measures to enable monitoring of progress against the strategy. These priorities then formed the basis of funding agreements with DHBs, who were the primary agents responsible for implementing the strategy. Local and regional needs assessments commissioned by DHBs and assorted advisory committees also helped enable local decision-making and prioritisation processes. In pursuit of greater transparency DHB, performance around implementation has been benchmarked and published.

Table 11: New Zealand Health Strategy Priorities

Reducing smoking.	Improving nutrition.	Reducing obesity.	Increasing the levels of physical activity.
Minimising harm caused by alcohol and illicit and other drug use.	Reducing the incident and impact of cancer.	Reducing the incident and impact of cardiovascular disease.	Reducing the incident and impact of diabetes.
Improving oral health.	Reducing violence in interpersonal relationships, families, schools and communities.	Improving the health status of people with severe mental illness.	Ensuring access to child health care services and immunization.

Note. Adapted from *The New Zealand Health Strategy* by A. King, 2000, p.13. Wellington, New Zealand: Ministry of Health. Reprinted with permission.

The NZHS operated from the assumption that increased public health activity contributes to the improvement of population health outcomes and the reduction of health inequities. This was reinforced by the inclusion of determinants of health analysis and emphasis on intersectoral activity within the strategy. The influence of generic public health thinking is reflected in many of the key strategic objectives, which relate to behavioural risk factors that both the public and primary healthcare sectors have long wrestled with. The rationale for these priorities and the interventions themselves were primarily generated through epidemiological analysis.

Progress on implementing the NZHS has been regularly published in the Ministry of Health's *Health and Independence Report (Ministry of Health, 2001a, 2002e, 2003b, 2004c, 2005, 2006a, 2007a, 2008b, 2009a, 2010a)* alongside the Director-General of Health's supplemental reporting on the state of public health and implementation of the sector's quality improvement strategy. These reports illustrate steady improvements in a range of areas including life expectancy and declining smoking rates. In 2007, this reporting on the *NZHS* was reconfigured by the introduction of core health targets agreed upon between Ministry and DHBs, as a key focus for consolidated attention within a specified year. Under the Labour-led coalition these targets were largely a continuation of priorities lifted from the *NZHS*, but did lead to restructuring within the Ministry to enable clinical leadership of each target.

He Korowai Oranga

> *He Korowai Oranga* places whānau at the centre of public policy. It challenges us to create environments that are liberating and enable whānau to shape and direct their own lives, to achieve the quality of life Māori are entitled to as tangata whenua in Aotearoa-New Zealand
> (A. King & Turia, 2002, p. iii).

Launched in 2002, *He Korowai Oranga*[108] is a framework for the public sector to take responsibility for its part in supporting the wellbeing of whānau. Boulton (2005) argues it represents a change of direction in Māori health policy by,

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[108] *He Korowai Oranga* translated means the cloak of wellness.

shifting emphasis from an individualistic approach to health and wellbeing, to one more inclusive of Māori worldviews. Whānau ora became central to Māori health policy, recognising that health and wellbeing is influenced and affected by the circumstances of the collective as well as that of the individual (Ministry of Health, 2002B). Within *He Korowai Oranga* the authors attempt to address the aspirations of both Māori and the Crown (as depicted in Figure 15), while working with the Royal Commission on Social Policy's (1988) Treaty principles. As with the NZHS, the Crown restated its commitment to reducing health inequities between Māori and non-Māori.

WHĀNAU ORA

Māori Aspirations
Building on Gains
Crown Aspirations
Rangatiratanga
Whānau & hapū development
Reducing Inequalities
Māori Participation
Working across sectors
Effective Service Delivery
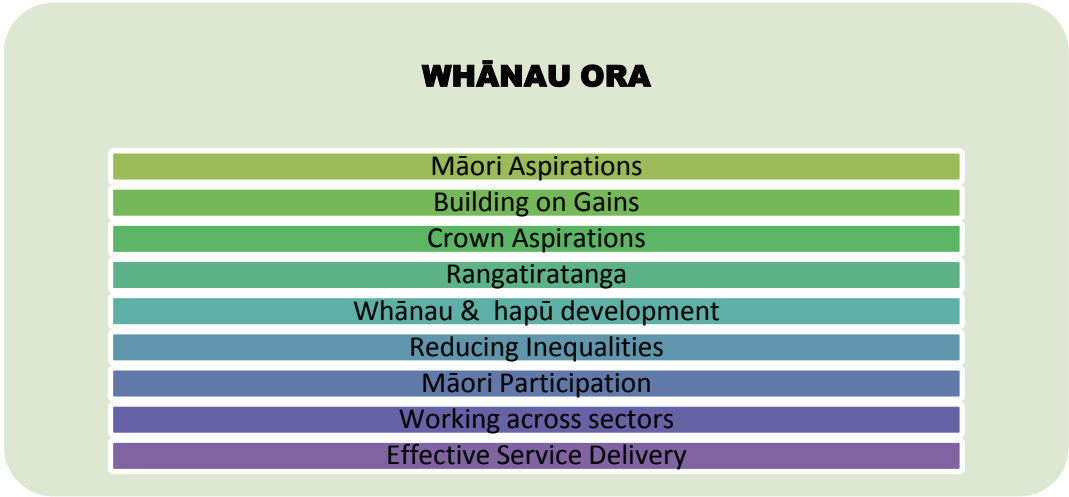
Figure 15: **He Korowai Oranga**
Adapted from *He Korowai Oranga: Māori health strategy*, by A. King & T. Turia, 2002, p.4. Wellington, New Zealand: Ministry of Health. Reprinted with permission.

Beyond achieving whānau ora, the purpose of the strategy was twofold, to affirm Māori approaches to service provision and to strengthen Māori health outcomes. Māori-led initiatives, holistic models and approaches to hauora (health) were emphasised within *He Korowai Oranga* recognising the desire of Māori for tino rangatiratanga; i.e. to seek Māori solutions and have Māori run and owned health services. The strategy recognised that public policies promoting quality education and employment opportunities and addressing systemic barriers (including institutional racism) were all necessary if whānau ora were to be achieved. The strategy was premised on the need for a reorientation to occur in how health services were planned, funded and delivered.

He Korowai Oranga was implemented through the release of the *Whakatātaka*[109] series of action plans (see Ministry of Health, 2002h, 2006c). These plans specified the roles, responsibilities, performance expectations, measures and initiatives for implementing the strategy. Within the first action plan, Crown officials attempted to achieve change at the level of systems and processes. It emphasised building on the strengths and assets within whānau and Māori communities. The second plan emphasised whānau development and community-

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[109] Whakatātaka refers to the weaving of strands, creating a pattern step by step, and eventually forming a taonga such as a korowai.

led initiatives including strengthening whole-of-government initiatives. Embedded across the action plans were Māori specific performance indicators and reporting requirements for DHBs.

Achieving Health for All

> Promotion of healthy communities and environments will assist in moving the focus from individual risks and behaviour into the nature of the community and the environment in which we live
> (Ministry of Health, 2003a, p. iii).

Achieving Health for All (Ministry of Health, 2003a) was developed as the public health sector's response to the NZHS. It affirmed the relevance of the *Treaty of Waitangi* to public health practice and reinforced both the importance of reducing inequalities and tackling the determinants of health. It highlighted the *Ottawa Charter for Health Promotion* (World Health Organization, 1986, November) as a framework for public health planning. Emphasis was placed on mobilising the core public health sector as well as territorial local authorities, the wider health sector and other government agencies into engaging in public health activity aligned to the targets of the NZHS. Rather than focus on behavioural change, the strategy highlighted building healthy communities and environments. In order to strengthen the sector the strategy also had components around the utilisation of research and evaluation in public health policy and practice, achieving measurable progress on health outcomes and enhancing public health leadership.

Māori public health action was highlighted across a range of the priority areas to enable the pursuit of whānau ora. *Te Pae Mahutonga* was identified as an appropriate model from which to develop comprehensive public health programs. Commitments were made to strengthen Māori public health infrastructure and expand the use of Māori models of health and kaupapa Māori research in the development of policy and practice.

In summary, the fifth Labour-led government created a decade of relative stability in health policy. It could be characterised as having both a strong prevention focus and a commitment to addressing inequalities through improving access to primary care. Official rhetoric was supportive of Māori health development and a whānau ora policy platform was established.

National-Led Coalition Government (2008-Onwards)

> The National Party is founded on principles of individual responsibility, private enterprise, and reward for individual effort. These principles are the only sure path to a society of personal freedom and rising standards of living for all
> (National Party, n.d.).

Under the leadership of the Right Hon. John Key (2008, November 17), the primary policy focus of the National-led government is generating economic growth, to create a globally competitive economy which will deliver prosperity to

all New Zealanders. The policy platforms to achieve this goal of growth includes support for science, innovation and trade, better regulation and public services, investment in infrastructure, improved educational outcomes and a growth-enhancing tax system (Ministry of Health, 2010g, p. 8). The National Party website[110] emphasises the importance of encouraging ambition, valuing families, limited government, competitive enterprise and rewards for achievement as the cornerstones of their conservative political philosophy.

Their coalition parties include the ACT party, the Māori party and United Future. Their respective health policies focus on having a competitive healthcare environment, investing in innovation and technology (see ACT Party, n.d.), whānau ora, strengthening tobacco control, ending child poverty (see Māori Party, n.d.) and an emphasis on healthy lifestyles (see United Futures, n.d.). Elements of these policies are reflected in the National Party's respective coalition agreements.

Despite the ideological differences between the Labour-led and National-led governments in relation to health policy, the core structure of the health sector remains defined by the NZPHDA. Core policy documents such as the NZHS, the *New Zealand Disability Strategy*, the *Primary Health Care Strategy* and *He Korowai Oranga* all remain current until the National-led government refreshes or reframes these. Within this section I examined National's health manifesto *Better Sooner and More Convenient* (Ryall, 2007), the recent review of the health sector (Ministerial Review Committee, 2009) and new developments in *Whānau Ora* (Whānau Ora Taskforce, 2009) as core policy documents.

"Better, Sooner, More Convenient"

> Our "cultural hard drive" has to alter so that healthy choices are preferred. A successful long-term approach will provide people with the education, skills and desire to make healthy dietary and lifestyle choices and stick to them
> (Ryall, 2007, p. 28).

The National Party's (Ryall, 2007) approach to healthcare is outlined in their discussion document *Better, Sooner, More Convenient* (see Table 12). Central to the policy platform is the belief that increasing prosperity and opportunity improves health outcomes. This approach aims to halt the growth in health bureaucracy within Crown agencies, to tackle waiting lists and to strengthen workforce capacity (Ministry of Health, 2009d, p. 5). Savings were expected to be generated because of a comprehensive line-by-line review of spending that ensures savings are redirected to front-line health services. Integrated family health centres were to be developed and hospital-based services were to be devolved into a more accessible community-based primary healthcare environment within a climate of greater collaboration between primary and secondary healthcare providers.

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[110] See http://www.national.org.nz/

Table 12: Guiding Principles of National's Health Policy

Putting patients first	Patients at the centre of health services and being able to make informed choices.
Care close to home	More healthcare services close to home, complex healthcare close to best medical technology.
Integrated care	Seamless service delivery as a result of partnerships within the sector and with social and community organisations.
Trusting health professionals	Importance of clinical professionalism to secure public trust in the health sector.
Working together for better care	Effective use of finite health resources, through shared decisions and innovation.
Healthier lifestyles	Access to information to make informed choices, support people chronic illness.

Note. Adapted from *Better sooner more convenient: Health discussion paper* by T. Ryall, 2007, p.3. Wellington, New Zealand: National Party. Reprinted with permission.

National's health policy is silent in relation to public health except the over-arching commitment to growing the economy, to raise standards of living (and thereby health) and an emphasis on promoting individual responsibility for lifestyles choices. *Better Sooner More Convenient* outlines no specific strategy or position on Māori health.

The National-led government health policy is further outlined within the Minister of Health, Hon. Tony Ryall's (2009, February 19) annual *Letter of Expectations* to DHBs, the Ministry's *Statement of Intent* (2011c) and through refreshed and reconfigured health targets. The 2009 *Letter of Expectation* had a clear focus on improving hospital-based services including requesting action on improving cancer treatment and emergency department waiting times, increased elective surgery, emphasis on fostering clinical leadership and clinical staff retention. Devolution of secondary services to integrated family healthcare centres and regional co-ordination across DHBs were also encouraged. Due to the deepening global financial crisis, service reconfigurations were expected to be achieved within existing resources through the reallocation of resources from back-room bureaucratic roles into "front-line" healthcare.

Ministerial Review

> New Zealand must strive to get more health service from existing spending by
> reducing waste and bureaucracy and by lifting productivity
> (Ryall, 2008).

National Party concerns regarding the relative strength of the health system, the challenges ahead in terms of an aging population and ballooning healthcare expenses, led them to commission a major review of the health sector under the leadership of Murray Horn[111] (Ministerial Review Committee, 2009). This substantive report identified two types of recommendations i) those that encouraged changes in culture and processes to enable clinical leadership and improve integration within the health system, and ii) structural change aimed at

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[111] This report is widely known as the Horn Report.

reducing waste and bureaucracy to enhance quality and financial viability. Central to the report's recommendations was the notion of affecting change within existing resources and the current legislative framework.

The Ministerial Review committee (2009, p. 53) identified a number of what they considered key gaps in the current legislative framework. They wanted to see greater clinical-managerial leadership, stronger national and regional decision-making, improved frameworks for rapid development of new models of care and a better rationale for determining access to public funding for new services. If DHBs would commit to the new approach, the committee recommended that more health funding be devolved to them. The committee warned that more fundamental change might well prove necessary if the sector did not respond to the challenges of cost containment and innovation.

Amongst the structural changes proposed was the establishment of a NHB and an associated business unit within the Ministry. As stated previous, the role of the NHB is to "…co-ordinate planning and funding of national services, arbitrate in regional service disputes and undertake national capacity planning and funding for workforce, information technology and capital" (Ministry of Health, 2010g, p. 3). The NHB also assumes responsibility for monitoring DHBs performance to enable a complete view of health service planning and funding.

Since the release of the Horn Report (July 2009) a variety of actions have been implemented as outlined in the Ministry's recent *Statement of Intent* (2010g). The NHB has been appointed and has commenced work on consolidating planning and funding, workforce planning and capital investment. Revised health targets[112] and government priorities that reflect both the focus of the Horn Report and *Better, Sooner, More Convenient* have been established. Significant Ministerial and Ministry Advisory Committees and staffing levels within Crown agencies have been rationalised. A comprehensive line-by-line review and an in-depth spending review to prioritise expenditure from low value to higher value services as of mid 2011 remains active.

As part of the realignment to a new strategic direction, the Ministry of Health has identified two new health and disability system outcomes. First, that New Zealanders live longer, healthier and more independent lives and secondly, that New Zealand's economic growth is prioritised (Ministry of Health, 2010g, p. 9). The later reflects a marked change in the ideological orientation of the health sector from the previous Labour-led government. As with *Better, Sooner, More Convenient*, the Horn Report is predominately silent on both public health and Māori health.

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[112] These include shorter waiting times for cancer treatment, improved access to elective surgery, shorter stays in emergency departments, increased immunisation, better help for smokers to quit and better diabetes and cardiovascular services (Ministry of Health & National Health Board, 2011).

Whānau Ora

> The Whānau Ora philosophy... recognises the many variables that have the potential to bring benefits to whānau and is especially concerned with social, economic, cultural and collective benefits. To live comfortably today, and in the years ahead, whānau will be strengthened by a heritage based around whakapapa, distinctive histories, marae and customary resources, as well as by access to societal institutions and opportunities at home and abroad (Whānau Ora Taskforce, 2010, p. 7).

Parallel to the Ministerial review under the auspices of *Whānau Ora*, a taskforce was established in June 2009 to work across government to develop an evidence-based framework[113] for a preferred approach to interventions with whānau. Picking up on the initial intent of *He Korowai Oranga* - to reorientate government funding mechanisms - the proposal developed by the Whānau Ora Taskforce (2009) and their subsequent report (2010) are an attempt to develop a new approach for the design and delivery of government funded services and initiatives to whānau. The framework is about improving collaboration between funders, providers and practitioners to enable whānau to manage their own affairs more effectively, and to contain compliance costs.

As articulated in *He Korowai Oranga* (A. King & Turia, 2002, p. 1), whānau ora can be defined as Māori families supported "...to achieve their maximum health and wellbeing". The concept of whānau ora recognises that whānau play a central role in the wellbeing of Māori, individually and collectively, as "...a source of strength, support, security and identity" (Ministry of Health, 2006c, p. 1). Since its coalition negotiations, the National-led government has articulated its hopes to facilitate whānau ora to achieve:

> …positive and adaptive relationships within whānau and recognise the interconnectedness of health, education, housing, justice, welfare, employment and lifestyle as elements of whānau wellbeing (Ministry of Health, 2009d, p. 3).

The Whānau Ora Taskforce (2009, 2010) has identified a number of key elements and principles of whānau-centred service delivery (see Figure 16). Central to these elements is recognising the distinct roles of whānau, hapū and iwi and the contrasting responsibilities of government agencies in strengthening whānau ora. The principle of ngā kaupapa tuku iho is also vital; this refers to how whānau are part of a wider system embedded in Māori epistemology, driven by inter-generational transmission of knowledge, culture, reciprocity and resources. The framework is deliberately strengths-based, requiring innovation, adequate resourcing and a 'whole of government support' to succeed.

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[113] The report was based on relevant literature, developing case studies from the experiences of health and social service agencies, an analysis of oral submissions received at 22 hui and over 100 written submissions from individuals and organisations (Whānau Ora Taskforce, 2010, p. 6).

Figure 16: **Whānau Ora Framework**
Reproduced from *Whānau Ora: Report of the taskforce on whānau-centred initiative*s, by Whānau Ora Taskforce, 2010, p.21. Wellington, New Zealand, Ministry of the Community and Voluntary Sector. Reprinted with permission.

The taskforce reaffirmed the importance of Te Tiriti and the Treaty as a key instrument to guide development, and called for the establishment of an independent trust to administer dedicated government appropriation. Building on existing provider capabilities, the taskforce emphasised a primary focus on whānau outcomes, through integrated and comprehensive delivery. Rather than focussing on what work had been done by agencies, they are interested in what has been achieved with whānau, and how whānau can become stronger and more resilient into the future.

Upon the release of the taskforce's initial proposal, National Party leadership distanced themselves from the strong by 'Māori for Māori' position. Wright (2010, February 15) quoted Right Hon. John Key for TV3 news saying, "Our policy is based on needs, not race, and that's the way it will be implemented", he explained, "not all families in need are Maori... and we're a government that want to provide support to New Zealanders in need". Consequently the National-led government did not accept all the taskforce's findings (Small, 2010), and *Whānau Ora* has shifted from being by Māori for Māori to a program accessible for all New Zealanders. Te Puni Kōkiri was appointed the key government agency responsible for *Whānau Ora* with key roles also for the Ministry of Health and Ministry of Social Development. National and regional governance arrangements have been confirmed and funding sourced through the reconfiguration of existing Māori funding streams from assorted government departments.[114]

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[114]Funding is being sourced through the Government's housing, health, education, justice and social welfare agencies.

In summary National Party health policy is one of containing costs and reorientating services from bureaucrats to front-line service delivery. They are committed to reducing waiting times and lists and from a policy perspective appear to have limited interest in public health and even slighter interest in Māori public health. The National Party has reconfiguring *Whānau Ora* into a model of service delivery suitable for all New Zealanders.

7.3 Meso Health Planning

> Often measures are recorded not because they are important, or useful, but simply because they are easy or convenient to record
> (Boulton, 2005, p. 53).

Within the realm of public policy, there are often hierarchies of documents guiding the purchasing and ultimately the provision of services. Within the health sector, macro-level policy and strategic direction are usually initiated and led by the Minister of Health. The core documents for public health policy since 2000, despite the change of government, remain the NZHS (A. King, 2000) and *He Korowai Oranga* (A. King & Turia, 2002). Underneath this macro, policy lays a range of issue-specific strategic and operational level planning led by senior Crown officials. This meso level planning is frequently web-like with complex interconnections across strategies and plans, with references to earlier, and at times forthcoming, strategic documents.

Smith (1994) in his analysis of excellence in public sector management argues there needs to be clear link between macro and meso level policy and planning. Planning logic, he contends needs to flow into contracted activities and organisational practices. There are currently two key planning approaches being promoted within the health sector; i) program logic outcome based planning (Ministry of Health, 2007b; Steering Group Managing for Outcomes, 2002); and ii) results based accountability planning (Friedman, 2005). The effective and inclusive utilisation of both approaches requires a range of competencies including technical knowledge of planning and epidemiology, understanding of Māori worldviews and the aspirations and circumstances of communities.

Wren (2007, p. 2) asserts program logic outcome based planning is a management tool to facilitate accountability, direct change, enables the prioritisation of resources and highlights areas requiring further attention. It is a mechanism to define and track changes in health status and health determinants and inequities, resource and service utilisation and programs responsiveness to a target population. Emphasis is placed on selecting a few outcomes to monitor, that are attributable to a program of work, that are timely, show the cost-benefits of an intervention and that are robust enough to withstand public scrutiny.

Results based accountability frameworks championed by Friedman (2005) allows communities and agencies to identify what they want to attain and then tracks back how this could be achieved. It involves assessing the current base-line data around the issue being targeted and developing performance measures and indicators to monitor progress. At an operational level it involves identifying how much has been done, how well that was done and what impact has occurred.

Central Government Public Health Plans and Strategies

The Ministry of Health and at times other central government agencies has been involved in the development of an extensive collection of strategies and plans (see Table 13) to enable the vision of the NZHS. During the Labour-led coalition the Minister of Health and or senior Ministry of Health officials has led out most of this work. Others strategic documents were developed through the Minister of ACC, the Minister of Social Services and Employment and some were overseen by various Ministerial committees.

Table 13: Core Public Health Strategic Plans

NZ Influenza Pandemic Plan	Immunisation in NZ: Strategic Directions	National Drug Policy	National Alcohol Policy	Clearing the Smoke: A five year plan for Tobacco Control
NZ Cancer Control Strategy	Healthy Eating Healthy Action: Strategic Framwork	Breastfeeding: A Guide to Action	NZ Suicide Prevention Action Plan	Good Oral Health For Life: The Strategic Vision for Oral Health
Like Minds Like Mine National Plan	Building on Strengths: Mental Heatlh Promotion	HIV/AIDS Action Plan	Sexual and Reproductive Health Strategy	NZ Injury Prevention Strategy
Te Uru Kahikatea: The Public Health Workforce Development Plan	Preventing and Minimising Gambling Related Harm	An Integrated approach to Infections Diseases: Priorities for Action	Te Rito :NZ Family Violence Prevention Strategy	

Note: This table shows a range of core public strategic plans including those produced by the Minister for ACC, Minister for Social Services and Employment, the Ministerial Committee on Drug Policy and a range of Ministry of Health publications. The shaded plans were developed under the Labour-led coalition government the blank ones under the National-led coalition government.

The plans, frameworks and strategies take many forms. The *National Drug Policy* (Ministerial Committee on Drug Policy, 2007) for instance is a high-level plan, which acts as an umbrella for alcohol, tobacco control, methamphetamine, and other illicit drug strategic planning. The recently developed *Influenza Pandemic Plan* (Ministry of Health, 2010e) in contrast is a highly technical plan to co-ordinate a whole of government response to the human, social and economic threat of a pandemic.

The bulk of meso level planning currently undertaken to implement the NZHS, reflects generic public health traditions and is dominated with bio-medical

understandings around disease prevention. Māori public health traditions are not represented in the selection of issue areas for policy development. Central to Ministry of Health planning is a strong emphasis on quantitative population level data and epidemiological analysis of disease and injury patterns. Improving population level surveillance and strategic use of research and evaluation findings are highlighted areas for further action across many of the plans. Frequently a literature review is undertaken as part of the planning process, which is sometimes published as a companion document.

Most plans and strategies[115] are developed with input from a sector and/or an expert reference group with a small to large-scale consultation process, depending on the significance and priority of the strategy or plan. The *HIV/AIDS Action Plan* (Ministry of Health, 2003d) is an exception to this process, as the New Zealand AIDS Foundation, who are also contracted to deliver services in that area, led it. Māori are consistently represented within reference groups but remain a minority within these forums.

The most frequently cited framework across this planning, mentioned in over half the plans and strategies is the *Ottawa Charter for Health Promotion* (World Health Organization, 1986, November). The five core strands of the Charter are often identified as action areas within plans and form the structural basis of others (Ministry of Health, 2002b, 2003c). Subsequent WHO health promotion declarations and or charters such as the *Jakarta Declaration on Leading Health Promotion into the 21st Century*[116] (1997, July), the *Bangkok Charter for Health Promotion in a Globalized World* (2005, August)[117] do not enjoy the same level of attention. Māori models of health such as *Te Wheke* (Pere, 1991), *Te Whare Tapa Whā* (Durie, 1994b) and *Te Pae Mahutonga* (Durie, 1999) are periodically mentioned but have not been utilised as the organising framework for planning documents.

A common theme across several of the plans and strategies is achieving compliance with various United Nations agreements, WHO and International Labour Organisation guidelines that the New Zealand governments have endorsed. Domestic legislation and government regulation also pre-determine

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[115] The process used to develop the breastfeeding, immunisation and gambling plans is not described within the documents.

[116] The Jakarta Declaration (World Health Organization, 1997, July) reiterated the importance of the Ottawa Charter (World Health Organization, 1986, November) and introduced new priorities for health promotion in the 21st century. These included promoting social responsibilities for health, increased investment in health development, consolidating and expanding partnerships for health, increase community capacity and empowerment of individual and strengthen infrastructure for health promotion.

[117] The Bangkok Charter (World Health Organization, 2005, August) pledges action to address the determinants of health in a globalised world. It emphasises the importance of building alliances, investment in sustainable policies, building capacity for policy development, regulating, legislating and advocating for health.

elements of public health responses and actions within the areas of tobacco control, drug policy and pandemic planning.

Many of the plans from the early 2000s make specific mention of the *Treaty of Waitangi*. More specifically, they name the Royal Commission on Social Policy's Treaty principles of participation, protection and partnership as part of their 'setting the scene' sections. Since the mid 2000s, post the Brash (2004, January) Orewa speech[118], terminology has changed, with the removal of Treaty references in favour of acknowledgement of the special status of Māori as tāngata whenua (see Ministry of Health, 2008e, 2010e) or more recently references to whānau ora (see 2006b; Ministry of Health, 2010f). Many strategies and plans emphasise the need to develop targeted approaches to engaging with Māori communities, without detailing how this might be achieved.

In summary central government meso-level, strategic planning has a strong epidemiological base and a population wide analysis. The Ottawa Charter is the most widely used framework within the plans/strategies, with the increasing use of outcomes and results based frameworks. Various commitments to Māori health are articulated across most of the plans. Under the National-led coalition government there has been only two meso-level public health planning projects undertaken (gambling and pandemic), which restricts the usefulness of a comparative analysis across the coalition governments at this time. The National-led coalition has however demonstrated low-level interest in public health and decreased regard for consultation.

District Health Board Planning

DHBs are charged with identifying health needs within their respective districts and developing plans to address those health needs, aligned to central government priorities. They are required to develop a *Health Needs Assessment* (HNA) and a DSP, from which DAPs are generated. Many DHBs also produce a range of lower level plans to support the implementation of their DSP. Although each of the twenty DHBs across Aotearoa has unique health needs and population profiles, there are many commonalities across much of this planning. These commonalities occur due to the prescriptive frameworks that documents must comply with in order to be endorsed by the Minister of Health. The following section profiles the planning processes of Northland DHB as an example of DHB level planning.

Northland DHB Strategic Plans

Northland DHB provides health services for over one hundred and fifty thousand people, covering the Far North, Whangarei and the Kaipara districts. Thirty percent of the population are Māori. Thirty eight percent of Māori living in Te Tai Tokerau are under fifteen years of age. The primary Northern tribes are Ngāti

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[118] The Orewa speech advocated for the removal of affirmative action programs and references to the *Treaty of Waitangi* in legislation. It was widely accused of fuelling racist sentiment against Māori.

Whātua, Ngāti Wai, Ngā Puhi, Ngāti Hine, Ngāti Kahu, Whaingaroa, Ngāi Takoto, Ngāti Kurī, Te Rarawa, and Te Aupōuri (Northland DHB, 2005b). Both Te Tiriti and *He Whakaputanga o Te Rangatiratanga o Nu Turei* hold particularly meaning in Northland, as it was here that they were signed. Te Tai Tokerau has a relatively deprived and scattered population with high rates of chronic disease and poor oral health (Northland DHB, 2005b).

Historically inherited from the local RHA, North Health, the Northland DHB (2005b, 2009b) until 2010 had a treaty-based relationship with both Te Tai Tokerau MAPO Trust[119] and Tihi Ora MAPO.[120] These relationships operated at both governance and operational level, as co-funding partnerships. Te Tai Tokerau MAPO Trust had a written partnership agreement with Northland DHB and were active in relation to, prioritisation and funding decision-making, strategic and service planning, consultation and communication with Māori, health providers and other stakeholders, contract negotiations, management and monitoring and Māori provider and workforce development (Northland DHB, 2005b, pp. 54-55).

The evidence base for most DHB-led health planning within Te Tai Tokerau is their HNA (2005a). This information forms the foundation of the DSP (Northland DHB, 2005b), under this lies population specific (See Northland DHB, 2007b; 2008, 2009a), and issue-specific health plans (see Northland DHB, 2007a, 2007c, 2007d; 2006a, 2006b) that provide the content for the DAP (Northland DHB, 2009b). Figure 17 Te Kahukura Oranga o Te Tai Tokerau shows how the Northland DHB authored and/or endorsed plans engage with Dahlgren and Whitehead's (1991) model of the determinants of health. This foundation is then overlaid with Durie's (1999) *Te Pae Mahutonga* and *Te Tiriti o Waitangi*, to represent Māori aspirations and paradigms (used in both the *Te Tai Tokerau Strategic Māori Health and Public Health Plans* see below).

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[119] Te Tai Tokerau MAPO Trust governance structure consists of representatives drawn from Ngā Puhi, Ngatiwai and the five Muri Whenua Iwi of the Far North, this agreement covers the Whangarei and Far North districts.
[120] Tihi Ora MAPO is governed by Te Runanga o Ngati Whātua and represented the interests of Ngati Whātua in Te Tai Tokerau, as they related to the Kaipara region.
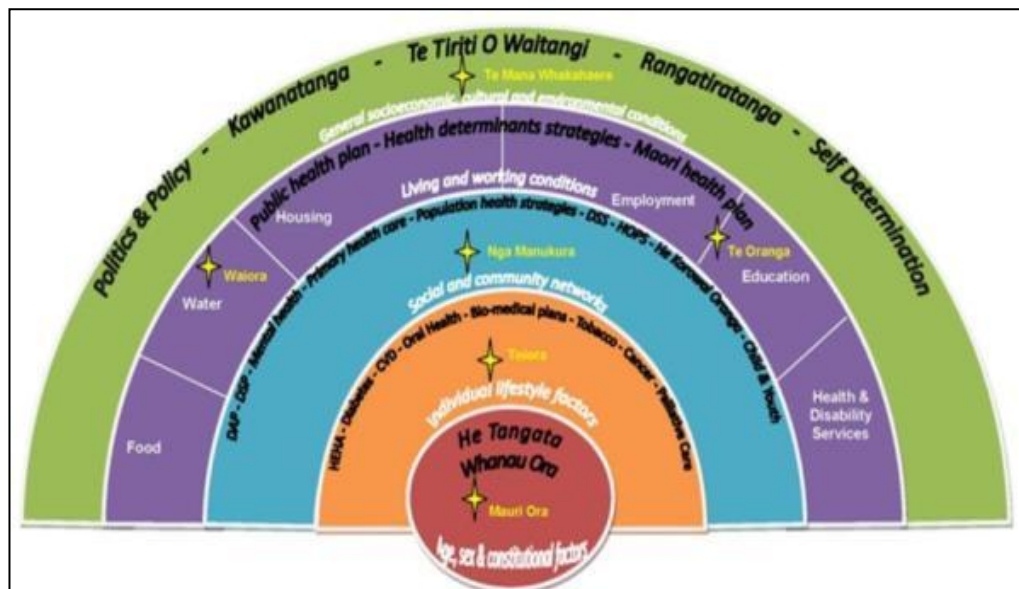
Figure 17: **Te Kahukura Oranga o Te Tai Tokerau**
From Te Tai Tokerau strategic Māori health plan 2008-2013, Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008, p.18. Whangarei, New Zealand: Northland DHB. Reprinted with permission.

The HNA (2001, 2005a) outlines the current demographic profile of the population of Northland and through epidemiological analysis quantifies trends in morbidity and mortality. This information informs operational planning around the provision of both treatment and public health services. The HNA benchmarks disease and injury rates of Northland residents with other DHB areas, and hence identifies areas requiring greater attention. Sub-regional analysis reveals inequities across Northland residents, most notably life expectancy gaps between Māori and non-Māori. Within the HNA, these inequities are located within a wider context of restricted access to the social and economic determinants of health for many residents and the recognition that poor lifestyle choices continue to contribute to the growing prevalence of diabetes, obesity, cardiovascular disease and cancer.

HNA analysis is both strongly quantitative and bio-medical in its perspective. This pattern is adopted consistently by DHBs across the country, to enable funders to quickly identify the major (illness) priorities they might invest in (Northland DHB, 2005a, p. 3). The HNA authors concede there are considerable information gaps within their analysis and note the difficulty and expense in addressing these gaps, as at times data does not exist or cannot be usefully broken down to a local level. Kaupapa Māori measures and indicators to track health status are not currently included within the HNA.

A companion document of the HNA, the DSP (Northland DHB, 2005b) describes the high-level intentions of how Northland DHB intends to address the health needs of its residents over a five-year period. In accordance with the NZPHDA, intricate to its development is a consultation process of public meetings, supplemented by a written submission process to enable community and provider engagement. Key frameworks utilised within the plan include the Ministry's

reducing inequalities framework (2002g) and leading for outcomes models (Ministry of Health, 2007b) and a locally adapted prioritisation framework.

Northland DHB has identified both a set of strategic priorities (diabetes, cardiovascular disease, cancer, oral health and elective services) and several population subgroups with high health needs (Māori, Pacific peoples, children and youth and older people) as the focus of their DSP. Particular reference is made within the DSP of the importance of promoting healthy eating and physical activity as a vehicle for preventing and managing chronic disease. The importance of healthy lifestyles and reducing inequalities is highlighted throughout the plan with no further detail provided on how this might be achieved. Healthy public policy is mentioned in the context of oral health, but the remainder of the plan is largely silent in regards to public health.

The DSP reiterates the commitment of Northland DHB to Te Tiriti and the Treaty and to fulfilling its statutory responsibilities to Māori. To achieve these ends the Northland DHB identified a variety of strategies to improve Māori health aligned to *He Korowai Oranga* (A. King & Turia, 2002) and the Whakatātaka series of action plans (Ministry of Health, 2002h, 2006c). These strategies aim to significantly reduce the life expectancy gap between Māori and non-Māori by 2015 and involve including Māori in health system planning and delivery at all levels. They aim for equitable resource allocation for kaupapa Māori programmes and for any new or expanded initiative and tracking health status and service use by ethnicity to enable effective monitoring.

Within Northland's hierarchy of plans underneath the DSP are the Te Tai Tokerau Strategic Māori Health and Public Health Plans (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008; Te Tai Tokerau MAPO Trust & Northland DHB, 2008). The first was written collaboratively by the Māori health leadership group Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau[121] and the second was co-authored with Te Tai Tokerau MAPO Trust. Both affirm Māori public health traditions and represent Māori aspirations in relation to health. A review of Northland DHB board minutes (from Sept 2008 to Sept 2011) and responses to OIR (Roach, 2011, August 11, 2011, September 12) provided no verifiable confirmation that either plans has yet been substantively implemented.

Building on previous planning undertaken by the Te Tai Tokerau Strategic Māori Health Alliance, the Māori Health Plan (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008) originates from a Māori worldview[122] and is infused with public

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[121] Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau is made up of membership consists of the chief executives of Te Tai Tokerau Māori Health Strategic Alliance, Te Tai Tokerau MAPO Trust, Northland DHB and local Primary Health Organisations.
[122] The principles of Māori health plan are enmeshed in tikanga Māori, they include the concepts of tika (that which is just, fair and proper), pono (truth and sincerity), aroha (love and respect), kotahitanga (collaboration or working together), whakapiki ake (building capacity) and ngā

health thinking. This plan was developed collaboratively through a series of workshops and extensive debate amongst the local Māori health leadership. Te Tiriti forms the heart of the plan, with strong emphasis on the importance of partnership between the Crown and Māori. Te Rōpū Kai Hapai, as the Māori health leadership forum within Te Tai Tokerau strongly asserts they should be involved in the determination of funding and other decisions made in respect of Māori health in the region.

Within the Māori health plan, Te Rōpū Kai Hapai expressed concerns (2008, p. 2) regarding health inequities and called for a new approach based on the realities of the circumstances in which many Māori in Te Tai Tokerau live. Central to this proposed approach (2008, p. viii) was a focus on "...addressing the social and economic determinants of Māori health – poverty, employment, education, housing, the natural environment and Māori leadership, without distracting from the provision of effective health and disability services". The premise being that improving the conditions of daily life, by tackling inequitable distribution of power, money and resources is likely to improve health status in its broadest sense.

The plan is a matrix that links the contributions of existing local, regional and national strategies back to Māori health goals. One axis relates to the building blocks of hauora, the other covers a series of crosscutting themes and action areas. The themes include kotahitanga, he tangata in this context referring to leadership, workforce and capacity building, he rangahau hauora (research) and he putea related to equitable resource distribution. Across the plan child, health also has prominence, with many of the recommendations from the Child Poverty Action Group's (St John & Wynd, 2008) report, *Left Behind: How Social and Income Inequalities Damage New Zealand Children* incorporated into the plan. Another key proposed action is the development of a Māori Hauora Index, as an authoritative compendium of a range of Māori data to inform future health policy and planning. The plan also specifically named addressing institutional racism as an action area.

The central framework for the public health plan (Te Tai Tokerau MAPO Trust & Northland DHB, 2008) is Durie's (1999) *Te Pae Mahutonga*. The plan was initially informed by interviews and focus groups with Māori stakeholders and a review of Māori health literature. Later a representative reference group was established and written submission process was instigated targeting those working within the sector. The plan introduced a Te Tai Tokerau approach to public health (see Figure 18) which takes into account both epidemiological and kaupapa Māori evidence and analysis and community aspirations within plan. Central to the approach is recognising the realities of the circumstances in which many

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tūmanako me ngā whakapaunga kaha a te Kāwanatanga (a commitment to reduce health disparities) (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008, pp. 1-2).

Northlanders live. The plan has two key platforms, i) strengthening action on the building blocks of hauora; ii) improving public health workforce capacity.
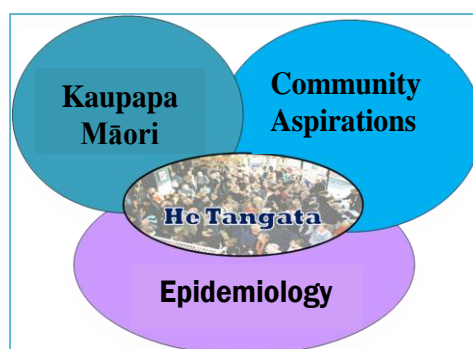
Figure 18: **Te Tai Tokerau Approach to Public Health**
Adapted from Te Tai Tokerau strategic public health plan 2008-2011, by Te Tai Tokerau MAPO Trust & Northland DHB, 2008, p.7. Whangarei, New Zealand: Northland DHB. Reprinted with permission.

The building blocks of health are about ensuring individuals and whānau have access to the essentials of life (food, shelter, clean water, sanitation, peace etc) health and determining what the health sector can contribute to ensuring this access. Other elements of the plan emphasises strengthening collective leadership around advocacy, embedding a regional approach to Ministry defined public health issue areas, hapū and community development, a commitment to environmental health and communicating and engaging effectively with Māori. Significant to this research the plan (Te Tai Tokerau MAPO Trust & Northland DHB, 2008, pp. 20-21) names both personally mediated and institutional racism as action areas needing to be addressed.

Northland DHB also has a range of additional operational/strategic plans with some relevance to public health (see Table 14). Given the sequence of their development, these plans are not yet all aligned to the strategic direction outlined in the Māori health and public health plans. As these plans are renewed, the intention is their alignment will be strengthened. Key actions from these strategies/plans are lifted out annually to populate the DAP which delineates the operational purchasing and work-plan for that year.

Table 14: Core Northland DHB Strategies and Plans

The standard DHB planning process involves a review of relevant national strategies, local epidemiological and/or demographic data, followed by a stock take and gap analysis with various levels of sector engagement. Usually an advisory/reference/planning group is established, predominately made up of DHB staff from both the funding and provider arms, alongside representation from external stakeholders including Māori providers. Reference lists of cited material are frequently omitted making it difficult to identify what if any literature has been reviewed beyond Ministry documents. When peer review is undertaken, the pattern is to utilise staff from other DHBs and/or the Ministry (Northland DHB, 2007b, 2007d). Formal sign-off of the plan/strategies occurs at Board level, which includes both locally elected representatives and Minister of Health appointees.

With the exception of the oral health strategy (Northland DHB, 2007d) all strategies/plans reviewed included standard setting the scene statements about Crown-defined Treaty principles and the importance of whānau ora as defined within *He Korowai Oranga* (A. King & Turia, 2002). These Treaty statements emphasise the importance of Māori involvement at all levels and stages of health system planning and delivery. The *Northland Diabetes Strategy* (Northland DHB, 2006b, p. 2) goes further however, stating a commitment to equitably resource kaupapa Māori programmes on any new and or expanded initiatives. Māori health models are not named or used as frameworks in any of the reviewed plans.

The plans/strategies fit into two primary categories: those focused on sub-populations, and those concentrating on chronic disease management and prevention. The population specific plans emphasise the importance of accessible services and addressing the particular health needs of that population. Consumer input was deliberately sought in the development of both the disability and older people strategies. The particular health needs of Māori are mentioned variously within the plans but limited Māori specific actions are identified to address those stated needs. In the *Health of Older People Strategy Action Plan* (Northland DHB, 2008) for instance the only planned Māori specific activity for the term of the strategy is undertaking a small-scale research project to define need further.

The reviewed plans/strategies have a strong clinical base, which is reflected in how the health "problems" are defined, through to the selection of membership of the reference groups and planned activity. The life-course approach to chronic disease management is a useful framework to strengthen the interface between primary and secondary services (Halfon & Hochstein, 2002). Discourse around reducing inequalities is present within all reviewed Northland DHB plans and strategies. The mechanics of how the Ministry's inequalities framework (2002g) and the HEAT tool (Ministry of Health, 2004d) have been applied in decision-making around action areas is not transparent.

7.4 Summary

Government policy wields considerable influence over the public health sector defining strategic priorities, preferred approaches and paradigms and at a resourcing level determining which health programs are purchased. In this chapter I outline macro and meso-level health policy from 2000-2010 based on a desktop review of Crown documents. Understanding the assumptions and omissions within such policy and identifying whose worldview is being privileged is critical to understanding how institutional racism manifests within policy.

The Labour-led government and more recently the National-led government have defined macro level health policy within Aotearoa over the last decade. The Labour-led coalition had a strong focus on prevention and reducing inequities between Māori and non-Māori. They also introduced whānau ora approaches to health policy through *He Korowai Oranga* (A. King & Turia, 2002). The National-led government has primarily emphasised containing costs and improving efficiency; and through their coalition partner have expanded and reframed *Whānau Ora*.

Based on my policy review New Zealand's public health policy throughout the last decade, across both coalition governments, has been based on population level epidemiological analysis of preventable morbidity and mortality. Macro-level policy has been predominately framed around biomedical understandings of disease prevention and risk reduction, with the exception of whānau ora. The hegemony of western bio-medical traditions is demonstrated within the selection of sector-wide health targets (Ministry of Health, 2009c, 2010d) with their emphasis on treatment and the management of chronic disease.

At DHB, level there is a strong commonality in health planning due the prescriptive requirements imposed by the Ministry of Health on DHB around the HNA process. These requirements have served to consolidate epidemiology as the ontological base of health planning. The assumptions and bio-medical focus of HNAs then cascade through DHB strategic and operational planning.

Over the last decade in relation to health policy, Māori health has been addressed in one of two ways. Firstly through targeted health policy such as *He Korowai Oranga* and the whānau ora policy platforms and secondly through variously levels of inclusion within non-targeted policy and strategic planning. From a public health perspective, the challenge in relation to targeted Māori health policy is the failure of funders to resource relevant Māori public health activities to implement this planning (discussed in chapter ten). In relation to non-targeted policy, Māori concerns and aspirations are often restricted to discrete paragraphs and/or sections (or are rendered invisible). Within non-targeted policy, Māori paradigms simply do not form part of the ontological basis of planning.

The following chapter outlines counter narratives from those whom have been targeted by racism sharing their experiences of Crown-led policy development, implementation and evaluation processes.

CHAPTER EIGHT: COUNTER-NARRATIVES: RACISM WITHIN THE POLICY CYCLE

8.0 Introduction

> The Crown will lie, it will manipulate, it will change the law, it will do everything to maintain its power and that is the overt face of institutional racism. We know they will not muck around, if it comes to anything they will take whatever they need off us, to ensure they maintain their power... Policy is a reflection of the Crown ensuring it will maintain its position, always, be in no doubt (Berghan, 2010, November 7, p. 6).

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Having represented Crown master policy narratives in the previous chapter, in this and later in chapter ten, I engage with their converse - counter narratives. These counter narratives consist of the perspectives of Māori and Pākehā from outside Crown structures, the voices of subalterns working within the system, and the observations of the staff of the Crown's former co-funding partner. As introduced in chapter two, these storytellers draw on extensive experience within the health sector, from working within both Māori and Crown agencies over decades. Individually these standpoints provide an informed but partial view (see figure 19). When supplemented by relevant literature and my co-funding field notes they begin to reveal the detail and extent of how in this case the phenomenon of institutional racism manifests within policymaking.

Figure 19: **The Wave**
This is a widely utilised structural analysis tool was introduced to Aotearoa by Father Fanchette from Martinique and was developed by Jenny Rankin for the Auckland Workers Education Association, retrieved from http://awea.org.nz/sites/default/files/Wavecolfooteronly.jpg Reprinted with permission.

Although this and chapter ten are essentially a deficit analysis, the purpose of this scrutiny is to rouse transformative action. Several of those sharing counter narratives wished to recognise the positive contribution of the many subalterns working within the Crown, who attempt to practice their duties with integrity and who wish to contribute to positive systemic change. I tautoko the acknowledgment of these efforts and recognise the constraints and the pressures that affect those working within the public service within strategic and operational roles.

This chapter is framed around the stages model of policy making, which is among the most widely utilised western policy development frameworks (Fafard, 2008). The stages model, adapted by Howlett, Ramesh and Perl (2009), identifies several stages in the policy cycle: agenda setting, policy formation, decision-making, policy implementation and policy evaluation. Although the model presented is largely linear, the identified sites of racism are often overlapping across stages.

In reading the counter narratives provided within this chapter I encourage consideration beyond the detail of the specific examples to see patterned behavior, as it is in these patterns of practice that institutional racism manifests.

8.1 Agenda Setting

> Processes of citizens input are shaped and facilitated by the requirements of government agencies involved. This inevitably restricts the range of issues and questions discussed as the agenda for discussion is usually determined by the agency concerned (Tenbensel & Gauld, 2001, p. 34).

The agenda setting stage of the policy cycle is when decisions are taken as to what policy areas and concerns will be prioritised for further development. Often this is initially done internally within political parties through the establishment of political manifesto prior to an election. This manifesto is then refined within an MMP environment through coalition negotiations. Fafard (2008, p. 9) argues agenda setting is influenced by promises made during election campaigns, advice received from the public service, the policy and program priorities of majority political parties, policy and initiatives developed by the previous government, and personal priorities of key politicians.

Counter storyteller, Māori Policy Analyst (2010, November 16, p. 2) explains that for Māori the agenda setting stage is among the most critical parts in the policy cycle.

> ...if you don't get the stuff on the agenda then the rest doesn't matter, because after that it is the dominate discourse that will determine what happens. If it is Pākehā discourse, values and ideology that are dominant at the time at the agenda setting level, that is just going to play out right through the whole process, the policy formation (p. 2).

Two primary factors emerged from counter narratives that shed light on manifestations of racism in relation to agenda setting. Firstly the theme of the tyranny of the majority and the structural challenges for Māori brought about by becoming a numerical minority. Secondly the notion that racism is fluctuating and changeable, something that C. Jones (2003), Griffith et al. (2007) and Barnes-Josiah and Fitzgerald (2004) describe as racial climate.

Tyranny of the Majority

> The conversations happen, the arguments are put forward, and the debates are held, invariably the default is back to the numbers, inevitably, it is the tyranny of democracy (Berghan, 2010, November 7, p. 5).

Majoritarian democracy is upheld by many as the epitome of fairness in parliamentary systems and decision-making practices. Counter storyteller, Berghan explains, "...if you are in the mainstream... it [majoritarian democracy] seems the fairest, because it is based on everyone gets a say, so we [all] get a say". This notion of looking after the interests of the bulk of the population is reflected within much policy, which is frequently based on population level analysis of needs and aspirations. Former Human Rights Commissioner, Hosking (2011, p. 370) asserts policy is also based on what is palatable to the bulk of the electorate, to the detriment of minority interests.

Political commentator, O'Sullivan (2003) asserts when indigenous peoples become a minority in their own country, the imposition of majoritarian democracy becomes a culturally specific manifestation of historic racism. A majoritarian decision-making process - whether it is when political parties develop their policy manifesto, in governance bodies across the health sector or within senior management teams in Crown agencies – opens up a structural likelihood that the interests of the majority could subsume the interests of minorities. Political philosopher, John Stuart Mill (1859/2006) called this tension between majority and minority interests as the 'tyranny of democracy'.

Within Aotearoa Te Tiriti, obligations should protect and promote the interests of Māori regardless of their proportion of the population. Counter narratives however, do not support the notion that Māori interests were either protected or promoted within the agenda-setting phase of policy development. Berghan (2010, October 18, p. 4) illustrates this through his experience in a prioritisation process while he was working for a Crown agency:

> I am the only Māori sitting around the table and there are ten of us. We are sitting up and arguing the prioritisation framework and I am arguing strongly that Māori health should be right up near the top because of poor Māori health outcomes. So we have the debate... you put it on the table,

you go hard for it and in the end... if you don't have the numbers, that is where the funding goes.

Counter storyteller, Māori Policy Analyst (2010, November 16, p. 3) recalled the struggle of two Māori women trying to get Māori issues on a policy and funding agenda. She explains:

I walk into the room and there is me and [my Māori colleague] and then the doctors come in and they are all Pākehā and then you have the CEO [who] is Pākehā, and the population strategist is Pākehā, and the cancer control people who are Pākehā, community groups who are Pākehā. And you know how the hell are we going to make a difference if all the people sitting around the table or the majority of the people sitting around the table making decisions about Māori health are Pākehā and so [my Māori colleague] and I would battle for a Māori voice to be heard, yet that would still be side-lined by the chair who was facilitating the discussion (p. 3).

These two narratives illuminate a pattern of Māori as a structural minority within Crown boardrooms and decision-making forums. This is repeated at both governance and senior management levels across Aotearoa on a daily basis.[123] A recent report by the SSC (2010, p. 5) confirms Berghan's perceptions revealing that only 8.3% of senior managers within the public service are Māori. A review[124] of the makeup of DHB boards, as of December 2010, confirms that only two board members per DHB (14%) have acknowledged Māori whakapapa. While in terms of DHB, governance this level of representation is proportional to population levels[125] counter narratives report, in the context of both governance and senior management, practically this level of representation within a majoritarian decision-making paradigm presents what were perceived as significant obstacles to Māori priorities being advanced.

Racial Climate: Political Will

...it doesn't' matter whether you have a centre right or centre left government you still have the same racism. It just gets cloaked a bit differently (Berghan, 2010, October 18, p. 2).

Racial climate testing is a process of examining elements of an environment to gauge the hostility or readiness of an institution or community of interest to take on board indigenous concerns and/or transform racism. It exposes the changing

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[123] In making this statement I acknowledge that non-Māori on occasion and indeed some non-Māori consistently support positions put forward by Māori in decision-making forums; this is different however from equitable Māori representation within such forums.

[124] Within this review ethnicity was determined by information from DHB websites on board members and a review of enrolments on the Māori electoral roll a method previously used by Sullivan (2010) in her research into Māori representation within local government.

[125] Across New Zealand the indigenous Māori population is 14% (Statistics New Zealand, 2002) of the total population.

tides and faces of racism which can be useful in planning anti-racism interventions. Berghan (2010, November 7, p. 7) explains the related concept of political will, drawing from his experience in parliamentary election campaigns:

> ...there is always a line where the... government will not cross because they would have done their surveys of... where their backing is, and there comes a point where your constituency says we have had enough of the Māori stuff... and if you go any further your support goes from you... Every week they monitor the feedback... that is when political will is clearly demonstrated, and we get the messages in mainstream institutions that there is a no-go zone. So under MMP... they are trading all the time and... political will is subject to negotiation.

Within this political context, Berghan (1997) argues that Māori health is treated as a partisan or political issue rather than as a Te Tiriti obligation or a social/economic/cultural/political crisis that needs to be addressed. Constant tinkering within the health sector[126] has required Māori to constantly forge new relationships with ever-changing Crown entities, who experience high levels of staff turnover and constant restructuring (Te Puni Kōkiri, 2000b, p. 22). The constancy in Māori health therefore has not been Crown agencies or officials, rather the dynamics of whānau, hapū and iwi.

The concept of racial climate is a useful construct to understanding the way racism manifests within both a particular geographic context and within a discrete timeframe (see Came, 2011b). Counter storytellers through this study identified a range of distinct periods of racial climate: i) the mono-cultural era prior to the development of Māori health providers, ii) the stimulating period of innovative change under the leadership of the HFA and the RHA, iii) the fraught period post Brash's (2004, January) Orewa speech characterised by the rise of libertarian viewpoints, iv) the current period marked by the dynamics of fiscal restraint justified by the global economic recession.

As established in chapter three historically institutional racism was commonplace across the policies and practices of Crown officials. Counter storyteller, Kuraia (2010, September 22, p. 3) suggests even up until the early 1990s there was no detectable commitment to engage with Māori as strategic partners, nor were Māori world views incorporated into health policy or practice. Te Puni Kōkiri (2000b, p. 9), in a report on the views of Māori providers from the early 1990s, found:

> ...government departments did not recognise... cultural differences as important to service delivery. They also did not recognise that Māori could

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[126] Certainly the author while working for reincarnations of the same Crown agency over a ten year period had ten different senior managers.

deliver services as well as or better than government agencies and non-Māori providers.

Counter storytellers spoke positively of the racial climate under the leadership of the HFA and RHA. During this period, there was a commitment to funding by Māori and for Māori services, developing treaty relationships[127] and ensuring contract documents made explicit reference to the Treaty (Northern Regional Health Authority, 1996). Kuraia (2010, September 22, p. 2) suggests this groundwork led to an active movement to name racism as a determinant of health (see A. King & Turia, 2002; Ministry of Health, 2001a, 2002g) and to do something about both racism and health inequities as demonstrated through the development of the HEAT tool (Ministry of Health, 2004d). This momentum, she argues was lost as people in key positions within the sector chose to stay silent on the issue and/or were restructured out.

The impact of Brash's Orewa speech (2004, January) on racial climate has been discussed extensively elsewhere (see Barber, 2008; Callister, 2007; L. Stoddart, 2007). Counter storytellers saw this speech and the subsequent response as a reversal of potentially progressive policy initiatives. Brash's speech triggered the Labour-led government to direct the SSC (2004b, 2004g) to undertake a comprehensive whole of government review of targeted [race-based] policies and programmes. Peace Movement Aotearoa (2007) in their parallel report to CERD published a memo from a senior Ministry official (see Wall, 2006) confirming a policy decision had been taken to remove systematically Treaty references within policy and contracts within the health sector. Kuraia (2010, September 22, p. 2) asserts this decision was an illustration of institutional racism. She cites the recommendations of United Nations Special Rapporteur, Stavenhagen (2006, p. 5) following his visit to Aotearoa, which was reconfirmed by his colleague Anaya (2011) that the *Treaty of Waitangi* should be entrenched into constitutional law as supporting this assessment.

Counter storytellers speculated that the current international global recession (since 2007) is another racial climate marker. In my survey of public health providers in December 2010, several Māori providers disclosed that they had lost contracts, in spite of track records of strong service delivery. These cut backs to Māori programs appears to have occurred in two waves: i) through the line by line review established to contain costs; ii) through the reallocation of funds from Māori programs to the reconfigured *Whānau Ora* program. During this period Māori workforce development expert, Berghan (2010, October 18, p. 2) asserts that restructuring and job losses disproportionally affected Māori and Pacific practitioners. He suggests the restructuring was ostensively driven by pressure from Crown funders:

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[127] Within the Northern region, this was when the MAPO strategy developed to enable Māori involvement in decision-making (Kiro, 2000).

> ...to get more effective and productive with the limited resources they
> have. The immediate default position is to take out...Māori and Pacific
> Island people who have the least qualifications... [as] it is much easier to
> be able to justify getting rid of those people... I think this is the
> institutional racism... they defend themselves by saying it's not about
> Māori... it's actually about getting the best value for the dollar (p. 2).

The ability of Māori and non-Māori allies alike to promote and maintain Māori
policy concerns on the policy agenda is affected by both majoritarian decision-
making and changeable racial climate. These structural and political barriers to
Māori policy concerns entering the policy cycle are compounded through the
subsequent stages of policy development and implementation, entrenching, I
maintain, the marginalisation of Māori.

8.2 Policy Formulation

> ...policy and policymaking are infused with dominant values, Eurocentric ideals,
> institutionalized biases, and vested interests. So deeply embedded are racialized
> notions about what is normal, desirable, or acceptable with respect to policy
> design, underlying assumptions, priorities and agenda, and process that
> policymakers are rarely aware of the systemic consequences that privileges some,
> disempower others (Maaka & Fleras, 2009, p. 8).

The formation stage of the policy cycle is when a range of possible responses to a
policy problem are identified by Crown officials. This process of determining
which policy and program choices are included and excluded from final
consideration is complex, involving the management of multiple stakeholders,
who can hold conflicting standpoints. The scope of this problem solving is often
contained by the dominant paradigm of the governing political parties. Fafard
(2008, p. 10) argues problem definition is critical as how a given issue is framed
has a significant impact on what evidence is considered relevant, and channels
policy makers towards particular interventions. He notes that if a policy issue is
framed as a technical problem, experts can and often do dominate the process of
decision-making.

Two related concerns consistently emerged from counter storytellers in relation to
policy, formation. The first related to the evidence base used as the foundation of
health policy and the second to the cultural competency levels of some Crown
officials.

Incomplete Evidence Base

> Kaumātua may be considered repositories of kinship principles, but "uneducated"
> in a non-Māori sense. Other cultural forms of knowledge and values may be
> needed for a balanced perspective. In development of a bicultural milieu,
> knowledge and values from both cultures have to be taken into account
> (Kawharu, 2001, p. 4).

What is considered valid knowledge and what is recognised as evidence are contested sites within both academic and policy contexts (Crotty, 1998). Policy centered in Te Ao Māori and mātauranga Māori have a profoundly different ontological base than policy centered in western bio-medical understandings of health. The prevailing ideological hegemony has a powerful impact on both the framing and content of policy. As delineated in chapter seven the dominant discourse of Crown-developed health policy in Aotearoa is epidemiological analysis of morbidity and mortality patterns.

Population level analysis has become the core platform of Crown health planning. It is used to assess trends at a national level and determine what interventions will maximise health gain for the majority of New Zealanders. Kawharu (2001, p. 3) suggests such analysis is useful for mapping general themes, but in relation to social development policies, an exclusive reliance on this type of information is inadequate. Without ethnic-specific analysis, the dominant majority masks the dynamics of Māori patterns of disease and injury and planned interventions may simply not be effective within an indigenous context.

Counter storyteller Bradbrook (2010, October 4, p. 5) commenting on the Ministry's (2004a) tobacco control strategy explains it:

> ...is about tobacco control dogma and what is current global policy of the day, which then comes into a New Zealand context. Someone says quit attempts are really important and so inevitably what happens in New Zealand is we take on that mantra.

He asserts policy is simply rolled out without adequate analysis to ensure what is best practice in Europe or elsewhere (where ever the policy is lifted from) is relevant or effective within indigenous communities. This practice occurs despite the often disproportionate high health needs of Māori.

Kuraia (2010, September 22, p. 4) points to a published case study undertaken by Otago University (L Signal et al., 2008, pp. 22-24) to test the revised HEAT tool using a draft tobacco control plan as an illustration of the misuse of evidence. The HEAT tool trial showed that the DHB-proposed tobacco control approach was flawed and that "...it was likely to increase rather than decrease inequalities". She explains:

> ...it was demonstrably shown that the particular (so-called) strategic approach the DHB were wanting to take was wrong... there was a complete ignoring of that reality and an insistence on continuing on the pathway that they had determined... it was like "whatever, we are still going to do it" and that is exactly what they did...flying in the face of all the evidence that was piled up in front of them about that approach not being workable for Māori (p.4).

Another counter storyteller (Senior Māori Executive, 2010, November 28, p. 1) shared concerns around how they felt DHBs rejected evidence provided by Māori.

> ... [we] would explain why our thinking would be in a particular direction and provide... absolute irrefutable [Māori] evidence... or talk about the necessity for tikanga for instance to be honoured within that contract or policy or strategic framework. Most if not all would be soundly ignored by the DHB. Because they in their white western thinking were not able to give [it] any credence whatsoever... Māori thinking was not welcome at the table (p.1).

In reviewing the evidence base of Ministry public health plans and strategies over the last ten years, only a handful of Māori health academics and research institutes are cited.[128] Durie's (1994b) book *Whaiora* overwhelmingly being the most frequently cited text. Much Crown-developed policy exclusively cites documents produced or commissioned by the Ministry of Health and/or cite no Māori health literature what so ever (see Ministry of Health, 2001b, 2002a, 2002f, 2003e, 2006b, 2007c, 2010f). As showcased annually at the Health Research Council sponsored Hui Whakapirirpiri[129] Aotearoa has a impressive collection of established and emerging Māori academics with a broad-based interest in health research.

It appears the process used by Crown officials to decide what gets included in literature reviews, consistently marginalises the voices of many Māori health academics from policy development. This process is compounded when those plans and strategies are then peer reviewed (see Ministry of Health, 2003c, 2003h, 2008e) primarily by international reviewers with no transparent external indigenous review process.[130]

Bradbrook (2010, October 4, p. 6) asserts policy relevant to Māori needs to located within the context of "...iwi and our aspirations as iwi Māori". Working with iwi, he has developed a Tupeka Kore[131] approach to tobacco control that contains a mix of conventional tobacco control measures but it also has a tikanga Māori framework. He maintains, "...none of those policies from Ministry ever include those [tikanga frameworks]. I think it is just too hard, having a kaupapa driven approach, it is an anathema to the system". Both *Te Tai Tokerau Strategic Public Health*[132] and *Māori Health Plans* (Te Rōpū Kai Hapai o Hauora o Te Tai

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[128] These include; Durie, Pere, Ratima, Dyall, Aspin, Reid, Te Rōpū Whāriki, Te Rau Matatini and Te Rōpū Hauora o Eru Pōmare.

[129] Hui Whakapiripiri is an annual Māori health research hui.

[130] The exception being the utilisation of Durie to peer review the *Building on Strengths: A New Approach to Promoting Mental Health in New Zealand/Aotearoa* (Ministry of Health, 2002b).

[131] Literally meaning without tobacco, as a tobacco control strategy it requires a focus on Māori communities, the assertion of tino rangatiratanga through the reclamation of tikanga and Māori leadership.

[132] This plan took twenty five iterations to reach agreement on this approach.

Tokerau, 2008; Te Tai Tokerau MAPO Trust & Northland DHB, 2008) are illustrations that policy can be developed inclusive of both epidemiology and kaupapa Māori traditions, though neither have yet been substantively implemented.

Cultural Competence

> Of course, we all view the world through our own eyes, so the way we view the world is determined by the way we were brought up. I have been in circumstances where I have challenged a particular viewpoint or policy on the basis of its mono-culturalism and people have been genuinely surprised at the comments that I have made
>
> (Berghan, 2010, October 18, p. 4).

Tiriti trainer, da Silva (2010, October 31) argues that cultural competency requires non-Māori practitioners to be aware and actively manage their dominant cultural viewpoints. It involves the ability to recognise a range of viewpoints and value systems different from one's own. Cultural competency is a core element of professional practice for a range of public health disciplines[133] (see Health Promotion Forum, 2011; New Zealand College of Public Health Medicine, 2008; Public Health Association, 2007). It appears not to be a requirement for either Crown policy makers nor managers (see State Services Commission, 2007).

Many of the counter storytellers participating in this research raised concerns about the prevalence of mono-cultural policy analysis, claims that are echoed in Māori health literature (see Lawson-Te Aho, 1995; Maaka & Fleras, 2009). With nearly two decades working as a policy analyst with the sector Kuraia (2010, September 22, p. 3) asserts that policy typically reflects the dominant cultural views of the time. Therefore, in relation to health policy the overarching culture sends the message that "Māori aren't as good as Pākehā". These prejudices she maintains are then embedded into policy decisions about defining issues, sourcing evidence and prioritising actions. When Crown officials do not have the necessary level of cultural competency to break through their dominant viewpoint, the result in her experience is often mono-cultural practice.

Senior Māori Health Advisor (2011, July 1, p. 1) clarifies this dynamic:

> …it is predominately about set values and one set of values being the norm and that is the benchmark that everything is put against. It is about systems then, that process those values and move them through into everyday working life and process them as the norm, they reinforce those views as the norm.

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[133] This is further entrenched for some groupings of health professionals who are covered by the Health Practitioners Competency Assurance Act 2003.

By way of additional explanation da Silva (2010, October 31, p. 2) asserts organisations can tend to be mono-cultural because they are "...largely run by people with a particular dominant cultural view and they employ people with that same view". She suggests even when policy documents emphasise the importance of responsiveness to Māori, policy makers and senior managers consistently avoid access to treaty or cultural competency training. Rather front line staff with client contact are often sent to complete such compulsory courses. Shortland (2010, September 17, p. 1) asserts, Crown agencies operate from archaic thinking and a safe historic knowledge base, "...so the education around what they are doing within their institution is well behind the times, it is not being challenged so then it is just an ongoing cycle".

From his involvement with Crown officials in a range of capacities over decades, Berghan (2010, November 7, p. 6) elucidates these claims of culturally incompetence. He asserts:

> ...these are good people... they are benignly incompetent... [they] don't take into account other values; it is kinda like the universality of western values... and that tends to happen through most of the policy processes... they [Crown officials] don't see the need to be competent because why should they?... it is the others that need to understand. When in Rome do as Romans do, so when in New Zealand do as Pākehā do; it is that kinda stuff.

Drawing on their background in health governance, several counter storytellers expressed concerns about the appropriateness of a range of DHB board members who have limited or no background in either health or Te Ao Māori. However, they are involved in making high-level decisions affecting Māori. Speaking more broadly Wano (2011, June 24, p. 2) suggests that although some DHBs are better than others are, some are simply "not as competent in engaging with iwi or Māori providers".

As illustrated in chapter seven and reinforced here, much health policy is based on bio-medical traditions of epidemiology at the exclusion of other traditions and evidence. When combined with inconsistent levels of cultural competency among Crown officials, mono-cultural analysis can become a defining feature of policy formation.

8.3 Decision-making

Rarely is government policy the result of a single decision-the inherent complexity and contestability of policy means that taking action will require many decisions, perhaps over several weeks, months or even years (Fafard, 2008, p. 12).

Once policy evidence is reviewed and courses of action identified, decisions are then made about what specific areas to include within a policy document and how it should be framed. Decision-making processes contends Fafard (2008, p. 11), can range from involving a handful of people (as in technical decision-making), to complex processes involving dozens (as in Cabinet decision-making). He observes that at times, within politicised policy environments, evidence is assembled retrospectively in order to justify a decision that has already been taken – a practice which sociologist, Tilley (1999, p. 49) coined as 'policy-led evidence'.

From their extensive experience on policy reference and/or advisory groups for the Crown, several of the counter storytellers highlighted that policy decision-making was often problematic for Māori. Counter storyteller, Māori Policy Analyst (2010, November 16, p. 3) suggests decision-making processes within the health sector are like a battlefield. They explain:

> I have sat around decision-making bodies that developed policy with just Māori or in the education sector, and it just hasn't existed, the kind of violence I experience in the health sector, it is all about resources, it is all about money, and they [Crown officials] lose track of the kaupapa, because if they had their eye on the kaupapa then all the money would be going to Māori health (p. 3).

Kuraia (2010, September 22, p. 6) also likened Crown decision-making processes to a battlefield. She shared her experiences of a prioritisation process:

> ...we had prepared our bids alongside our colleagues in the DHB and we [MAPO staff] get in there and we have to argue for every little point about it. And because all our bids focussed on Māori rangatiratanga, Māori provider development all of those sorts of things they were automatically challenged, it didn't matter that we could point out the policy at the macro and DHB board level, which all of our bids fits into... all the Māori bids they just seem to get stuck. And the DHB colleagues were getting their bids processed and there was very little questioning of them... I am proud we did things in a way that are tika and pono... we had the appalling situations of people that definitely should know better getting up and storming out of rooms (p.6).

Within this sub-section, I examine three key themes arising from counter narratives in relation to decision-making. These are the active marginalisation of Māori viewpoints, flawed consultation processes and the impact of Crown filters through policy sign-off processes.

Marginalisation of Māori Viewpoints

Marginalisation of Māori viewpoints was a reoccurring macro theme of counter storytellers across all the policy development stages in this study with both subtle and more overt manifestations. Marginalisation is widely recognised as an observable manifestation of institutional racism (Kearns, Moewaka-Barnes, & McCreanor, 2009; Nettleton et al., 2007).

MAPO through their fourteen-year co-funding partnership with the Crown enjoyed unique access to the workings of the Crown in relation to its policymaking and funding practices within the Northern region. MAPO staff attended the vast majority of funding and planning related meetings with both Ministry of Health and Northland DHB with both generic and Māori public health providers over that period. This enabled the organisational staff to witness the behaviour of Crown officials across different groupings of providers. A counter storyteller (Senior Māori Executive, 2010, November 7, p. 4) clarifies "...the MAPO were there to represent the viewpoints and the korero directly from the leadership of Māori health providers and their governance levels".

Working on a daily basis with the Northland DHB for twelve years, Kuraia (2010, September 22, p. 5) notes that over a period of some years, expert Māori health analysis provided to the DHB, was actively rejected and marginalised. She explains:

> The input we [MAPO] were providing would be written out, it would be ignored, it would be twisted, it would be reframed, we would reframe it back again into what it was supposed to be and then it would be left out entirely. And when we challenged it, when we questioned it, excuses usually came in the form of "oh we were under time pressure to get this produced because the CEO wanted it published" or some such thing. Basically they'd say "we ran out of time so just couldn't put your stuff in" (p.5).

Kuraia confirms the frequency and the intensity of this behaviour varied depending on the racial climate at the time. However, overtime it escalated to becoming a commonplace, every-day experience.

Kuraia (2010, September 22, p. 6) illustrated her point with the specific example of the development of regional strategy. She explains:

> They [DHB] weren't analysing Māori data properly... Māori in Northland had the worst access of everybody across the region... But what was getting to me was the analysis was so victim blaming, [the DHB were saying] it was because Māori didn't turn up to their appointments and presented late for diagnosis... I couldn't quite articulate it myself why I felt it was so wrong. Then [a senior Māori academic]... gave me the words...

> "This is an example of inequitable and racist analysis of the numbers, of using the numbers to try and portray a line that Māori are wrong and bad"... So I expressed all of this in writing to the DHB, because they were using this…analysis to make decisions that were affecting people's lives... it was ignored (p.6).

Reid (2007) has consistently presented and published on the tendency of Pākehā to misrepresent Māori experience and apply 'racist' cultural deficit analysis to quantitative data to explain Māori ill health. She often cites the work of sociologist, Nazroo (1999, p. 215) who describes this process as the radicalisation of health issues. He explains:

> ...by identifying the health disadvantage of ethnic minority groups as inherent to their ethnicity, a consequence of their cultural and genetic 'weakness' rather than a result of the disadvantages they face because of the ways in which their ethnicity or race is perceived by others (p. 215).

Rather than focussing attention on structural determinants of health, with a racialised analysis the gaze remains fixed on finding fault with the minority group experiencing the disadvantage.

Berghan (2010, November 7, p. 5) shared his experiences of a sector-wide workforce development review that was broken up into review teams covering different occupational groups, nursing, doctors, and public health and so on. He explains:

> There is no mention of Māori, not one mention all through that [review]. The assumption is that Māori will be captured in each of those service reviews... So what happens is when they end up doing these reviews the particular needs of Māori in the workforce are disregarded (p. 5).

Berghan had advocated for a dual strategy of developing a particular Māori workforce stream as well as including Māori analysis within each service review team. He suggests an inclusive process would have included an overview of the cultural needs and skills needed to work with Māori. These omissions he asserts "...is a continual denial of Māori as Māori" I suggest this is an illustration of the marginalisation of Māori policy concerns.

Flawed Consultation

> I applaud the ones that come out and ask questions...[but] somehow it tends to get
> lost as they go to write
> (Māori Provider CEO, 2010, November 1, p. 5).

Well-planned consultation can build on knowledge and experience, test assumptions and produce workable solutions. As outlined in chapter seven, it is a

statutory and legislative obligation of both DHBs and the Ministry to undertake consultation processes to engage with communities and particularly with Māori. Consultation is a key mechanism within many Māori responsiveness frameworks to solicit Māori opinion and engagement. Both Ministry of Health (2002c) and Treasury (2009a) have developed specific consultation guidelines to enable effective consultation. Māori health advocate, Lawson-Te Aho (1995, p. 24) suggests internal consultation with Māori Crown officials is not comparable with external engagement.

Ministry of Health (2002c, p. 7) consultation guidelines acknowledge the difficulties of identifying whom to contact and listen to within Māori communities. Māori providers (see Te Puni Kōkiri, 2000a, p. 25) have similarly expressed concerns about the ability of Crown agents to assess effectively Māori needs at the community level. This concern stems from Crown agencies perceived lack of local relationships and understanding of the dynamics of Māori communities.

Counter storyteller, Shortland (2010, November 17, p. 1) succinctly maintains Crown officials are "[j]ust not listening, the writers who are writing the policy don't have a paradigm about an articulation of what is on the ground...". Furthermore, she suggests Crown-led policy often has incorrect information about demographics and communities and there is a clear lack of accountability and feedback to communities who could provide correct and accurate information. Te Puni Kōkiri (2000b) in their research into Māori experiences of Crown contracting practices, identified Māori providers often play a middle ground between the government and Māori communities. Māori providers are often very aware of the particular needs of communities and have established informal and formal accountabilities back to whānau and hapū.

The following examples relate to the introduction and/or revision of key policy development by the Ministry of Health. Bradbrook (2010, October 4, p. 7) comments on the introduction of the new brief intervention approach to tobacco cessation. He argues, "Suddenly it was the only thing... no consultation, no discussion, this is just the way it is". He maintains this was problematic for Māori on two fronts, firstly as the new approach was incompatible with the long established aukati kai paipa[134] intensive cessation programs run by Māori across the country, secondly he asserts there had been no analysis or study to show the efficacy of brief interventions for Māori. Additionally the brief intervention approach denies the body of evidence that demonstrates the relevance of culture to health (Durie, 1994b; Ramsden & Erihe, 1988).

The *Public Health Service Handbook* (Ministry of Health, n.d.) as introduced in chapter six has been the basis of most public health contracting in New Zealand

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[134] Aukati Kaipa is a kaupapa Māori kanohi ki te kanohi smoking cessation program.

since the early 1990s. In 2010, the Ministry of Health updated and refreshed these service specifications and transferred them to the National Service Framework Library. The consultation process as it has been explained to me consisted of two parts. Firstly, issue-leads from the Ministry of Health engaging with health promotion practitioners at existing scheduled forums and secondly a full-draft of the revised service specifications were sent to DHBs for comment.

The leadership of Māori health providers were not given the opportunity to participate formally in this review process. Given the significance of the specifications to public health contracting and the historic problems with the *Public Health Service Handbook* a collective of Te Tai Tokerau Māori providers (Te Tai Tokerau MAPO Trust et al., 2009) drafted and submitted a substantive unsolicited submission. The Ministry never acknowledged the submission nor addressed its concerns.

The DAP is a document that DHBs are required to consult with their respective communities about. It lays out what activities the DHB plan to deliver through their provider arm and fund for the next year. It is crucial in relation to prioritising funding, as unless the project is an emergent issue, if it is not in the DAP it is not usually funded. The following are my observations   (Field notes, January 28, 2009) of a DAP consultation process.

> Today the DHB had a public stakeholder meeting to discuss the DAP and outline the Ministers new priorities 'Doing more with the same or less resources'. The presentation mentioned neither Māori health nor Te Tiriti. The analysis presented could have been relevant to workers in a tyre factory; the principles outlined were the same, we were given no overview of the substance of the content of the DAP. My colleague asked what was planning around Māori health and indicated she was going to forward a series of written questions. The DHB indicated they were waiting for the final Whānau Ora Taskforce report. It turned out that meeting was the only forum or mechanism to contribute and/or feedback on the draft DAP. The questions forwarded by my colleague remain unanswered.

Māori input into this process was compromised by the agency's failure to provide information to enable informed input - a practice inconsistent with Ministry of Health (2002c) consultation guidelines for DHBs.

Impact of Crown Filters

> What happens, as happens all the time with government policy it had to go through all the iterations, and it had to be approved by non-Māori, and because of that because of the political environment what happened was, most of it got cut out, so we got this... very safe version
>
> (Berghan, 2010, November 7, p. 8).

Before health policy is formally signed-off, it must pass through various Crown filters and decision-makers within and at times beyond the health sector. These filters ensure policy is aligned to the strategic direction of the current government, that it conforms to a range of rules and regulations, and that enough funding is available to resource its implementation. Counter storytellers identified these Crown filters as sites of institutional racism.

Berghan (2010, November 7, p. 8) asserts that Crown filters serve to dilute and water down Māori content in policy as, depending on the racial climate, it is seen as "politically untenable". He asserts decisions at this level are not based on evidence but rather the political ideology of the day and elaborate processes of "risk management". From their experience in policy making, Counter storyteller Māori Provider CEO (2010, November 1, p. 4) describes the Crown filter process as "...passed by the Crown law office, possibly passed by Treasury to see how much it is going to cost, passed by the political team to make sure it is not going to cost to many votes".

In illustrating this dynamic further, Berghan recalled the development of *Raranga Tupuake* (Ministry of Health, 2006b) in which he was a reference group member. He explains it went through seventeen iterations, and initially "...it started off as a really wonderful product which was crafted by people who knew their stuff, Māori workforce development". However, when it went through the sign off process:

> ... it missed out a whole lot of the key stuff we wanted, which they [Crown officials] saw as being problematic, because it came out as the sometime as Don Brash was doing his stuff and Helen Clarke was getting very sensitive around Māori politics... it is the perfect illustration of the stuff that Māori go through, which does not have institutional racism written across it but actually when you delve down and look through it all, and across all the hoops, it is a classic example of what goes on... it has affected our ability to develop the Māori health workforce (p. 4).

Māori Policy Analyst (2010, November 16, pp. 2-3) explains her experiences of Crown filters in relation to the development of cervical screening policy, they explain:

> We had just spent months reviewing the policy through a variety of settings and levels, talking to policy makers, documentation, talking to kaimahi and people that use that service. It was clear through my analysis that the Māori were saying the Treaty needed to be dominant so I was sitting around the table, [with] the policy makers and decision makers... I kept saying it is very clear to me that kaimahi and Māori are saying the Treaty is important and needs to be there. The person who was responsible

for making the policy kept sidelining it, ignoring it, and choosing not to do anything about it. I view that as a form of institutional racism (p. 2-3).

Māori viewpoints and perspectives, as illustrated in the examples above, are marginalised throughout the decision-making stage of policy development. At its core, I suggest this marginalisation represents a dismissal by Crown officials and decision-makers of the relevance and worth of Māori public health traditions and evidence. Flawed consultation processes and the impact of Crown filters through sign-off processes reinforce the marginalisation of potential Māori contributions to health policy.

8.4 Policy Implementation

> It is typical policy which is lots of words and aspirational language and in reality don't really equate or translate into something meaningful
> (Bradbrook, 2010, October 4, p. 5).

Once policy direction decisions have been formulated and set the next critical challenge in the policy cycle is their successful implementation.[135] Fafard (2008, p. 12) argues making a high-level decision such as prioritising expanding physical activity "…triggers a complex series of subsequent decisions about funding and policy implementation". At this point evidence is of particular importance, as assessments are made of 'what works' in relation to the target population. Fafard (2008, p. 13) concedes that at the implementation stage policies and programs can change often quite dramatically, usually as the result of decisions made by what he describes as "street-level bureaucrats".

Counter story teller Wano (2011, June 24, p. 2) maintains one of his biggest concerns in relation to the implementation of policy and strategic planning is that it often "bears no relationship to how the budget, how resources are allocated". He explains:

> I've had too many experiences where the planning process has been used as a way of getting a tick in the box for addressing inequalities but actions have not followed or been sustained for long enough to make a difference (p. 2).

He argues Māori health plans in particular are often waved around and get quoted and referenced but there is no significant change in terms of improved outcomes. The plans he suggests are often discreet and disconnected from other planning and there is not enough emphasis on planning that drives systemic improvement and change.

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[135] Implementation of health policy through the funding of health services is the substantial focus of chapter ten.

8.5 Policy Evaluation

> Mainstream experience and sensitivity at handling Māori issues within policy development has not been particularly successful in achieving equality in health outcomes for Māori (C. Cunningham & Kiro, 2001, p. 68).

Assessing the effectiveness of interventions is a key stage of the policy cycle. Robust evaluation of what works and does not work in relation to policy provides a valuable evidence base from which to build more relevant and effective policy interventions. This can occur through a rigorous formal evaluation process using a range of techniques or at times rely on the arbitrary judgment of a Crown official and/or decision maker with or without specialist knowledge in either public health or evaluation.

The key theme of mono-cultural practice in relation to the evaluation of policy and the use of culturally relevant performance measures are examined later in this section. I address inequitable health outcomes, such as disparities in life expectancies, as a macro indicator of the failure of Crown agencies to administer the health system effectively enough to address the needs of Māori.

Mono-cultural Practice

> They are coming at it from one worldview, dominant culture... and it's not Māori. Then they are trying to evaluate something they don't actually know about and therefore not unsurprisingly it doesn't work… They don't touch on the issues that are pertinent to Māori policymaking and whether or not it is effective (Kuraia, 2010, September 23, p. 4).

As outlined in relation to other policy stages deficiencies in cultural competency and utilising an incomplete evidence base are key components of mono-cultural practice. Underlying such practice is often a colonial assumption that the dominant cultural perspective is more worthy or valid than indigenous knowledge and perspectives (Tuffin, 2008). This form of cultural blindness allows dominant and unchecked cultural assumptions to filter through the framing of performance measures within policy. As such, this can also be embedded within evaluation strategies and plans.

Just as ethnic specific analysis is critical to ensuring policy is relevant to indigenous minorities, evaluations need to be tailored to capture indigenous aspirations and measures when assessing their effectiveness. Kingi and Durie (2000) maintain that given cultural factors influence perceptions of health and therefore need to be considered when determining outcomes; otherwise, the reliability of outcome assessment will be compromised. A plethora of Māori academics such as Ratima, Edwards, Crengle, Smylie and Anderson, (2006), Durie, Fitzgerald, Kingi, McKinley and Stevenson (2002) and Durie (2005, April), have developed Māori health indicators. Although the bulk of this work

has been commissioned by Crown agencies, my fieldwork has revealed they have not been embedded into Crown practice.

Several counter storytellers felt bio-medical measures alone could not effectively quantify or represent the complexity of Māori understandings of health and wellbeing. One counter storyteller (Māori Provider CEO, 2010, November 1) reiterated the point that Māori health status is impacted on by a complex interplay of education and employment opportunities, patterns of incarceration and debt generated through the complexities of multiple-owned Māori land. Monitoring Māori rates of diabetes, cardio-vascular disease, and cancer are all important but measures and monitoring of health status needs to encompass the wider determinants of Māori health.

The following is an account from my co-funding field notes (August 9, 2009) which reveals my experiences of reviewing an evaluation proposal with a Crown colleague. This account illustrates systemic mono-cultural practice:

> One evaluation proposal in particular was structured in such a way that the completed evaluation was not going to show whether the programme would work for Māori or not, nor did it include an inequalities analysis. I provided written advice on three separate occasions outlining specific concerns in relation to the evaluation plan and suggestions how to address them. The Crown official felt they knew better and used their institutional power to find a decision-maker that concurred with their assessment. The flawed evaluation was subsequently commissioned and funding was later cut to that program.

Counter storyteller, Māori Policy Analyst (2010, November 16, p. 4) argues when evaluating policy it needs to be based on Māori values:

> ...Māori ways of doing things, mātauranga, Māori tikanga. If we are going to use non-Māori, they are there for their expertise, they cannot dominate, and it has been my experience that sometimes when Pākehā come on board they dominate, and so their views come through and Māori are once again sidelined.

The irony of the persistence of mono-cultural practice among Crown officials is that, as introduced in chapter six, various models and frameworks have been developed to assist Crown Officials and others to assess policy and programs in relation to their responsiveness to Māori.[136]

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[136] These include *He Taura Tieke* (C. Cunningham, 1995), *The CHI Model: Culturally Appropriate Auditing Model* (Durie, 1993a), the *Whānau Ora Impact Assessment* (Ministry of Health, 2007e), *Kaupapa Hauora Māori Treaty Framework* (Ministerial Advisory Committee on Maori Health, 1990), *Decision Tree and Impact Checklist* (Te Kete Hauora, 1993a, 1993b), *Te Raranga Kete* (Te Puni Kōkiri, 1993a), *Treaty Methodology* (Te Puni Kōkiri, 1993b), *Hauora*

Lawson-Te Aho (1995, p. 5) asserts these attempts to introduce such tools into various Crown agencies have not been well received or put into practice because they have not been understood nor adequately translated into practical strategies that staff can use. Furthermore, the frameworks have deviated too far from organisational culture, and staff have been unwilling to change their attitudes to be more inclusive of Māori perspectives in their work.

Inequities in Health Sector Outcomes

> ...the disparities between Māori and Pākehā health outcome is a manifestation of institution racism and I think about how big those disparities are and I think it kinda demonstrates how big institution racism is
> (Māori Policy Analyst, 2010, November 16, p. 1).

Since the introduction of the NZPHDA[137] it has been a requirement of both the Ministry of Health and DHBs "...to reduce disparities by improving the health outcomes of Māori". Table 15 depicts life expectancy gaps between Māori and non-Māori broken down by ethnicity and gender over the last fifty years. I contend that the consistent disparity in outcomes suggests something is wrong with our health system. One explanation is that this disparity is a key indicator of the failure of the health system to address the high health needs of Māori. A counter storyteller (Māori Provider CEO, 2010, November 1) reflects on his involvement in the health sector:

> What has policy done to improve Māori [health]? There has got to be something wrong with how they are developing that policy. They are culturally inept to be able to write Māori health policy... they may even have a Māori writing it for goodness sake, but that person has been indoctrinated in that system.

Māori Checklist (Department of Health, 1990) and the *Māori Policy Analysis Framework* developed by Lawson-Te Aho (1995).

[137] NZPHDA (part 1, section 3 (1) b).

Table 15: New Zealand Life Expectancy by Ethnicity
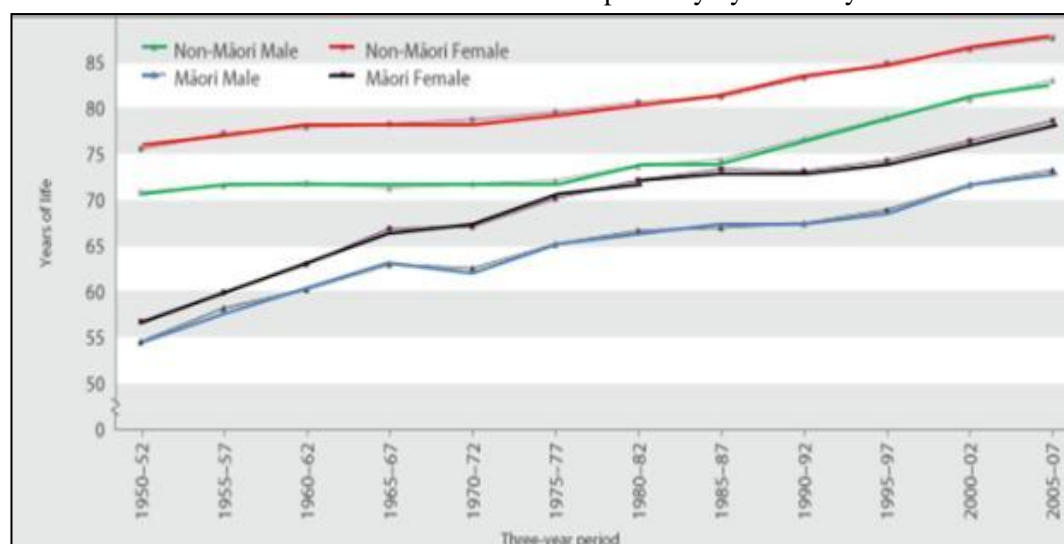
Note. Adapted from *The social report 2010*, by Ministry of Social Development, 2010, p.27. Wellington, New Zealand: Author. Reprinted with permission.

Several of the counter storytellers argue a reduction of life expectancy gaps between Māori and Non-Māori would be a powerful measure of Crown performance in relation to their administration of the health system. One counter storyteller (Māori Provider CEO, 2010, November 1, p. 1) commented that, "...since the inception of the DHB, they have been in place for something like ten or eleven years now, the Māori health issues remain hugely the same". They assert that the impact of this life expectancy gap on whānau, hapū and iwi is far-reaching and often under-estimated by policy makers. They explain:

> ...it effects the transfer of knowledge of tikanga, the kaupapa on our marae, the oratory, Te Reo; which all cumulates to the health of Māori and if all that transfer isn't happening then there are some serious issues happening where we are not going to be able to carry on as we have been on the marae, in terms of our manuhiri [visitors] coming on we don't have the men as tangata whenua to greet them and we are relying on our younger people to carry out those roles. We now have communities of kuia with no kaumātua or very few kaumātua because of that. The impact of that isn't being considered at all, what might be the cost in terms of Māori health through all of that loss of culture (p.1).

The process of policy evaluation mirror those issues associated with other stages of the policy cycle: mono-cultural practice shapes what evaluation questions are asked, and then culturally irrelevant evidence is considered throughout the process. Māori continue to call for the use of Māori measures to evaluate the impact of policy and propose the reduction in disparities in life expectancy to be a key measure of the successful administration of the health system.

8.6 Summary

Having robust and inclusive policy is critical to effective public health funding and planning practices, as policy determines resources allocation and what interventions are funded. Public policy is indeed intended (to be understood) as written for everyone. However, the primary qualitative research data presented here revealed that a policy cycle with embedded racism and privilege is likely to generate policy that advantages one group of people and disadvantages another, unless measures are taken to transform such biases. The counter narratives from senior practitioners, whom have worked across the health sector for decades, were consistent in their challenge that Māori viewpoints are marginalised across all stages of policy development.
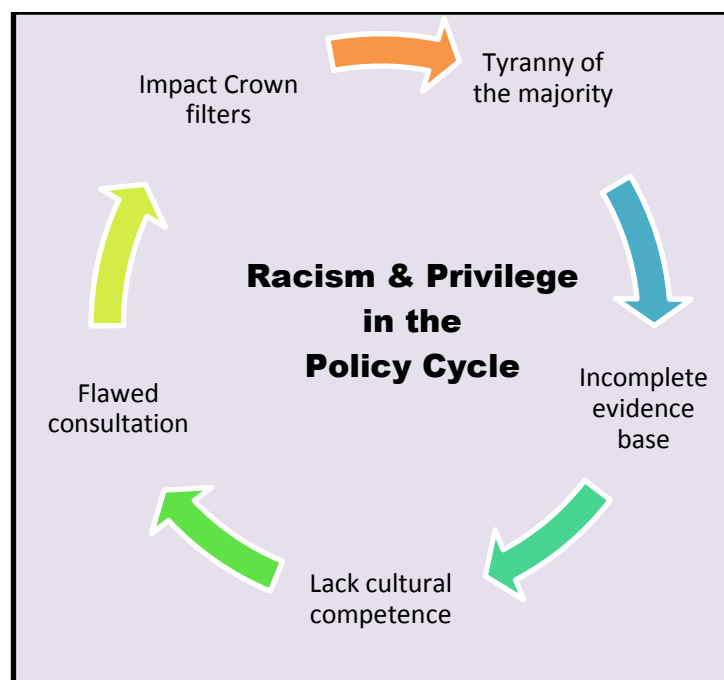
Figure 20: **Racism and Privilege in the Policy Cycle**
This figure depicts how the dynamics of privilege and racism, as identified in this study, manifest within the policy cycle, from agenda setting to policy formation.

Figure 20 identifies a range of sites of racism across the stage of policy development. Firstly, during the agenda setting stage of policy development I assert Pākehā viewpoints are privileged through majoritarian decision-making practices and Māori are marginalised through being a minority voice within senior management and governance roles across the health sector. In relation to policy formation, Crown-led health policy privileges population level epidemiological analysis, overlooking Māori understandings of health and evidence in both the frame and content of health policy.

Levels of cultural incompetence amongst Crown officials during policy formation serve to reinforce this mono-cultural analysis. Consultation processes, when they occur, are often flawed in what is asked, how it is asked and who is asked. As policy progress through bureaucratic sign off processes, I argue elaborate Crown filters simultaneously silence and marginalises Māori perspectives and privilege

western understandings within policy. Together these sites constitute an ongoing cycle of racism and privilege within public health policy making. These sites of racism as discussed in chapter eleven are also sites for anti-racism interventions.

Within the next chapter, I examine Crown funding practices and present a macro level analysis of public health investment.

CHAPTER NINE: CROWN FUNDING PRACTICES

9.1 Introduction

> There are increasing expectations about what acceptable conduct is for public officials and what constitutes the responsible use of public resources. Public entities need to recognise and respond to these expectations when they enter into funding arrangements...
>
> (Controller and Auditor-General, 2006, p. 4).

Once macro and meso level health policy is established, a major responsibility of Crown officials administering the health system is the purchase of health services to manifest the policy into action. DHBs have responsibilities of administering the bulk of personal health (clinical) monies at a district level. The Ministry of Health retains responsibility for the bulk of public health funding (Ashton, 2005). There is much government policy and regulation guiding Crown officials about how to conduct themselves in the purchasing of health services.

This chapter as with chapter seven represents the 'master narratives' of the Crown and are presented without critique. The substance of the chapter is based on a desktop review of Crown documents and was refined through dialogue with a Senior Crown official to clarify operational praxis. The funding analysis in particular is populated by data secured by a series of OIR to clarify public health and Māori public health expenditure.

In this chapter, I present the Ministry of Health's systems change approach to quality assurance developed for the health sector and the parameters of funding prioritisation processes. I then overview Crown procurement practices including service specifications, contracting practices and the main groupings of public health providers. Finally I examine Crown monitoring, reporting and auditing practices and outline both Ministry and DHB public health funding allocations from 2005-2010.

9.2 Quality Assurance Processes

> Quality can always be enhanced even though very good work is already happening (Ministry of Health, 2003f, p. iii).

Quality assurance processes are the mechanism by which efforts to improve and refine work processes are systematically organised to achieve desired outcomes. The success of such effort is reliant on an open culture and a commitment to invest in developing and arguing robust systems. Viewed from a quality assurance frame, inequities in health outcomes between Māori and non-Māori, contributed

to by the administration of the health sector could be described as a quality deficit worthy of further investigation.

Based on work done by the National Health Committee (2001), the Ministry of Health (2003f) developed a systems change approach to quality assurance for themselves and the sector. A systems approach recognises quality is achieved through the complex interaction of people, teams, organisations and systems. The key dimensions of quality within their strategy include people-centeredness, access and equity, safety, effectiveness and efficiency, which rest on the foundations of the Crown-defined principles of the *Treaty of Waitangi*. Cultural competency, defined as the "...ability to integrate different cultural perspectives and respond appropriately to the cultural needs of individuals and communities", is relevant to all levels of the health system (National Health Committee, 2001, p. 5). Emphasis is placed on the importance of working with iwi, hapū and whānau. The strategy is predicated on the involvement of Māori at all levels in decision-making, planning, development and the delivery of health services.

Quality is enabled operationally within funding activity though the *Operating Policy Framework* (OPF) (Ministry of Health, 2011) designed to facilitate national consistency in health funding practices. This framework covers a range of areas including development of services, financial operations, monitoring and reporting. It is a living document, reviewed, updated annually, and endorsed by the Minister of Health. The OPF sets out legislative and statutory requirements applicable to Crown officials[138] working in health funding. It also reinforces the requirements of Crown officials to engage with Māori in the areas of health needs assessment, prioritisation, planning, service delivery, monitoring and evaluation of services and Māori health plans.

Prioritisation Processes

> Even in an environment of plenty, decision-makers need to be aware of the 'opportunity cost' of funding decisions, that is, what is the value of the chosen service is compared to alternative uses of the funds
> (Joint DHB and Ministry of Health Working Group on Prioritisation, 2005, p. 1).

Prioritisation processes are a key site of quality assurance activity within health funding. The OPF denotes that it is mandatory for Crown officials to demonstrate the use of equity tools such as the *Reducing Inequalities Intervention Framework* and the HEAT tool (L Signal et al., 2008) in all service planning. Both DHBs and Ministry of Health are required to carry out principles-based prioritisation processes in order to meet the objectives of the NZPHDA. They have jointly developed a framework (see Joint DHB and Ministry of Health Working Group on Prioritisation, 2005) to gather and assess evidence about how services contribute to the shared principles of effectiveness, equity and value for money.

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[138] Focusing particularly on the NZPHDA, the Crown Entities Act 2004 and the Public Finance Act 1989.

The framework is designed to produce an approach which "...allows decision-makers to make informed judgments about what services to fund in a transparent and consistent way" (Joint DHB and Ministry of Health Working Group on Prioritisation, 2005, p. iv). Such an approach relies on decision-makers having strong professional ethics.

The joint DHB/Ministry prioritisation framework has a three-step process of identification, analysis and decision-making. As part of the routine surveillance of health status and monitoring of service delivery, the identification phase is about flagging services needing further analysis and attention. A current service may be identified as producing inequitable outcomes or concerns might emerge through community consultation. The analysis phase involves gathering and reviewing evidence of how existing or proposed services contribute to the achievement of funding priorities and making recommendations for decision-makers. The decision phase involves assessing the resource implications, the acceptability and impact of the decision and weighing up potential risks. Underscoring the framework is also a consideration of whānau ora, whether a proposal might contribute to reducing/increasing health inequities and/or lead to improved health outcomes for Māori.

The former Public Health Directorate, within the Ministry of Health (2004f, p. 1) have developed their own prioritisation framework to guide proposal-level decision making for one-off and discretionary monies. Components of their criteria include strategic importance, heath need, demand and acceptability, effectiveness, equity, Māori health need and cost effectiveness.

9.3 Procurement Practices

> Many public entities find procurement a challenging and confusing area, and it is not always clear how the various sources of rules and guidance fit together
>
> (Controller and Auditor-General, 2008b, p. 2).

Both government departments and Crown agencies are expected to manage public resources effectively and efficiently on behalf of the citizens of New Zealand. According to the Controller and Auditor General's office (2008a), all public spending is expected to be guided by a series of key principles as summarised in Table 16. These principles are supplemented by an extensive collection of guidelines, benchmarks, mandatory practices and legislation in relation to procurement practices developed as a complex web of imperatives by a range of Crown agencies over time.

Table 16: Principles that Govern All Public Spending

Accountability	Public entities should be able to give complete and accurate accounts of the use of public funds.
Openness	Public entities should be transparent in their administration of funds to promote clarity and shared understanding of roles.
Value for Money	Public entities should use resources effectively for the best possible outcome.
Lawfulness	Public entities must act within the law.
Fairness	Public entities must act reasonably and be seen to be impartial in their decision-making. At times, need to manage the imbalance of power in some funding arrangements.
Integrity	The standards applying to public servants are clear.

Note. Adapted from *Procurement guidance for public entities*, by The Controller and Auditor-General, 2008, p.11. Wellington, New Zealand: Author. Reprinted with permission.

The *Mandatory Rules for Procurement for Department* (Ministry of Economic Development, 2010) is among the most important of procurement guidelines. It outlines a range of standards and requirements for Crown agencies to embed within their respective organisational procurement policies and practices. These mandatory rules establish that an open tendering procedure should be the default procurement position unless in exceptional circumstances. The Government Electronic Tender Service website[139] is promoted as the primary medium for promoting tenders and is a requirement for all tenders over $100,000. A staged process is allowed where pre-qualified suppliers are invited to register an interest, followed by a formal request for tender from selected respondents.

The *Government Procurement in New Zealand: Policy Guide for Purchasers* (Ministry of Economic Development, 2007) emphasises the overall responsibility of Chief Executives for the efficient and effective operation of their respective Crown agencies including operational matters such as procurement. This guide presents procurement as a means to get value for money through open and effective competition. These guidelines (2007, p. 16) specify that Crown officials are expected to undertake sufficient market research to ensure that tender documents are robust and "avoid specifying any feature which unnecessarily discriminates, either directly or indirectly, against any supplier or group of suppliers". The guide recommends evaluating tenders against both functional and performance criteria through a well-documented and auditable process. The Ministry of Economic Development and/or the Auditor-General and/or Ombudsman may investigate complaints by suppliers who feel they have not been given "full, fair and reasonable" opportunity within a tender process. Valid complaints, which have not been satisfactorily resolved, may then be referred to the Minister of Commerce and other relevant Ministers with recommendations for action.

The Auditor-General (2006, 2008a, 2008b) has developed a series of good practice guides in response to findings from their regular audits of Crown

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[139] The GETS website is www.gets.govt.nz.

agencies to enhance procurement practices. They address areas such as funding to NGOs, managing funding arrangements with external parties and general guidance around procurement. Across these documents the Auditor-General argues for a principled based approach to procurement which involves managing risk, being open and transparent about decision making, while achieving the best possible public benefit from the resources invested. He also emphasises the importance of collaboration in funding arrangements and the need for strong and sustainable relationships with providers. This relational approach is further affirmed in a statement developed by the former Labour-led government (Clark & Maharey, 2001, p. 1) about its intentions for relationships with the voluntary sector. Their statement-emphasised relationships should be based on "...honesty, trust and integrity/tika and pono, compassion and caring/aroha and manaakitanga, and recognition of diversity".

The guide on *Public Sector Purchases, Grants and Gifts: Managing Funding Arrangements with External Parties* (2008b) also developed by the Auditor-General advocates for a strategic approach to procurement recognising that the purchasing of services is a means to advance the aspirations of public entities. He encourages the development of tailored procurement strategies that consider the benefits, costs and management consequences of different procurement approaches and funding choices. If capacity building is important to a Crown entity, for instance he suggests it needs to be embedded within the chosen procurement approach.

This guide (Controller and Auditor-General, 2008b) distinguishes between conventional and relational purchases by public entities. Conventional purchases are items often and routinely purchased by Crown agencies. Relational purchases have a significant relationship dimension. The procurement of public health services falls within relational purchasing due to the absence of a "meaningful market" for these specialist services, which are of strategic importance. The Auditor-General (2008b, p. 19) explains:

> In such situations, conventional market-based systems for managing a contract may not be appropriate or particularly effective. It may be more useful to give greater weight to the relationship or strategic dimensions of the contract and to set up other systems to manage the dimensions usually managed by competitive market mechanisms.

The Auditor-General (2008b, p. 30) argues Crown agencies need to be clear on what they are trying to achieve and "process should not dominate at the expense of outcome". He advocates for keeping funding arrangements as simple and practical as possible and that it is appropriate to consider the compliance costs for the parties concerned and seek to reduce them. He suggests the key to procurement is to get the right balance between risk and expected benefit. Funders

need to recruit suitable skilled staff to tailor purchasing to the needs of the individual situation.

Through the course of this study a Senior Crown Official (2011, April 29, p. 2) clarified that operationally the Ministry of Health can make its own procurement rules as long as these are consistent with the principles espoused by the Ministry of Economic Development, Treasury, and the Auditor-General. In relation to this the Senior Crown Official (2011, April 29, p. 4) maintained that decisions in relation to cost of living adjustments or Future Funding Track (FFT) changes are made between Treasury and the Ministry of Health. If adjustments are included in the budget the decision regarding what providers are eligible are made at a senior management level. They confirmed that recently no FFT or demographic adjustor has been available for funding managed by the Ministry for the public health sector. However, Ministry officials can submit special cases for funding pressures to be addressed. Sometimes these cases are for individual provider, other times a grouping of providers.

Operationally relationship management is primarily undertaken through portfolio managers. Dialogue with a Senior Crown Official (2011, April 29, p. 3) confirmed that no processes were in place to ensure consistency of engagement across providers in relation to access to funders and/or information. Furthermore they (2011, April 29, p. 5) confirmed the process of inviting providers to participate in Ministry-led steering and advisory groups was "highly arbitrary".

Contracting for Services

> The contract will record the basic expectations each party has of the other, and where the relationship is working well; there will usually be no need to enforce the terms of the contract. The NGO... should be encouraged to provide feedback on the Government agency's performance
> (Treasury, 2009a, p. 40).

Contracts are an entity, which establishes a relationship usually between two parties and creates rights and duties between the parties. Boulton (2005, p. 54) maintains contracts within the health sector are used to:

> ...link financial resources to health service outputs and outcomes; clarify responsibilities and roles with [a] view to improving accountability; focus service delivery; and allow adjustments over time and re-negotiations in response to changes in need and other factors.

Government guidelines (see Controller and Auditor-General, 2006; Treasury, 2009a) outline a series of principles of good contract management for Crown officials. They recommend establishing robust accountability mechanisms for public monies, reflecting the needs of the recipients of the service, acting in good faith and understanding the nature of the organisations one is contracting with.

Treasury (2009a, p. 5) guidelines affirm that contractual relationships between a provider and a Crown agency "...should not be used to prevent the NGO commenting on public policy matters". In turn, providers must "...deliver services in a manner consistent with the values and standards the government expects".

Treasury (2009a, p. 12) guidelines further emphasise that contracting needs to be informed by historic evaluations of the effectiveness of interventions, relevant national standards, and consultation with the users of the service. Consultation in this context is more than formal notification of Crown intentions, rather:

> ...it implies providing parties with sufficient information to allow intelligent responses to be made, and the agency entering into consultation without having finally determined its position (Treasury, 2009a, p. 13).

The desired policy outcomes, whether that is a reduction in health inequities between Māori and non-Māori, should inform the entire contracting process. Furthermore, Crown agencies need to put themselves in a position to deal with Māori in terms of their totality that is being open to contract holistic services within kaupapa Māori frameworks (Treasury, 2009a, p. 14).

Treasury guidelines advise Crown officials to exercise flexibility in their dealings with providers and to avoid being over-prescriptive in form and content. Specifically, they (2009a, p. 28) recommend that officials "...avoid trying to control an NGO's activities outside of their contractual rights and obligations". They (2009a, p. 5) also recommend that Crown officials approach negotiations in a collaborative rather than a confrontational manner.

Being mindful of the duplication of administration and monitoring effort associated with administering many small contracts across the public sector there is a significant focus on outcome based contracting and developing integrated approaches (see Ministry of Social Development, 2007; The Treasury & State Services Commission, 2007; 2010). Managing for outcomes and results based accountability (see Friedman, 2005) are seen as a methodology for creating a strategic approach to health funding. This approach is about improving the performance of Crown agencies (and their partners) through better planning and reporting.

Integrated contracts and their newer manifestation high-trust contracts (see New Zealand Government, 2009, September 15) are a related attempt to streamline contracting, to refocus on outcomes as opposed to contract inputs. This reframing is designed to enable providers to deliver and report on their services to multiple Crown agencies without having to negotiate multiple contracts and break the information down into separate reports while providing data for separate audits. This process is expected to minimise compliance costs for those involved

(Ministry of Social Development, 2007). To date few public health providers have made the transition to high trust contracts.

One of the key resources to enable the contracting of health services is the National Service Framework Library.[140] This library houses a virtual collection of recommended service specifications for health funders to enable a level of nationwide consistency in approaches to funding, monitoring and analysing services. A governance group made up of Crown officials oversees the collection. As introduced in chapter six, the *Public Health Service Handbook* (Ministry of Health, n.d.) historically forms the basis of the Ministry's purchasing of public health services. This collection of specifications is used alongside a legal framework to form the basis of contracts between the Ministry of Health and public health providers.

Table 17 shows the historic (tier two) public health service specifications and funding streams. The specification template is made up of a health goal, rational and key issues from national planning, service objectives, components of service, service descriptions/activities and information about references, and supporting documents. Some services have specific mandatory requirements and regulations such as the provision of information, notifications of public health risks and minimum standards of coverage. Other programs are designed to service the whole population, such as health protection services, which focus on the monitoring of risk, provision of advice, investigation of complaints. Health promotion programmes are generally targeted to particular priority communities.

Table 17: Tier Two: Public Health Service Specifications

Regulatory Services	Physical Environment	Communicable Diseases	Social Environments	Well Child
Screening	Alcohol and other Drug Related Harm	Tobacco Control	Nutrition and Physical Activity	Sexual Health
	Mental Health Promotion	Injury Prevention	Public Health Infrastructure	

Note: Adapted from *Public health service handbook*, by Ministry of Health, (n.d.), Wellington, New Zealand: Author. Reprinted with permission.

During the course of this study dialogue with a Senior Crown Official (2011, April 29, p. 3) confirmed as part of the transition from the Handbook to the National Service Framework Library Ministry officials are writing a new overarching tier one specification. This specification will incorporate the essential functions of public health, based on definitions derived from a range of sources

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[140] See http://www.nsfl.health.govt.nz/

notably work by the WHO Western and Pacific region and British Columbia (see Pan American Health Organization, 2008) adapted for the New Zealand context. The tier two public health specifications are currently being progressively reviewed in line with developments in the tier one specification.

A Senior Crown Official (2011, April 29, p. 5) clarified operational practice in relation to setting contract timeframes. They maintained such decision-making is influenced by two key elements firstly level of funder confidence, they will continue to be funded to deliver services in that particular area. Secondly the risks associated with funding that particular provider, specifically they (2011, April 29, p. 4) clarified "...whether the provider is reliable and has the capacity and capability to continue to provide the service for a longer period". They confirmed Ministry officials could contract for up to about three year timeframes.

Public Health Providers

The Ministry of Health and/or DHBs purchase public health services from a range of providers including PHUs, NGOs, Māori Providers and Primary Healthcare Organisations (PHOs) amongst others. As of August 2011 the Ministry of Health were contracting with 243 providers for public health services.

PHUs usually consist of a team of Medical Officers of Health, health protection officers, community workers and health promoters. The origins of PHUs lie within the district offices of the Department of Health. Since 1989, Area Health Boards, then Crown Health Enterprises, then Hospital and Health Services and finally DHBs have hosted PHUs. The scope and function of their hosts have changed over time but the core activity of PHUs has largely endured. These offices are charged with protecting and promoting population health in their districts. Holding legislative responsibilities PHUs remain in close contact with the core government funding agency and are central to New Zealand's front-line public health emergency response capability. With the amalgamation of public health service delivery across several DHBs in parts of the country the equivalent of thirteen PHUs currently exist. All participated in my provider survey.

Public health focussed NGOs such organisations like the Heart Foundation, Mental Health Foundation, New Zealand AIDS Foundation and the Cancer Society emerged in the 1980s and the 1990s. These NGOs have developed specialised technical knowledge about their core public health priorities and have strong interests in advocacy and disease prevention. Often with some independent income from fundraising, these boutique-specialised providers have thrived within an environment of state devolvement of health services. Although NGOs may hold government contracts, they are not an extension of the government. As of August 2011 Ministry of Health were contracting with 115 diverse local and national NGOs, nineteen of whom participated in the provider survey.

As part of a wider strategy of Māori development adopted by successive governments, Māori providers emerged during the 1980s and 1990s.[141] Within a context of growing awareness of the Treaty, Māori enthusiastically pursued a vision of delivering quality holistic health services for whānau, hapū and iwi. For more than a decade Māori, providers were inundated with pilot programs as funders learnt to trust their capacity to deliver quality services. Māori providers now play an essential role in delivering public health services to Māori communities. In August 2011, Ministry was contracting with 85 Māori providers. Fourteen of whom participated in the provider survey to supplement the counter narratives already shared.

The newest part-time public health providers, PHOs, were developed in the early 2000s as part of the primary healthcare strategy to bring health services into the community to reduce pressure on secondary clinical services. The *Primary Healthcare Strategy* (A. King, 2001) affirmed the *Alma Ata Declaration* (World Health Organization, 1978, September) and encouraged PHOs to engage in prevention as well as treatment of their enrolled population. At the time of the provider survey there were over seventy PHOs variously delivering public health services with many involved in an extensive restructuring and amalgamation process. There are now twenty-three PHOs working under a version eighteen PHO contracts. In the provider survey, I surveyed ten providers some of whom have since been amalgamated.

9.4 Monitoring Effectiveness

> Departments cannot and should not monitor everything – but they will question activity to ensure entities' output delivery matches output agreements (Treasury & State Services Commission, 2006, p. 24).

The Auditor-General (2006), Treasury and State Services Commission (2006) all argue that Crown agencies need to be able to monitor the effectiveness of their funding initiatives. Specifically Crown agencies need to be able to demonstrate to their respective Crown Ministers how programs they fund contribute to the strategic outcomes of their respective agencies. Treasury and the State Services Commission (2006, p. 24) in their *Guidance to Departments in Relation to Crown Entities* recommend the development of a high-level monitoring plan to focus monitoring efforts. This might include establishing a schedule of monitoring visits, maintaining risk assessments of the sector, ensuring performance information is available, commissioning benchmarking studies and doing rolling reviews of interventions.

Effectiveness is usually assessed by Crown officials within the health sector through monitoring of provider funding, inputs, outputs and outcomes. This involves a range of routine contract monitoring visits, desktop reviews of

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[141] Not with standing organisations like the Māori Women's Welfare League who have delivered health services (inclusive of public health) to Māori communities for over fifty years.

documentation and a schedule of financial and compliance auditing. The level and nature of monitoring differs based on what Treasury calls "informed judgement" according to the nature of the service being funded, the track record of the provider, the amount of money involved and perceptions of risk. Treasury (2009a, p. 39) in their *Guidelines for Contracting with Non-Governmental Organisations Services Sought by the Crown* argue the basis for such assessments of required levels of monitoring should be documented by Crown officials.

In the same guidelines, Treasury (2009a, p. 39) acknowledges the potentially high compliance costs associated with monitoring and contract management for both funders and providers. They recommend Crown officials pursue a range of strategies to contain costs from, being realistic about reporting requirements, keeping documentation simple and where appropriate developing contract and capacity building objectives that are consistent with the providers own performance management systems. They further recommend that outcomes reported against should be culturally appropriate, particularly to Māori, hapū and iwi providers and be relevant to the providers chosen service provision model.

Over time, the Ministry of Health and its predecessors have commissioned a range of tools to assess the effectiveness of service delivery to Māori. Those with most relevance to this research are the *CHI audit model* (Durie, 1993a) and *He Taura Tieke* (C. Cunningham, 1995). Both focus on the effectiveness and cultural appropriateness of service delivery to Māori. The *CHI audit model* provides a framework for cultural audits of contracts in the areas of Māori development, health gains for Māori and Māori cultural beliefs and values including cultural safety. *He Taura Tieke* focuses on the elements of technical and clinical competence, structural and systemic responsiveness and consumer satisfaction.

Operationally a Senior Crown Official (2011, April 29, p. 5) clarified that all providers have a portfolio manager who provides basic communication and monitoring. This monitoring usually takes the form of two site visits per annum and the level of intensity of monitoring is a management decision. If the Ministry thinks a provider needs or wants, more intense monitoring that is provided depending on funder capacity at the time. The Ministry is currently pursing what they call a relational approach to contracting so there is sufficient trust and confidence for the provider to be able to ask for help. A Senior Official (2011, April 29, p. 5) explains:

> My philosophy of contracting is that it is an agreement between two equal parties and there has to be a meeting of the minds, about shared outcomes. In which case to have a relationship based on mistrust and fear is not conducive to achieving the outcome.

In relation to auditing a Senior Crown Official (2011, April 29, pp. 5-6) explained Ministry have two approaches to auditing public health providers. They have routine audits of a whole service and/or an issue based audit focussing on

diagnosing and addressing service problems. They maintain that auditing is a way of "...telling us [Ministry] if we are getting what we pay for. Whether or not we are paying for the right things is about evaluation".

A Senior Crown Official (2011, April 29, p. 6) argued that financial reporting is a fundamental component of accounting for the expenditure of public money. They recognise that historically there have been times when providers have not been required to submit any financial reporting whatsoever. Current operational practice they believe is "...asking for at least annual audited accounts". During the dialogue, I disclosed my knowledge of a number of providers that had been asked to provide additional financial reporting. The Senior Official explained:

> That makes me think they are struggling. Again, if the relationship is right that should be seen as an opportunity to help them not punish them. However, I have to acknowledge that is not the universal attitude across the Ministry (p. 6).

9.4 Overview of Public Health Funding

The approximately twelve billion dollars of health funding annually appropriated through parliament and overseen by the Ministry Health is collectively known as vote health. Approximately three quarters of this resource is devolved to DHBs, to purchase and deliver health and disability services within their respective geographically defined populations (Ministry of Health, 2010c). The Ministry retain centralised funding for a range of national services including the bulk of public health funding, which makes up less than five percent of vote health. Another two percent of vote health is utilised by Ministry to administer the sector.

The focus of this analysis is on patterns of Ministry and DHB public health investment between 2005 and 2010.[142] This analysis is based on a desktop review of Crown documents, information from OIRs (from December 2010 through to September 2011) (see Appendix A and B), dialogue with several Chief Financial Officers and clarification of operational funding practice with a Senior Crown Official. Despite my best efforts there remain a handful of gaps within the data set, due to changes in Crown agencies financial systems and their inability to retrieve data. These gaps have been filled with estimates which are noted within relevant footnotes and/or text.[143]

A desktop review shows Crown agencies have produced a wealth of public health policy documents but the absence of an overall strategic funding strategy for public health purchasing. A Senior Crown Official (2011, April 29, p. 2) confirmed that in the early 2000s there was a strategic public health funding

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[142] Other public sources of funding for health include ACC, other central government agencies (i.e. Department of Corrections and New Zealand Defence Force) and local and regional government.
[143] Given these estimates please treat this analysis as preliminary and indicative only of macro-level patterns of public health investment rather than a definitive funding analysis.

formula but conceded it "…has fallen into disrepair". They argued that the Ministry's default operational practice for new purchasing is to run a competitive tendering process. They confirmed within public health historical funding predominates and new services are not currently being developed because of fiscal constraints. They indicated that if Crown officials could prove there is only one provider that can deliver a service (in that there isn't really a market) Ministry can and will engage in relational contracting.

Ministry of Health Public Health Expenditure

Treasury appropriation estimates and Ministry of Health annual financial reports provide broad oversight into the allocation of health funding. Treasury appropriation estimates are generated as part of the annual government budget process, which is overseen by Cabinet and endorsed by parliament. Table 18 shows budgeted (non-departmental) public health appropriations. These figures includes all direct Ministry purchasing of public health services but exclude appropriations relating to the departmental functions of the Ministry of Health such as: policy advice, administering health purchasing, monitoring providers, developing and administrating legislation and regulations, ministerial servicing and information services. The Ministry of Health's actual expenditure is tracked within their annual financial reporting.

Table 18: Ministry of Health Public Health Funding 2005-2010

	Year ($000)				
	2005/06	2006/07	2007/08	2008/09	2009/10
Budgeted Vote Health: Public Health Appropriation	297,208	328,795	359,603	453,201	495,327
Public Health Actual Expenditure	288,500	312,100	356,911	426,904	477,081

Note: Adapted from *Health Expenditure Trend* reports (Ministry of Health, 2008c, 2010b, 2010c) and *Vote Health* appropriations (Treasury, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009b, 2010).

These figures exclude the Ministry's internal (public health) emergency response capability, public health workforce and provider development monies, the meningococcal vaccination program, public health gambling services (due to the mixed personal/public health service delivery), primary healthcare sector health promotion capitation monies, Like Minds Mike Mind social marketing campaigns and DHB direct local investment in public health initiatives and PHO health promotion capitation monies.

Treasury appropriation estimates,[144] Ministry annual financial reporting, nor periodical *Health Expenditure Trend*[145] reports systematically track Māori health or Māori public health expenditure. The Ministry's Chief Financial Officer (Personal communication, December 10, 2010) through an OIR process

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[144] Within the appropriation estimates Māori health is mentioned in relation to the Māori provider development scheme and a funding line entitled national Māori health services. Both these minor funding streams relate to supporting Māori provider development and scholarship funding.
[145] These reports are an overall analysis of New Zealand's health expenditure to enable benchmarking with other OECD countries.

confirmed that Ministry do not track Māori health expenditure.[146] This statement was incongruent with a recent Ministry (2011a) document that states it is the role of Māori Health Directorate within the Ministry to monitor expenditure in Māori health.

Although Ministry of Health retain responsibility for administering the bulk of public health funding, their Chief Financial Officer (Personal communication, December 10, 2010) confirmed they do not have a definitive oversight of public health expenditure. In response to my OIRs (Came, 2010, December 6, 2011, August 24, 2011, February 14b, 2011, May 16) Ministry staff extracted data in relation to Ministry (non-departmental) investment into a range of public health providers (see Table 19). For the purposes of this analysis, a Ministry official (Morris, 2011, April 28, p. 1) defined Māori health providers, as "Māori owned and governed organisations that have or have had a provider contract with the Ministry of Health".

Table 19: Ministry of Health (Non-departmental) Public Health Expenditure 2005-2010

	Māori Providers	NGO	Regional PHU	Non Devolved
2009/10	215,230	315,826	62,690	98,826
2008/09	203,618	261,427	62,865	102,612
2007/08	187,297	197,019	55,007	104,885
2006/07	171,720	179,517	55,895	76,696
2005/06	154,214	194,970	56,209	38,903

NZ $ (000)
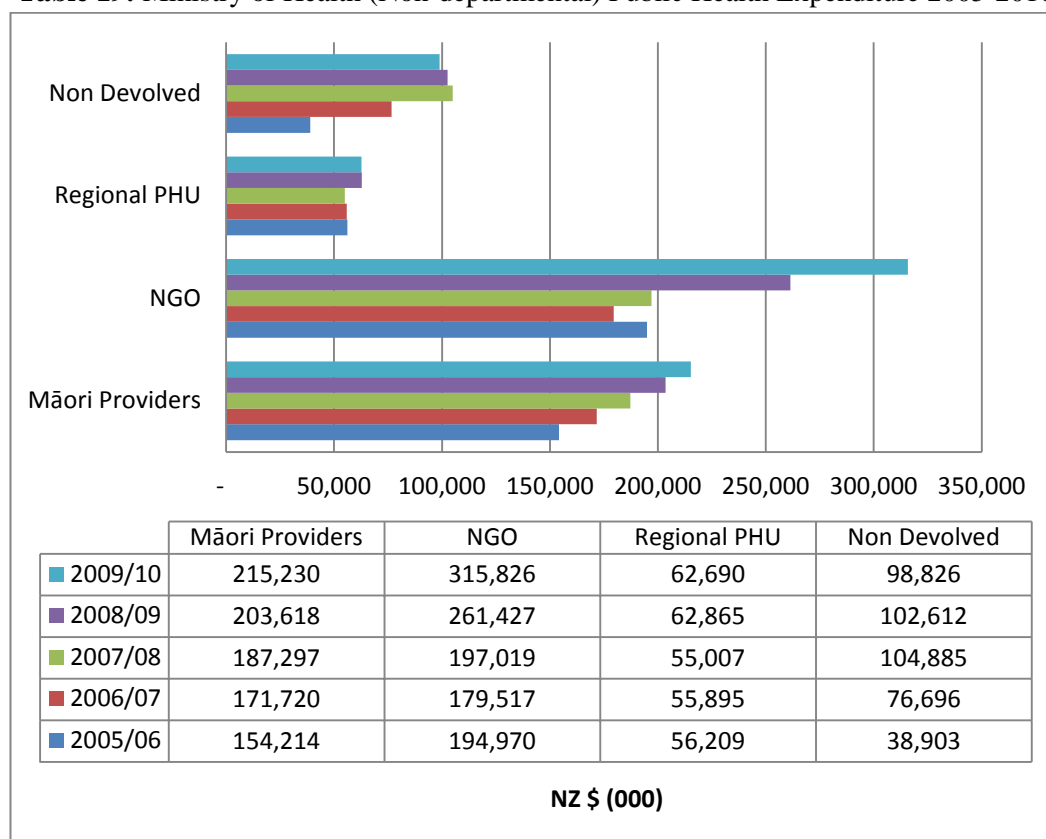
Note. This table is adapted from the Ministry of Health's OIR responses (Morris, 2011, April 28, 2011, June 13, 2011, September 6) and personal communication with their Chief Financial Officer. Copies and relevant notes are in possession of Heather Came.

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[146] The difficulties in monitoring Māori health expenditure he explained, were that Māori might be either high or low users of a range of primary, secondary and tertiary clinical services and that information is not extractable from how Ministry financial data is currently structured. Investment into Māori health providers could be tracked but they noted that Māori also chose to access health services from generic healthcare providers; which would complicate such an analysis. Furthermore they maintained that the bulk of health service purchasing was administered through DHBs.

Non-devolved public health funding refers to services Ministry purchases nationally on behalf of DHBs such as scientific services and anti-venoms.

The Māori provider funding listed pertains to both clinical and public health services as Ministry officials were unable to split this funding by appropriation.[147]

PHO health promotion capitation funding is administered by local DHBs so excluded from this table.[148]

Numbers have been truncated using Swedish rounding.

From Ministry's OIR responses over the last five years the bulk of their public health investment has gone into the NGO sector, a grouping that's funding has dramatic increased in recent years. Levels of investment in regional PHUs have remained static as have commitments to non-devolved services for DHBs. Investment in Māori providers has increased but as the figures presented are inclusive of both clinical and public health services, this compromises further analysis.[149] The inability of Ministry officials to break down Māori public health investment compromises the ability of Māori and interested others to monitor Crown performance in relation to such investment.

District Health Board Public Health Expenditure

DHBs have been devolved responsibility to identify local health needs and fund services to achieve population level health outcomes. As introduced within chapter seven and nine there is a range of directives DHB must follow when administering health monies. For instance, DHBs are required to establish targets in relation to Māori health spending and to report on payments to Māori health providers (Ministry of Health, 2011a, p. 3).

A desktop review of a cross section of DHB strategic documents confirmed that DHB public health investment is neither freely available nor delineated within annual financial reporting. Given this lack of data availability I sent an initial OIR to all DHB's (Came, 2011, February 14a), with individual OIR follow-ups to clarify the DHB's initial responses. Responses showed DHBs have variable levels of commitments to investing in public health services within their districts. Some prioritise public health activities and invest their core funding into public health priorities while others exclusively prioritise clinical interventions. The data generated from the OIR process presented in Table 20 is in collated form to illustrate high-level patterns of public health investment.

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[147] Although this data is inclusive of all Ministry by Māori for Māori funded programs; it is not sophisticated enough to capture any Māori focused work carried out by PHUs, NGOs and other providers.

[148] I can confirm however from my co-funding experience that at least one PHO contracts directly with the Ministry of Health to deliver a public health program; this suggests there may be omissions within the Ministry's OIR responses.

[149] For instant, a Senior Crown Official (Personal correspondence, August 24, 2011) released intended public health funding for 2011/2012 that showed only 11% was allocated to Māori health providers. (This data did not include mainstream service delivery prioritising Māori).

Table 20: DHB (Non-departmental) Public Health Expenditure 2005-2010

	Māori Providers	DHB: PHU & Other	PHO	NGO	Other
2009/10	1,257	2,653	10,133	2,471	2,094
2008/09	885	2,737	10,196	2,124	2,277
2007/08	791	1,252	8,695	1,391	802
2006/07	1,108	323	8,600	1,323	614
2005/06	1,629	801	8,185	1,201	217

NZ $ (000)
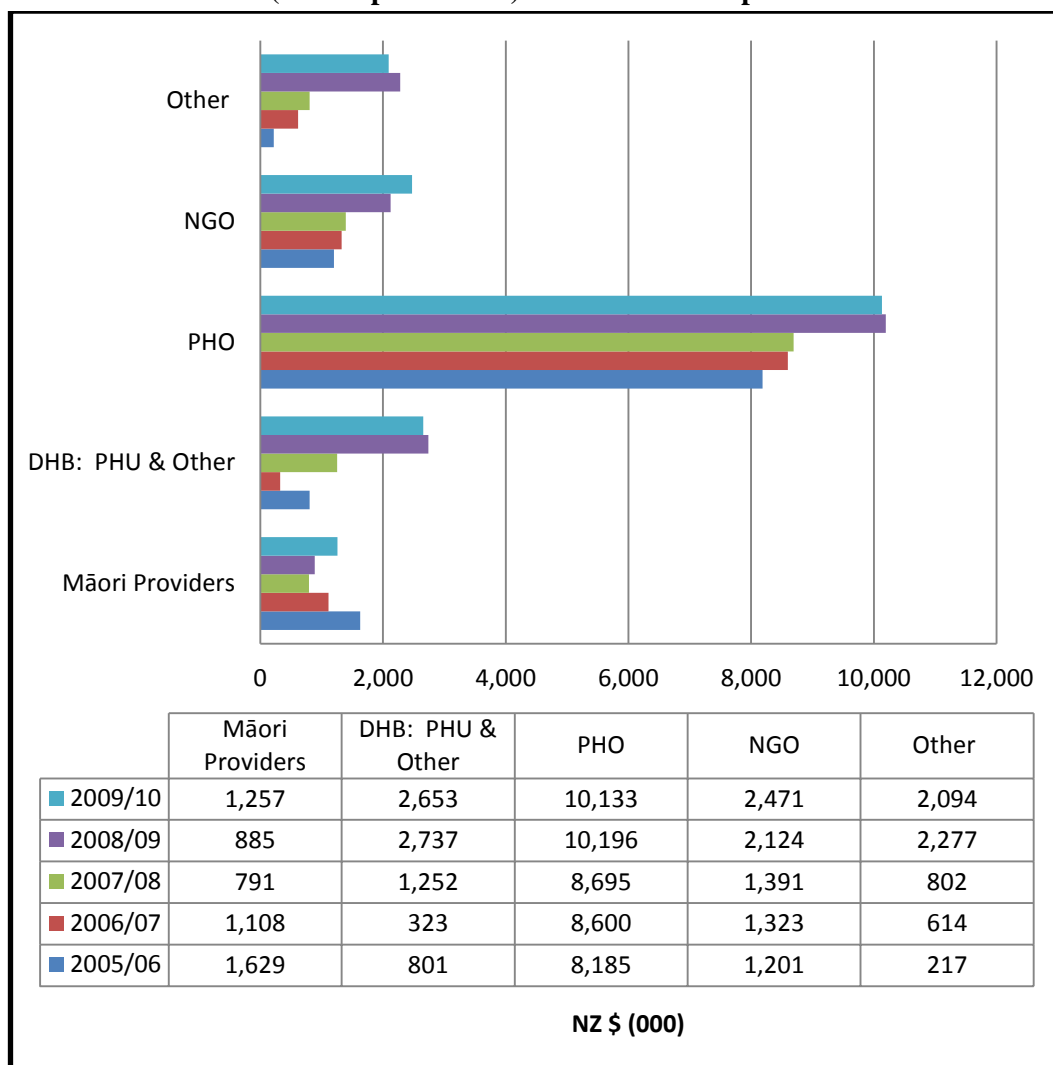
Notes. This table was informed by the responses of DHBs[150] to a primary OIR to all DHBs across the country and a series of follow up enquires to establish consistency across the data set. This correspondence in relation to the OIRs took the form of written letters, emails and phone conversations (see Appendix B). Copies and relevant notes are held by Heather Came.

As with the previous analysis, the direct departmental costs of DHB administering public health monies have been omitted. Also excluded from these figures are vaccination delivery, outreach immunisation, smoking cessation for DHB staff and all Nicotine Replacement Therapy costs, actual screening services, emergency planning in secondary and tertiary sectors, Meningococcal B vaccination program, mobile primary nursing, national immunisation register, pregnancy and antenatal education programs.

The provider grouping labelled 'other' in this instance refers to agencies such as local authorities, universities and consultants.

For the 2005/06 financial years within the collated PHO figures, data from Auckland, Counties Manukau, Lakes, Southern, Wairarapa and Whanganui DHBs are all estimates as they were unable to extract data from their systems. Similarly, South Canterbury and Taranaki DHB were unable to provide data beyond their PHO investment.

For the 2006/7 financial year within the collated PHO figures data from Auckland, Counties Manukau, Southern and Whanganui are estimates. Likewise, neither South Canterbury nor Taranaki DHBs were able to provide data beyond PHO capitation information.

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[150]Although Southern DHB was formed on 1st May 2010 as a result of the merger of Southland and Otago DHBs these figures are inclusive of both Southland and Otago DHB data.

For the 2007/08 financial years Counties Manukau, Southern and Whanganui DHBs provided estimates of the PHO capitation monies. South Canterbury DHB was unable to provide data beyond their health promotion capitation spend.

For the 2009/09 and 2009/10 financial year, the Counties Manukau DHB provided an estimate of their PHO investment.

Numbers have been truncated using Swedish rounding.

The majority of the public health monies DHB administered are *Healthy Eating Health Action* and tobacco control specific funding delegated to them by the Ministry through Crown Funding Agreements. These funding streams are incorporated within the previous analysis of Ministry public health expenditure so are excluded here. The bulk of the remaining DHBs public health investment is their PHO health promotion capitation-funding stream.[151] Capitation rates are based on a funding formula that incorporates both deprivation levels and ethnicity. The remaining DHB public health expenditure relates to investments such as healthy housing programs, rheumatic fever and family violence prevention, and Māori public health initiatives.

Table 20 illustrates proportionally high levels of DHB investment in public health activities delivered within primary health care settings.[152] Similar levels of DHB public health investment went into NGOs and Māori providers, with the remaining monies being utilised within DHBs and "other" providers. Across the last five years, funding has been increasing to all groupings of providers except Māori public health providers.

Table 22 shows combined Ministry and DHB public health investment. From this table it is clear that NGOs are the major recipients of public health funding, followed by Māori providers and non-devolved Ministry purchasing of national services for DHBs. In interpreting this data it is important to recall that the Māori provider investment is inclusive of the purchasing of both clinical and public health services. With this caveat in mind, since 2005/06 Māori public health investment has gone from 34% of public health spend down to 28% in 2009/10.

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[151] This funding was introduced in 2002 and can only be accessed by providers when they submit a successful proposal to their DHBs on how the resource will be utilised.
[152] Ideally this funding would have been included in Table 20 but the Ministry's Chief Financial Officer (Personal Communication, December 10, 2010) during the OIR request process clarified that primary healthcare comes from a separate funding stream to public health and they were unable to unbundle this funding.

Table 21: Combined Ministry and DHB Public Health Investment 2005-2010

	Māori Health Provider	DHB: PHU & Other	PHO	NGO	Non-Devolved MOH
2009/10	216,487	65,343	10,133	318,297	98,826
2008/09	204,503	65,601	10,196	263,551	102,612
2007/08	188,088	56,259	8,695	198,410	104,885
2006/07	172,828	56,717	8,600	180,840	76,696
2005/06	155,843	57,010	8,185	196,171	38,903

NZ $ (000)
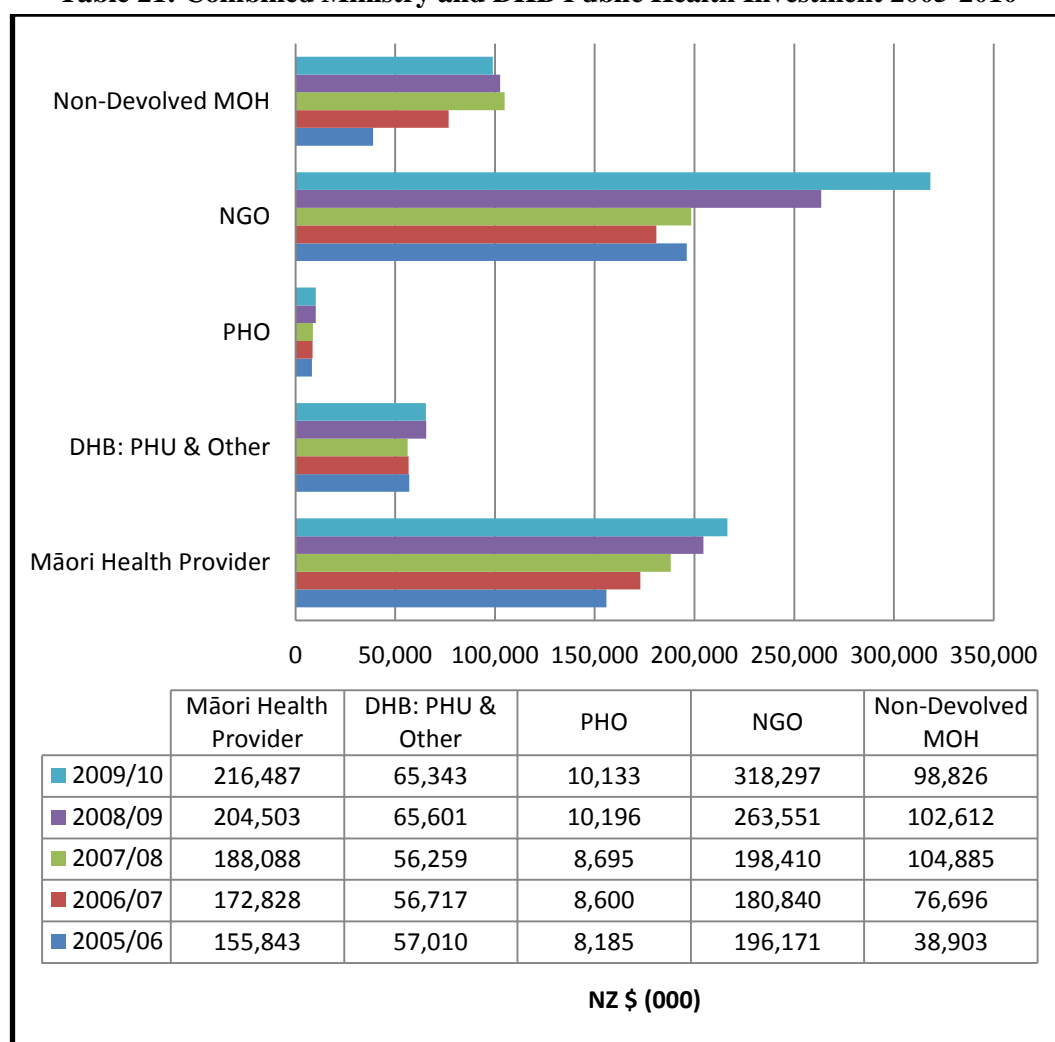
Note. This table is the compilation of data from both Tables 20 and 21. The same limitations to the data apply.

The failure of Crown agencies to collect systematically Māori health expenditure currently compromises any assessment of whether the funding allocations represented in Table 21 are fair, equitable or aligned to health needs. Despite decades of public health interventions, enduring disparities in life expectancy between Māori and non-Māori suggest the current configuration of public health policy and funding practices is failing Māori.

9.5 Summary

> You will have observed the difference between the Ministry's rhetoric and the reality(Senior Crown Official, 2011, April 29, p. 2).

A desktop review of Crown documents reveals there exists a web of elaborate operational guidelines, policies, procedures and mandatory rules to guide government departments, Crown agencies and officials in their administration of health funding. These guides cover every aspect of health from prioritisation processes, procurement practices through to monitoring. This web of accountability is held together by a systems approach to quality assurance driven

by commitments to both efficiency and effectiveness. As outlined in chapter four, these operational guides sit within a broader range of public sector accountability controls, domestic and international human rights, and Tiriti obligations.

The master narratives represented across these guidelines espouse values of fairness, transparency, equity and emphasise the importance of Māori health. They seem a powerful collection of controls to detect, prevent and minimise racism. The validity of this policy rhetoric is questioned within chapter ten, which presents the counter-narratives of those targeted by racism, informed by decades of operational interaction with Crown officials.

Tracking public health expenditure for this chapter was difficult, as it seems no one Crown agency has an overview of public health investment. In order to compile even a rudimentary funding analysis I utilised a series of OIR against Crown agencies. This process revealed that Māori public health expenditure is not systematically recorded making it problematic to track Crown investment. The data obtained did however indicate both the fractured nature of public health expenditure and proportionately low levels of direct investment in Māori public health.

CHAPTER TEN: COUNTER-NARRATIVES: DIFFERENTIAL TREATMENT OF PUBLIC HEALTH PROVIDERS

10.0 Introduction

> Institutionalized racism manifests itself both in material conditions and in access to power... With regard to access to power, examples include differential access to information, resources, and voice
> (C. Jones, 2001, p. 300).

Funding and planning activity, whether practiced by Crown officials from the Ministry of Health or by local DHBs, establishes which health providers gets what level of resourcing. It also determines what communities health needs are prioritised and addressed and whose get cursory attention. The funding and planning of health services in Aotearoa occurs within a context of rationing of health funding that recognises the existence of unmet clinical and public health needs (see Ministry of Health, 2004e, 2008a, 2011b; Te Rōpū Rangahau Hauora o Eru Pōmare, 2002). Research by Māori academics such as Robson and Harris (2007), E. Pōmare et al. (1995) and research on health disparities published by the Ministry of Health (T. Blakely, Fawcett, & Atkinson, 2004; Ministry of Health and University of Otago, 2006) raise concerns that Māori health needs are disproportionately unaddressed by the current health system.

This chapter examines Crown funding practices at an operational level. Specifically I examine providers' perceptions of their relationships with funders and levels of influence, experiences of contracting and funding practices and processes as possible sites of racism.

This chapter is developed from both counter narratives, my co-funding field notes and is informed by relevant literature. In response to emerging trends in my findings, this chapter also draws on the results of a telephone survey I undertook of public health providers. Through this survey, I benchmark the experiences of fifty-six senior public health managers from local and national NGOs, PHOs, PHUs and Māori health providers in their dealings with Crown officials.

The survey findings took the form of a mixture of quantitative and qualitative data examining experiences of contracting, relationships, levels of financial accountability and access to Crown officials and funding. Participating providers ranged from small to large organisations, including rural and urban providers spread across the length and breadth of Aotearoa. The graphs used to represent the

survey findings are based on percentages, which the proportion of providers that shared an experience as the number of providers surveyed in each category was uneven.

10.2 Relationships and Influence

> We don't have a hell of a lot to do with them [the funders], not a lot, [an] odd discussion about how things are (Māori provider, December 2010).[153]

Ashton, Cumming, McLean, McKinlay and Fae (2004, p. 4) in their review of health contracting for the WHO argued that good relationships were the key to successful contracting. They maintain there was a natural tension between funders and providers based on perceived imbalances in power between the respective organisations. When enquiring about the nature of funder/provider relationships they (2004, p. 60) found:

> ...the most common response from both parties was "It depends"! This was usually followed by an explanation of the variables that had affected their particular relationships over time.

This study found some public health providers reporting close and functioning relationships with their funders, while others revealed dynamics that are more complicated. How this relationship is navigated, given the renewed focus on relational contracting, can either ease or hamper contract negotiation processes and experiences of monitoring, reporting and auditing for providers. Leading health administrator Wano (2011, June 24, p. 1) in his counter narratives, asserted that funders tend to view Māori and non-Māori providers differently. He suggests the distinction is in "...the way that they interact and usually that shows itself in a compliance way. What you tend to see is a focus on audits and very low tolerance for risk, and high compliance". Other counter narratives echoed these concerns, asserting at a core level funders distrusted Māori providers with public money to deliver effective public health programs.

The public health sector in New Zealand is small and tight knit so it is not uncommon for personal relationships to co-exist alongside professional relationships. Practitioners work together in a variety of roles within a variety of organisations over the span of their careers. This movement of staff creates a web of connections and carries forward understandings of organisational culture and practice. Within the public health provider survey several of the PHU providers specifically mentioned that former PHU colleagues/friends of theirs now worked within funding roles with either the Ministry or a DHB. For Māori providers' whakawhanaungatanga was seen by many as intricate to the establishing of effective working relationships with funders.

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[153] Comment from public health provider survey conducted December 2010.

Exploring these issues, I benchmark providers' perceived levels of access to DHB and Ministry funders and reported levels of representation on steering/advisory groups as a reflection of their level of influence with funders.

Public Health Providers Reported Access to DHB and Ministry Funders

Within the provider survey, I asked senior managers to characterise their access to Ministry and DHB funders. The findings are depicted in Table 22. PHOs reported the easiest access to DHB funders. This access is likely to reflect their frequent contact with DHB officials whom pro-actively manage this sector as many DHB performance indicators are impacted upon by the activities of the primary healthcare sector.

PHUs also report easy access, with a small but significant grouping acknowledging their access was complicated. For larger PHU providers this complexity is likely to result from having relationships with several DHBs. The easy access for other PHU providers may reflect that structurally they are part of the same organisation, and for some PHUs, they are quite literally part of the funding and planning division. This organisational positioning of PHU enables them both formal and informal access to funders, information and access to technical expertise. One PHU provider reported funding and planning staff sit on their advisory group while another noted, "The public health portfolio manager is a friend of mine, we get on very well. So we talk on a weekly basis".

Table 22: Public Health Providers Reported Access to DHB Funders
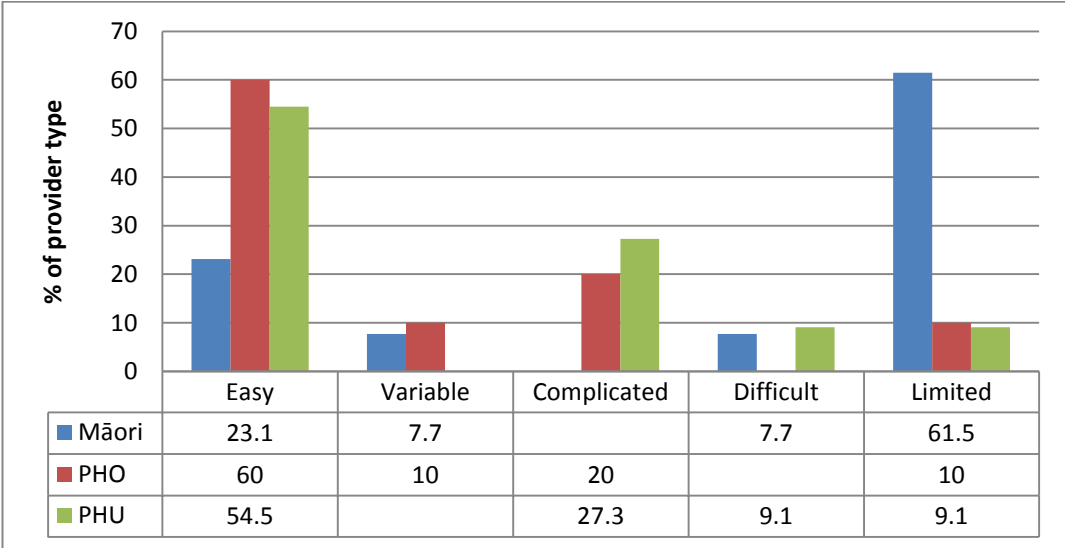
	Easy	Variable	Complicated	Difficult	Limited
Māori	23.1	7.7		7.7	61.5
PHO	60	10	20		10
PHU	54.5		27.3	9.1	9.1

Note. This table is adapted from the findings of my public health provider telephone survey. In this instance, it includes responses from the 36 participating providers that held DHB based public health contracts. As only one NGO fitted this category, their data was excluded.

The bulk of Māori providers reported limited access to DHB funders and decision-makers, although a small but significant group reported easy access. Providers in both Taranaki and Te Tai Tokerau noted that Tui Ora and Te Tai Tokerau MAPO Trust respectively acted on their behalf with funder's at times,

enabling providers to focus on service delivery. Regional leadership forums such as the Te Tai Tokerau Strategic Māori Health Alliance were mentioned as a regional site of engagement between providers and DHB funders.

Access to Ministry funders followed similar patterns (see Table 23). In this instance Māori providers reported having 'limited' or 'when required' access to funders. This contrasted with PHU providers reporting 'when required' or 'frequent' access. NGOs perceived access was spread across the full range of options, perhaps reflecting the diversity of NGO providers. Of those NGOs, managers that enjoyed frequent access, some had previously worked within the Ministry and/or had worked a long time in the sector. They recognised others without those connections would not have that same ease of access they enjoyed.

All the groupings of providers noted there was a high turnover of Ministry staff in recent years and officials exhibited variable knowledge of public health. Some providers reported these factors might have influenced the depth of their relationship with funders. An extreme example was a Māori provider who reported dealing with approximately thirty different Ministry officials over their public health contracts over a ten-year period.

Table 23: Public Health Providers Reported Access to Ministry Funders
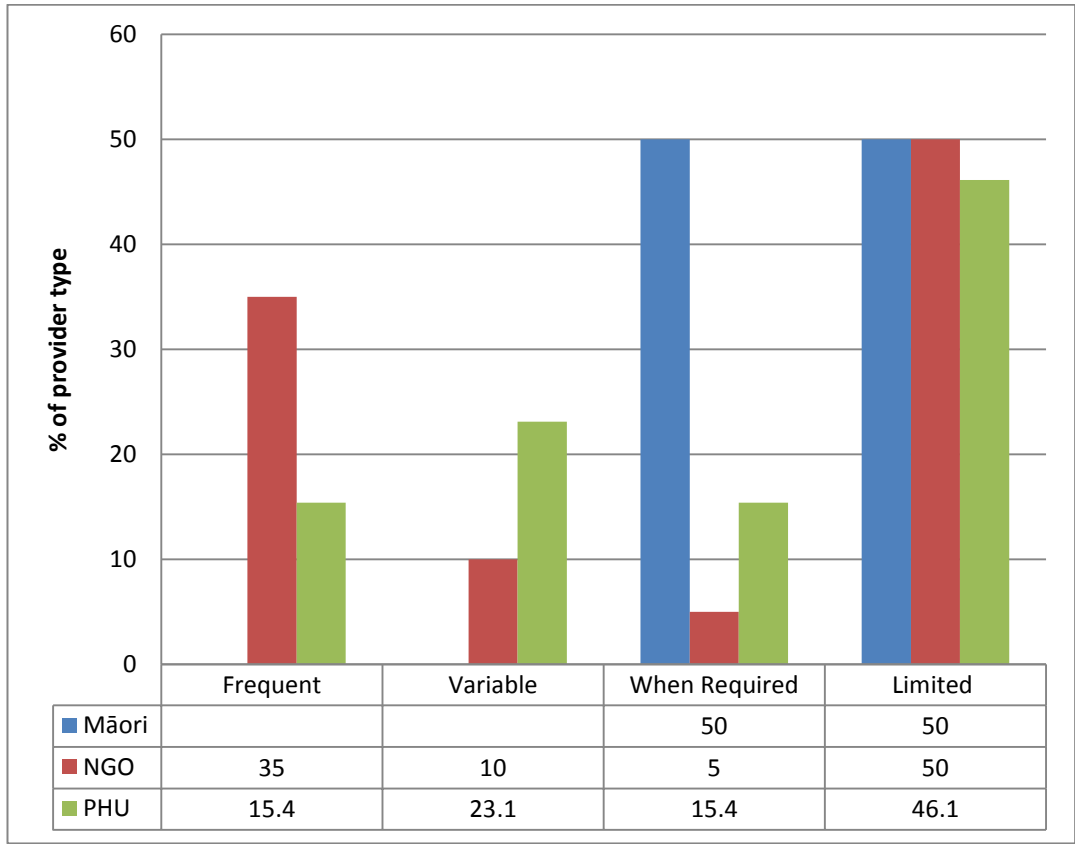
	Frequent	Variable	When Required	Limited
Māori			50	50
NGO	35	10	5	50
PHU	15.4	23.1	15.4	46.1

Note. This table is adapted from the findings of my public health provider telephone survey. In this instance, it includes responses from the 47 providers that held Ministry based public health contracts. As only one PHO fitted this category, their data was excluded.

One unique pathway PHUs utilise to access Ministry funders and decision-makers is through the Public Health Leaders Network which was instigated in 1998. One PHU provider explained, "I'm our representative on that and that has very positive relationships with Ministry people who come and present to us and they [Ministry] now see it as a valuable tool to talk to PHUs". The Health and Disability NGO working group, which includes both Ministry and two public health NGO representatives, provides a limited pathway for the NGO sector. However, other groupings do not appear to have a similar senior public health-focussed forum to engage with Ministry decision-makers.

From the provider survey, PHUs report easier access to DHB funders than other groupings of providers. Their co-location with DHB funders in the same organisation enables access to information and formal and informal relationships not available to other providers. Half of participating Māori providers reported only limited access to Ministry funders, while NGOs reported gaining access when required. PHUs reported mixed experiences accessing Ministry officials despite the existence of a range of dedicated forums to communicate with DHBs on specific public health issues.

Representation on the Steering and Advisory Groups of Crown Agencies

Both the Ministry of Health and DHBs regularly use steering and advisory groups to advance strategic planning and define purchasing priorities. Representation on advisory groups enables providers to formally and informally gain information and affect influence over policy directions and funding priorities. Reported participation in advisory groups is outlined in Table 24.

Table 24: Reported Representation of Providers on Crown Advisory Groups
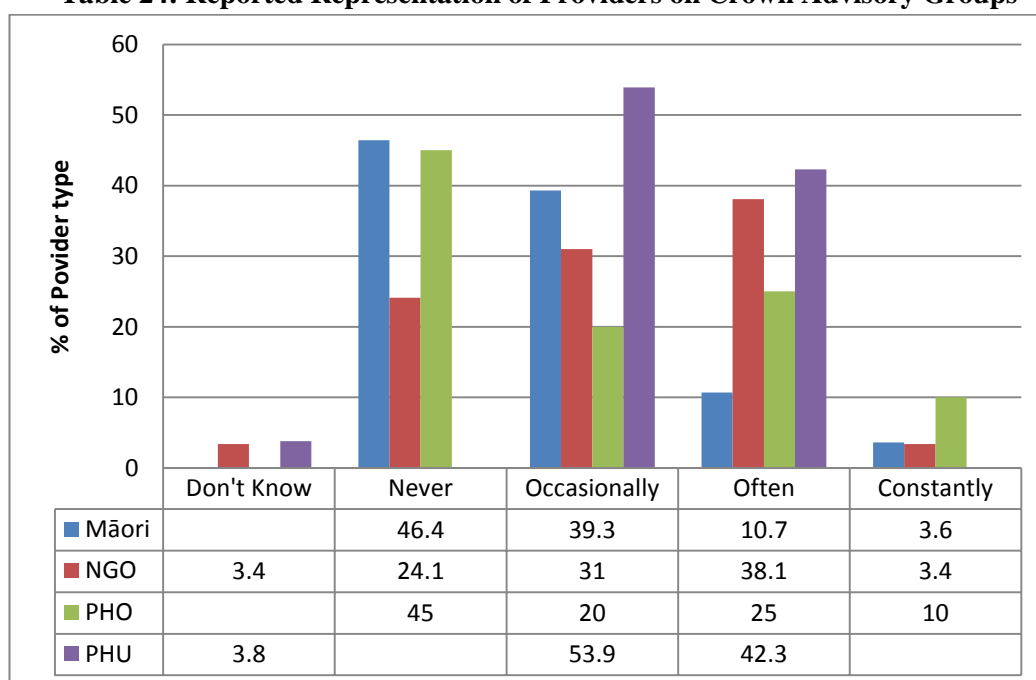
	Don't Know	Never	Occasionally	Often	Constantly
Māori		46.4	39.3	10.7	3.6
NGO	3.4	24.1	31	38.1	3.4
PHO		45	20	25	10
PHU	3.8		53.9	42.3	

Proportionately, PHU providers are most frequently represented on steering/advisory groups, with some providers reporting ten year plus involvements with particular references groups. PHU relative high representation may reflect their co-location with DHB funders and the technical expertise PHU often hold because of their employment of Medical Officers of Health and Public Health Medicine Specialists. Several PHU providers reported staff members were formally appointed to the DHB Community and Public Health Advisory (CPHAC) groups, others indicated they attended and presented several times at every CPHAC meetings. One PHU provider explained in the context of DHB steering/advisory groups "There was almost an expectation that either myself or [my colleague] get asked, "can you take part in it?" if not one of us, someone else from within the public health team".

Māori providers within the survey consistently reported they were occasionally or never involved in either DHB or Ministry steering/advisory groups. That was also observed in my co-funding experiences (January 15, 2009):

> Consistently at least half the membership of DHB-led steering and advisory groups are made up of DHB staff. For example I have been involved with was a Child and Youth Health Advisory Group which had about twelve people; of which only three were not DHB staff. In Te Tai Tokerau, over half of Māori are under 25 years old, making that cohort of particular strategic interest to Māori. There was a reluctance of DHB officials to recognise expertise beyond their organisation; despite the fact, they were doing planning for the whole sector.

Within the survey, national NGOs tended to have strong representation, particularly those with particular technical expertise. Indeed, some NGO providers reported representing the Ministry at WHO meetings and chairing technical and advisory groups both one-off and ongoing for the Ministry. Local NGOs reported relatively less representation. PHUs are most strongly represented in both DHB and Ministry advisory/steering groups, with specialist national NGOs also represented well. Māori providers are consistently least likely to be represented, which may affect Māori voices being 'heard' through this mechanism.

10.3 Contracting Practices

> DHBs are to be entirely separate from hospitals, and in that the role of the DHB is to plan and purchase from appropriate providers including hospitals (Gauld, 2009, p. 188).

As introduced in chapter nine contracting is the core mechanism by which Crown officials purchase public health services. Within this section, I discuss various themes that emerged through dialogue with counter storytellers in relation to contracting practices. These include the public health service specifications, negotiation processes and contract monitoring. Contract terms and auditing practices are also addressed based on the provider survey findings.

Public Health Service Specifications

Historically the *Public Health Service Handbook* (Ministry of Health, 2010f) contains the service specifications for the bulk of public health programs that are contracted for in Aotearoa. As discussed elsewhere these have recently been transferred to the National Service Framework Library and are being progressively reviewed. In 2009 as part of this process, Ministry of Health undertook a limited consultation in relation to the public health specifications. In a collective submission (Te Tai Tokerau MAPO Trust et al., 2009, p. 3) to the Ministry, several Māori health providers[154] identified a number of deficiencies with the specifications. Firstly, they noted that there is a tailored refugee and new migrant specification but no kaupapa Māori one. This omission is inconsistent with the Crown's Tiriti obligations to protect Māori interests.

The providers argued that Māori public health approaches should be reflected in both the content and framing of service specifications, as affirmed within *He Korowai Oranga* (A. King & Turia, 2002). The providers made the case that with an issue specific framework and focus on bio-medical outcomes, the handbook makes a cumbersome frame for an integrated Māori public health service. For instance the providers (2009, p. 15) argued in the context of communicable disease that successful service delivery to Māori communities:

> ...needs to work from a place of whakawhanaungatanga. Trusting relationships are critical to successful contract tracing and sharing of critical health information in both times of crisis and in times of calm. An understanding of the dynamics of whānau and Māori leadership are critical competencies for practitioners engaging in this mahi (work). Ideally communicable disease delivery needs to be embedded within a wider pro-active holistic whānau ora service.

Utilising the historical example of the 1918 influenza pandemic the providers reflected that generic approaches have often not worked for Māori communities, indeed they have on occasion resulted in devastating disparities in mortality.

Thomas (2002, October, p. 2) in his review of health care delivery identifies a continuum of service delivery approaches from what he calls:

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[154] In this instance Whakawhiti Ora Pai, Te Runanga o Te Rarawa, Te Hauora o te Hiku o Te Ika, Ngati Hine Health Trust, Ki Ora Ngatiwai and Te Tai Tokerau MAPO Trust.

...“mainstream” services and programmes which are essentially mono-cultural (providing a “standard” treatment for all clients or participants) through programmes which endeavour to ensure that the service provided is culturally appropriate for more than one cultural group to ethnic or cultural specific programmes intended to provide services for specific non-mainstream groups.

He asserts that there is considerable evidence to indicate that many programmes and services that follow a generic approach are inappropriate for some cultural groups. He also points to the research undertaken by Durie (2001) and Te Puni Kōkiri (1999) that highlights a lack of Māori participation in planning and delivery of services and the delivery of services in ways that are incompatible with, or inappropriate for, the cultural styles of Māori. The current public health service specifications do not reflect Māori understandings of wellbeing in its structure nor are Māori public health traditions substantially reflected in its content.

Negotiations Processes

There are considerable perceived and real power and resource imbalances between the vastness of Crown entities like the Ministry and DHBs and public health providers. An evaluation conducted by Te Puni Kōkiri (2000a, p. 12) on the HFA's service delivery to Māori, found that many Māori providers felt there was a lack of real negotiation with the Crown, instead the pattern of engagement was a series of perpetual contract rollovers. Berghan (2010, October 18, p. 5), who has negotiated contracts from both within Māori and generic public health providers, argues that when negotiating as a Māori provider it was necessary for him to be a lot more flexible. Based on her involvement in health funding, Kuraia (2010, September 22, p. 8) echoed this position, stating Māori providers, “...are not given the opportunity to properly negotiate their contracts, it is always a ‘take it or leave it’ situation”.

Bradbrook (2010, October 4, p. 2) acquired unique insight into Crown negotiation practices by deliberately entered into dialogue with senior managers across generic tobacco advocacy providers. This action was aimed at benchmarking their negotiation experiences against those of the Māori organisation he ran. He explains:

> ...we [a Māori provider] were made to do quite a number of things, to jump through hoops to prove that we were legitimate, that we had support... Suddenly there was criticism, suddenly there were audits, and suddenly there were questions about governance structures... The bottom line is through all of that period the language and the content of what was coming out in those conversations was markedly different from what was happening with our sister [generic] organisations. I was constantly asking

them, our sister organisations were they getting the similar treatment... The answer was no (p. 2).

Bradbrook confirmed he was dealing with exactly the same Crown officials who were negotiating with his sister organisations.

Through my involvement in co-funding activities, I sat in on negotiations with a generic provider that had a paired contract with a Māori provider. They were both charged with producing joint outcomes. I explain (Field notes May 10, 2009):

> As the contracts was paired they were mirror images of one another, except the generic providers contract was from sustainable funding streams and ran for a three year term and the Māori one was from one-off funds and for a single year. The justification for the difference was that the generic provider was in a "strategic position" and needed to "strengthen its public health capacity". At that point, the generic provider had held a vacancy for six months and their service delivery levels were nominal at best, service delivery on the Māori contract in contrast had exceeding output levels except, where engagement with the generic provider had impeded progress.

Bradbrooks' experiences of contract negotiation and the above example reveal how unclear criteria or processes are used to support decision-making. Even a rudimentary HEAT tool analysis (Ministry of Health, 2004d) favoured by funders for prioritisation processes, would have demonstrated both funding decisions would be likely to increase health inequities. There are many variables that affect a negotiation processes, but the counter-narratives suggest different levels of rigour are applied across provider groupings by Crown funders during negotiation processes.

Contract Terms

> But you know what I am talking about; the five-year contracts for the PHO and
> two years or one year for Māori, stuff like that
> (Senior Māori Executive, 2010, November 7, p. 5).

Contract terms can engender profound senses of security and insecurity in providers and variously enable and restrict strategic planning and the achievement of organisational goals.

Through the public health provider survey, I asked about the usual length of contracts. Table 25 shows that unique place of PHOs whom enjoy evergreen contracts with no expiry dates, instead health promotion plans are submitted annually for DHB approval. At the time of the survey 80% of PHU, providers held three-year contracts, with many national NGOs also having longer-term contracts. The survey indicated that from late 2009 there was a general trend

towards shorter-term contracts across providers. Māori providers were most likely to report having annual contracts with those retaining three-year contracts expecting to have reduced contract timeframes in their forthcoming negotiations.

Table 25: Negotiated Contract Timeframes
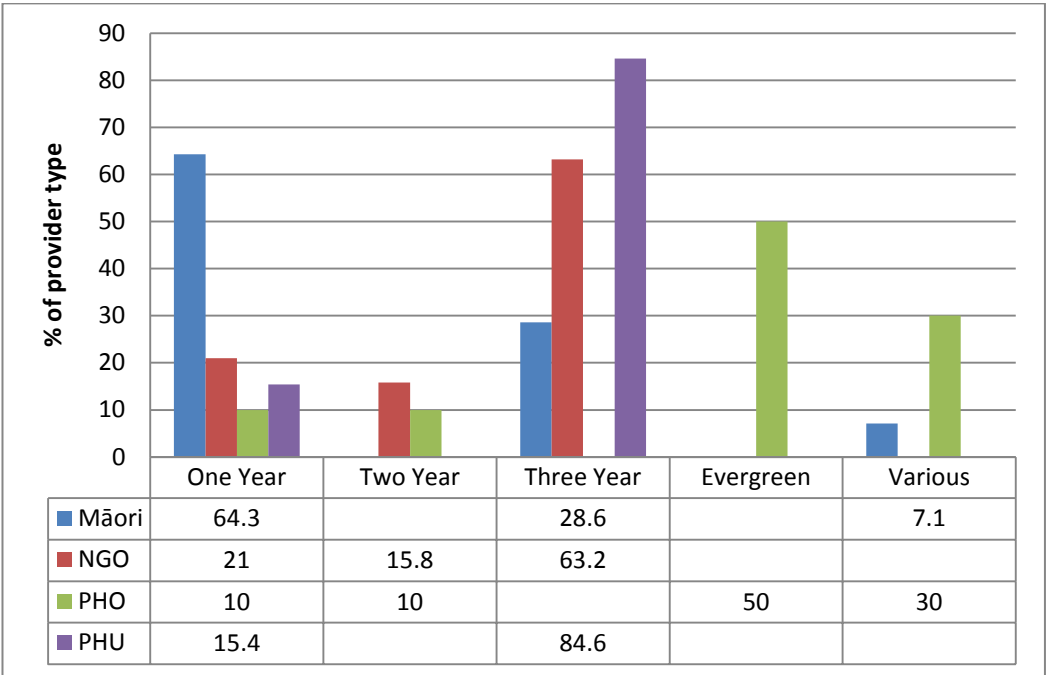
	One Year	Two Year	Three Year	Evergreen	Various
Māori	64.3		28.6		7.1
NGO	21	15.8	63.2		
PHO	10	10		50	30
PHU	15.4		84.6		

Note. This table is adapted from the findings of my public health provider telephone survey. It shows the usual contract timeframes providers were able to negotiate over the last five years.

Cram and Pipi (2001) argue that the term of a contract has profound impacts on the ability of providers to do long-term and strategic planning and their ability to recruit and retain staff. The impact of this uncertainty is reflected in anecdotal evidence that many working within Māori health are employed on short-term contracts, in part because of the lack of certainty around revenue streams. A review by Te Puni Kōkiri (2000) found although this practice minimises organisational risk, it affects the organisation's ability to compete effectively in the labour market for senior staff. Disparities in employment conditions across public health providers are further heightened with the Public Service Association's[155] negotiation of regional Multi-Employer Collective Agreements across DHBs in recent years and moves to develop national agreements.

The provider survey confirmed both a general trend towards reduced contract timeframes across the sector, and that Māori providers are the most likely grouping to hold one-year contracts.

Contract Monitoring

> It has to do with an air of superiority and privilege knowing better than Māori organisations by virtue of the fact that they were Crown agents and had the right apparently to treat Māori as children, who didn't know what they were doing (Kuraia, 2010, September 22, p. 8).

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[155] The PSA is the union that represents most workers within the sector.

Contract monitoring is a process that enables funders to ensure contracted providers are delivering services to a level and quality specified in their contracts. The standard benchmark for Ministry monitoring from the provider survey, is to conduct at least two site visits per year and provide verbal and written feedback to providers. Meetings are usually held between funders and management with practitioners sometimes involved to clarify points of interest or to resolve particular issues and challenges. Several PHO providers, reporting within the provider survey, claimed that they received little or no monitoring or other feedback from DHB funders of their public health activity. With this exception aside, the provider survey confirmed the frequency of contract monitoring was similar across providers.

In contrast, the counter narratives, many of whom had worked within both generic public health and Māori public health providers, suggested that there were inconsistencies in the level of intensity of monitoring across groupings of providers.[156] Berghan (2010, October 18, p. 6) who has worked for a range of providers asserts:

> ...we [Māori providers] really get put through the wringer... my experience is that there are different levels of monitoring, and Māori are seen as being a lot more risky and the funding is always being scrutinised and so on. There is less freedom to move and be creative.

Māori Policy Analyst (2010, November 16, p. 5) while working for a Crown agency recalls:

> I have sat in the [tea] room and heard them laughing about a [generic] provider who hasn't reported properly for ten years, and they are still funding them. God, if that was a Māori provider they will have shut them down... I just think there is more flexibility for Pākehā.

As part of co-funding activity with the Crown, I (Field notes January 17, 2009) was involved in co-monitoring both Ministry and DHB funded public health contracts for several years. During this time, I observed:

> ...Crown officials wield their institutional power... I witnessed one Māori provider being asked by their funder to provide information of the grades assorted kaimahi had achieved through a course they were funded to attend; not pass rates, actual grades. On another occasion, I witnessed a Crown official feeding back to a Māori provider to a level of detail that including pointing out spelling mistakes in a report... these officials seems

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[156] Note participants within the provider survey were not specifically asked about their experiences of the intensity of monitoring, though several providers shared their observations and experiences in relation to this.

to have forgotten they are dealing with an organisation with a long-standing and proven delivery of public health services... This contrasts sharply from when I worked in a PHU and the monitoring process of our multi-million dollar contract, on occasion could take less than half an hour and only involved mild questioning.

I suggest that even though frequency might be consistent, my observations from co-funding activity suggests intensity, level of scrutiny and time invested in monitoring does not appear proportional across providers. This observation would however need to be further tested.

As outlined in chapter seven, embedded within health policy is an enduring policy commitment to mitigate the chronic inequities in the distribution of illness and disease experienced by Māori (see A. King, 2000; A. King & Turia, 2002; Ministry of Health, 2007e, 2011b). Given this primacy all providers holding both Māori-specific and generic health contracts are expected to effectively deliver services to Māori. As introduced in chapter nine the Crown has commissioned and developed a range of tools to assess the effectiveness of service to Māori including the *CHI audit model* (Durie, 1993a) and *He Taura Tieke* (C. Cunningham, 1995). At an operational level during this study a Senior Crown Official (2011, April 29, p. 6) confirmed their organisation did not currently have the capacity to review the whole range of service delivery to Māori.

Despite providers' best intentions, based on my nineteen-year involvement in the sector I have regularly observed low levels of service delivery to Māori communities by generic public health providers. Within my co-funding capacity (Field notes, August 10, 2009) I regularly reviewed documentation that seemed to verify this observation and witnessed no remedial actions taken by the relevant Crown agency to address these service delivery gaps. Certainly none of the generic providers within the provider survey reported being performance managed by a funder in the last five years. This suggests to me there may be no contractual consequences for unsatisfactory service delivery to Māori and funders condone this.

Concerned about the levels of generic providers' service delivery to Māori, a grouping of Māori health providers in a submission to the Ministry of Health called for wider debate about public health funding. They advocated for public health investment to go into providers that can ensure they have the capacity to deliver effectively to Māori communities. They explain (Te Tai Tokerau MAPO Trust et al., 2009, p. 3):

> Māori providers should be leading service delivery to Māori communities within a Māori tikanga framework and on public health issue areas that Māori disproportionately experience the burden of disease. We believe

there is limited evidence of the effectiveness of 'generic' public health interventions with Māori communities at both a local and regional level.

With the exception of PHO, providers' equity in frequency of monitoring was confirmed through the provider survey. Counter narratives and some participants in the provider survey suggested Māori were more intensely monitored than other provider groupings. This coincided with my professional observation that generic providers experience low levels if any monitoring of their service delivery to Māori communities.

Auditing Practices

> ...we were audited to death, it affected our ability to manage the operations properly, my staff were always on edge, one government agency come... in the front door while the other leaving the backdoor basically, one after another (Māori Provider CEO, 2010, November 1, p. 1).

Auditing is a mechanism by which the Crown monitors performance to ensure contracted services have been provided, financial processes are robust and quality assurance systems and processes are in place. Within my provider survey, I asked about the frequency of which providers have been audited over the last five years. Table 26 shows Māori providers reported being the most audited followed closely by PHU providers. Both PHO and NGO providers reported experiencing similar levels of auditing. Several Māori providers noted that audits were used by funders to intimidate. A provider explains, "They threaten you with audits. They are always saying, "you better have this ready for auditing". Other groupings of providers did not report experiencing such behaviour.

Table 26: Recollections of Frequency of Auditing
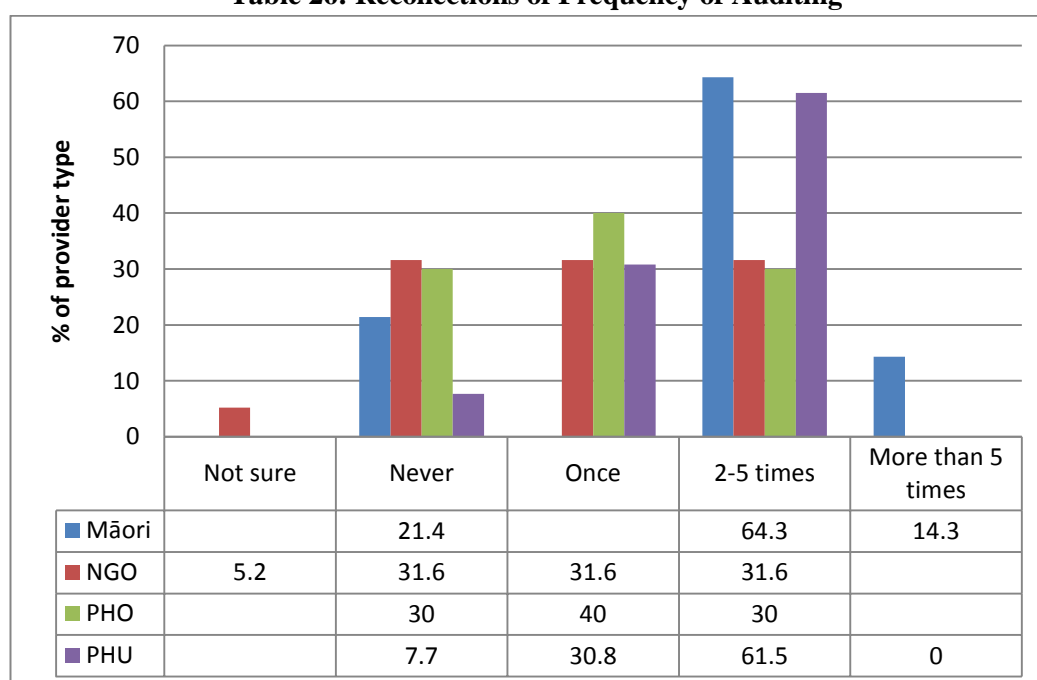
	Not sure	Never	Once	2-5 times	More than 5 times
Māori		21.4		64.3	14.3
NGO	5.2	31.6	31.6	31.6	
PHO		30	40	30	
PHU		7.7	30.8	61.5	0

Note. This table is adapted from the findings of my public health provider telephone survey. It shows providers recollections of the frequency of auditing over the last five years.

From his experiences working across the sector in a range of providers Berghan (2010, October 18, pp. 5-6) maintains the accountability processes applied to Māori are, "...a lot more rigorous, a lot more strident". Wano (2011, June 24, p. 1) concurs noting in relation to Māori providers that funders tend to have a low tolerance to risk and strong emphasis on compliance. He suggests, "the lowest common denominator tends to rule, and that is the lens that the system looks at Māori providers through, regardless of whether you are performing well or not". To illustrate this further, Berghan recalls talking to a Pākehā General Practitioner who had been in practice for twenty-five years and had never been audited. In contrast, a Māori provider disclosed that they had been audited every three to four weeks over one of their multiple of Crown contracts in an eighteen month period.

The current public health service specifications appear to marginalise Māori public health traditions. Negotiation processes often appear to reflect the unequal power relations between the Crown and Māori providers. Contract timeframes offered to Māori providers are generally shorter than those offered to other providers. Likewise, the levels of intensity of contracting monitoring and frequency of auditing appear inconsistent across providers.

10.4 Funding Processes and Practices

The desire for equitable access to funding was a clear aspiration from counter narratives within this research. Many felt the current system was unfair and disadvantaged Māori providers. Within this section, I examine historic funding allocations and Crown prioritisation processes. I also specifically address access to annual cost of living/future funding track (FFT) adjustors, discretionary one-off funding, levels of financial accountability and compliance costs. This analysis is based on narratives from counter storytellers, my field notes, related literature and findings from the provider survey.

Historic Funding Allocations

> ...as a PHU, I was just given money, millions of dollars, I didn't have to argue for it... it wasn't a purely contestable fund, we talked about how difficult it is, [but] every year it kept coming to me... I wasn't competing with anyone now that I think of it. It was just there. I was just given it
> (Berghan, 2010, November 7, p. 8).

Significant amounts of the public health funding were allocated prior to the emergence of Māori health providers. Despite significant developments in the field in terms of new policy directives and expanded knowledge base, these historic decisions continue to stand. This leaves the bulk of public health resources invested with PHUs and other generic providers. Bloomfield and Logan (2003, p. 18) in their examination of the prioritisation process in health funding noted that rigor has "...been applied almost exclusively to the allocation of new funding and rarely to current expenditure".

In a collective submission to Ministry developed by several Māori health providers (Te Tai Tokerau MAPO Trust et al., 2009, p. 17) some key issues were raised about these historic allocations. They argue:

> Substantive discussions about the delivery of public health contracts across Northland have not occurred for some time. It appears that funding decisions are currently being driven by portfolio managers rolling-over contracts rather than engaging in evidence based public health contracting processes that address health needs and chronic funding inequities across Northland (p. 17).

Within the context of their submission, the providers advocated for a review of the distribution of public health investment justified on Te Tiriti grounds, the high health needs of Māori, and the lack of evidence of the effectiveness of 'generic' delivery models.

The providers also questioned the 'monopoly' that PHU providers have over the considerable allocation of public health investment, particularly in school settings, while recognising the unique responsibilities of DHBs outlined in the NZPHDA. They elaborate (Te Tai Tokerau MAPO Trust et al., 2009, p. 17):

> As schools [particularly Kura Kaupapa and Te Kōhanga Reo] are often central to rural [and urban] communities, they are a natural setting for public health interventions. It is unfortunate that Public Health Units are the only providers nationally being resourced to deliver Health Promoting Schools. Māori providers who often have staff proficient in Te Reo me ōna tikanga and have longstanding whānau connections would be ideally placed to deliver within Māori education settings. We welcome debate about the equity and fairness of these longstanding funding decisions.

In support of their position, in part, the intention of the Commerce Act 1986 is to promote competition in markets, and it contains regulations that specifically prohibit a range of anti-competitive practices. Likewise, Treasury (2009a, p. 30) guidelines specify that where there is only one supplier of a service, periodically this should be tested through engaging in a tendering process.

Prioritisation Processes

At least annually, decisions are made regarding the allocation of health monies to address a variety of competing health needs. Due to the limited nature of health funding a process of prioritisation occurs. Funding decisions are traditionally aligned to Crown policy and planning documents as presented in chapter seven. Kuraia (2010, November 16, p. 5) shares her experiences of a prioritisation process from her co-funding experience. She explains:

> …we [MAPO staff] had prepared our bids to sit alongside our colleagues in the DHB and we get in there and we have to argue for every little point about it. And because all our bids were focused on Māori tino rangatiratanga, Māori provider development... they were automatically challenged, it didn't matter that we could... fit our bids to their repeatedly reconstituted prioritisation process… all the Māori bids they just seem to get stuck. And the other DHB colleagues were getting their bids processed and going through and there was very little questioning of them... (p. 5).

Theoretically the process Kuraia outlined meant proposals were consistently treated but in practice Māori focussed proposals appeared to be treated differently. I explain from my co-funding field notes (February 18, 2009):

> Some proposals were actioned immediately, and others like ours [Māori specific proposals] languished at the bottom of the pile. Some were tendered; others went out to existing providers that DHB staff had relationships with. The justification for the inconsistencies was that they were working to a tight time frame.

A Māori Policy Analyst (2010, November 16, p. 5) also reflects on a prioritisation process:

> I think the prioritisation process in our DHB is not a very good process... And last year Māori got a lot of the money, but it was all one-off money, Pākehā got all the ongoing money that is pretty tricky dirty dealing.

Prioritisation occurs when programs are funded and when funding is withdrawn. I recall from my co-funding field notes (May 18, 2009) a provider visit where a Crown official was cutting a program that serviced a high-needs Māori community:

> By way of explanation, the Crown official explained, "This is not an evidence-based decision, this is political". The phrase still bounces around my head from time to time. I attempted to clarify the situation and asked "what about the independent evaluation that had been commissioned on the programme?" and the Crown official's explanation remained constant.

Shortly afterwards a one-off Māori workforce development program came to the end of its contract term. I (Field notes, May 18, 2009) explain:

> There was consensus with all the funders and interested stakeholders that that particular program had been a success and indeed, it held potential as a useful model to be duplicated elsewhere around Māori workforce development. Such a programme was firmly aligned with *Te Uru Kahikatea* and both the *Te Tai Tokerau Strategic Public and Māori Health*

Plans but a search for funds to keep the program going was unsuccessful. Within months, another one-off program run by a local generic provider secured additional funding despite ongoing concerns about its traction within local Māori communities.[157]

These inconsistencies in Crown behaviour can be seen clearly from the privileged position of a co-funding viewpoint and to the subaltern working within the system. I maintain that it is this pattern of inconsistent treatment that reveals institutional racism in Crown decision-making.

Annual Cost of Living/FFT Adjustor

> [She laughed]. I don't know the funders knew what that [cost of living] meant
> (Māori Health Provider, December 2010).[158]

Within the health, sector providers variously secure and/or negotiate an annual cost of living adjustment sometimes known as FFT. This adjustor enables providers to accommodate rising petrol costs and continue to deliver the services they were contracted to provide without hardship. The provider survey (see Table 27) confirms different groupings of public health providers have differential access to cost of living adjustors. PHUs reported historically consistently getting an adjustment, but more recently for some, this has not occurred. One PHU provider explains, "I believe we have [consistently got an adjustment]; although for the last several years the cost of living adjustment has always appeared doubtful but I think it has eventually come through". PHUs remain the grouping most likely to receive an adjustor.

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[157]   A recent evaluation of this program provided no evidence that the program was successfully engaging Māori.
[158] Comment from public health provider survey December 2010.

Table 27: Recollections of Access to Cost of Living/ FFT Adjustor
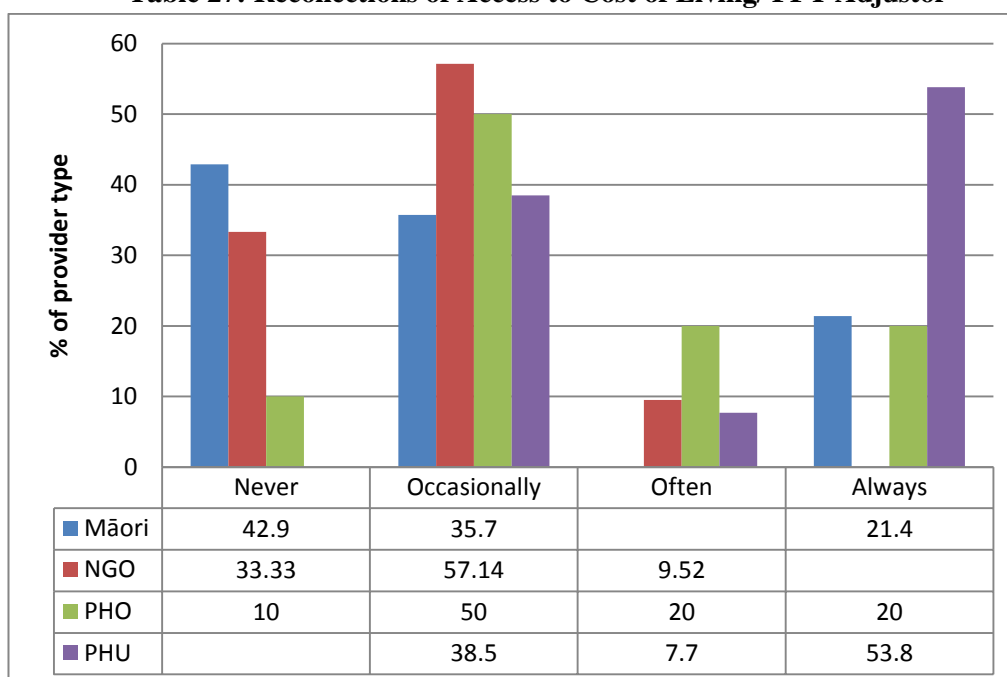
	Never	Occasionally	Often	Always
■ Māori	42.9	35.7		21.4
■ NGO	33.33	57.14	9.52	
■ PHO	10	50	20	20
■ PHU		38.5	7.7	53.8

Note. This table is adapted from the findings of my public health provider telephone survey. It shows providers recollections of the frequency of their access to cost of living/FFT adjustors over the last five years.

PHOs reporting a range of success in accessing FFT, reflecting that DHB funders have discretion in passing on increases they obtain from the Ministry. A participant in Ashton's (2007, p. 20) review of the 2001 health reforms suggest:

> DHBs will always award themselves a nice warm comfortable increase once a year to meet cost of living. They may award themselves 3%; if we are lucky, they might give the sector [NGO] 1% as though it is somehow cheaper out in the sector than it is in the DHB.

My survey shows that NGOs and Māori providers reported access at the "never" or "occasional" end of the spectrum. Māori providers are most likely to report they had never received a cost of living adjustment. Providers that were successful were more likely to be large, and report strong relationships with their funders.

From my co-funding experience (Field notes, May 18, 2009) I have observed variable applications of adjustments across providers. I explain:

> At one meeting with a Māori provider the Crown official clarified that there would be no FFT available that year due to budget constraints. Later in the same meeting, the official indicated that they had been lucky to have secured FFT for "their" PHU provider. A few months later a one-off contract came through our office for another provider granting them FFT. There seemed to be no consistency or transparency in allocations.

Based on the provider survey results, Crown practice in relation to cost of living/FFT adjustments is inconsistent. Some providers reported being offered adjustments each year and/or contract period. One exceptional provider reported receiving only one adjustment over a twenty-year period. I maintain the absence of a consistent approach in relation to cost of living/FFT adjustment enables institutional racism.

Discretionary One-Off Funding

> It comes down to if the Ministry knows what you are doing really well... then your likelihood of being able to put your hand up and say we want to do this extra over here. The likelihood of that being successful is much higher because they know exactly what you would do with it, whether you can be trusted with it, whether you will achieve what you say you are going to achieve
> (NGO provider, December 2010).[159]

Although health funding is generally allocated for particular activities, from time to time discretionary and one-off funding becomes available. As part of the provider survey, I asked providers about their access to discretionary and one-off funding (Table 28). The findings indicate that PHOs and PHUs have similar success in obtaining such funding. PHO levels are likely to be high as often services to improve access projects have a public health focus and therefore are routinely applied for through local DHBs, rather than allocated annually. Māori and NGO providers reported considerably less access to discretionary/one-off funding, with Māori provider access being the least frequent, if at all.

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[159] Comment from public health provider survey December 2010.

Table 28: Recollections of Access to Discretionary and One-off Funding
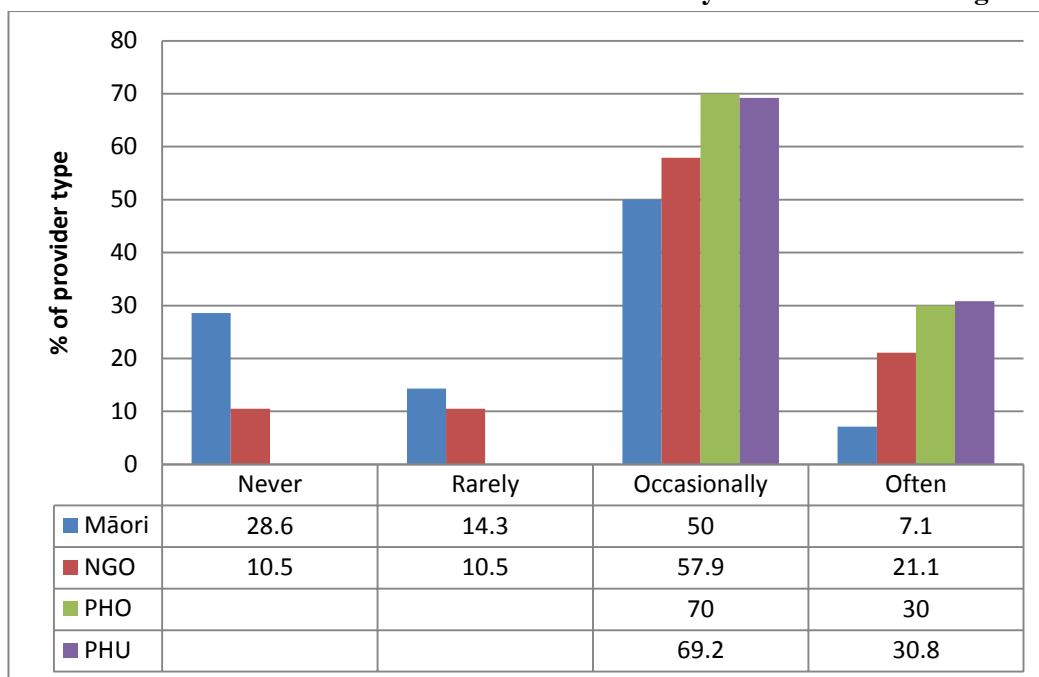
	Never	Rarely	Occasionally	Often
Māori	28.6	14.3	50	7.1
NGO	10.5	10.5	57.9	21.1
PHO			70	30
PHU			69.2	30.8

Note. This table is adapted from the findings of my public health provider telephone survey. It shows providers recollections of the frequency of their access to discretionary funding over the last five years.

Many PHU providers reported being approached by funders around one-off funding. One PHU provider explains, "Ministry quite often encourage us to go after one-off funding particularly recently", another confirmed, "DHBs have been coming to us, to get us to do things quite frequently". One NGO provider that often receives discretionary funding reported that his organisation regularly pitched ideas to funders and then the funders worked up the business case for them.

This pro-activeness by funders was not reported across all groupings of providers. One Māori provider shared a story of putting together what they believed was a substantive business case based on robust local research in relation to a specific health need in their area. Ultimately, the DHB invested money into their own provider arm to address the identified delivery gap, a provider perceived within Māori communities to have a historically low level of service delivery to Māori. Several Māori providers reported producing what they considered robust evidence and business cases that were unsuccessful in securing funding, with little clarity forthcoming from funders as to why they were declined.

One-off funding is occasionally made available for particular groupings of providers. An example being the Ministries drive to promote the use of *Health Impact Assessment* (Public Health Advisory Committee, 2005) and *Whānau Ora Impact Assessments* (Ministry of Health, 2007e) as a tool to enable health perspectives into policymaking. I explain from my co-funding field notes (November 8, 2009):

Training was set up around the country for practitioners to learn how to conduct impact assessments after the release of these assessment documents and funds were set up to resource impact assessments. All but the last funding rounds were exclusively opened up for DHBs to apply, thereby excluding Māori providers tendering. Intricate to both tools is a focus on inequalities and assessing the impact of policy on Māori communities, something Māori providers are uniquely qualified and well positioned to undertake.

The provider survey findings show groupings of public health providers have different levels of success in obtaining discretionary funding. PHU and some NGOs are clearly highly trusted and are offered opportunities not available to other providers. There is little transparency around health funders' policies and practices concerning discretionary and one-off funding. I suggest this lack of consistent practice enables institutional racism.

Financial Accountability

> …NGOs are expected to balance the books each year…. yet a DHB can live in debt… If the current provider of the service that they are contracting can't balance the books, they get someone else
>
> (Ashton, 2007, p. 20).

Being able to demonstrate financial accountability was important to many public health providers participating in the provider survey. The majority of participating providers assessed the level of financial reporting required by funders as being reasonable across all provider groupings. The usual standard of financial reporting by funders involves a breakdown of FTE, direct and indirect costs to be provided six monthly, usually less than half a page reporting for each program. Any significant financial variance is then discussed and addressed during routine contract monitoring.

In conducting the provider survey, it became apparent that funders have not been applying this standard consistently to all groupings of providers. One PHU provider explains their position on financial reporting, "We pretty much told the Ministry to get stuffed as far as that was concerned. It [the funders' requirements] is a bit of a burden because of the way we organise our accounts". I clarified this issue with the provider and they confirmed they had not provided the Ministry with financial reporting for years for their multi-million dollar contract. The rationale behind the decision was the provider "...reserves the right to deliver the outputs purchased by the Ministry in the way it sees fit and the Ministry should be satisfied the Ministry gets what is paid for".

Other PHO and NGO providers reported they chose to provide their organisations publicly audited financial accounts rather than using any Ministry templates,

thereby masking public health investment from direct scrutiny. Another NGO provider explains:

> We provide audited accounts to provide assurances that our money is managed well etc, which is completely reasonable. We don't really provide any other financial reporting on the basis of our understanding of the agreement we have with the Ministry is that they obviously buy a range of services/programmes and outcomes and we agree a price for those and then as long as we deliver them I wouldn't expected there to be more financial reporting.

Another NGO noted, "we have a high trust thing going on with the Ministry... the Ministry have always been very relaxed about our financial reporting".

Berghan (2010, October 18, p. 5) asserts that disparities in financial accountability requirements across providers is pronounced, with Māori subject to greater scrutiny. When working within a Māori provider he had to:

> ...provide all these reports on a regular basis quarterly and so on, you have to provide the financials you have got to justify every dollar and that happens all the time (p. 5).

In recent history, he notes Waitemata, Tairawhiti, Whanganui, West Coast and Capital Coast DHB have all been financially bailed out by the government at different times due to budget blowouts of assorted kinds. Based on his twenty years in the sector Berghan (2010, October 18, p. 6) maintains he is unaware of any Māori provider whom has been bailed out. Rather he asserts "...if you get in trouble, you would sink, you're gone". The Ministry's Annual Report (2009b, p. 85) shows the government spent seventy three million dollars in 2009 on deficit support for DHBs.

As part of strengthening accountabilities around public health monies in 1992 a public health, ring fence was developed to ensure public health monies were invested in public health activities (Public Health Association, 2010, April). Under the ring-fence arrangement, public health monies going into DHBs via PHU (after overheads have been extracted) have been expected to be exclusively invested in public health activity. Since the introduction of the ring-fence public health informants have confirmed a consistent pattern of seepage of public health specific resources into clinical and corporate services across DHBs (2000, p. 28).

I explain this based on my experiences working within PHUs:

> Our team was pretty good at working within budget, but clearly, it was problematic in other parts of the DHB to operate in the same frugal manner, with the unpredictable element of patient demand. Directives

would come regularly from senior management to tighten the purse strings and savings we made were transferred elsewhere in the organisation to minimise debt. When we had vacancies we weren't allowed to fill them, as the DHB had a freeze going on appointments to save money, we had staff seconded out of our service for months at a time and public health kept picking up the bill. These practices never seemed to get picked up by auditors.

Despite the consensus within the provider, survey of the reasonableness of financial reporting it seems not all financial reporting is equal. With some PHU providers refusing to provide any reporting and some NGOs and PHOs choosing to only, provide annual audited accounts. These inconsistencies in administering financial reporting are a manifestation of institutional racism.

Compliance Costs

Compliance costs are the costs incurred by a provider when applying for funding and reporting on how money has been spent. Te Puni Kōkiri (2000b, p. 28) suggest they include "...the time and resources expended in the process of accessing, completing and negotiating funding applications as well as the activities involved in reporting to meet the monitoring requirements of a contract". From the provider survey, (see Table 29) most providers found the compliance costs of administering their contracts reasonable. Despite this, many providers also acknowledged that reporting on their contracts was a significant amount of work that seasonally took up considerable resource. Smaller organisations were more likely to report compliance costs were burdensome.

Table 29: Provider Perceptions of Compliance Costs
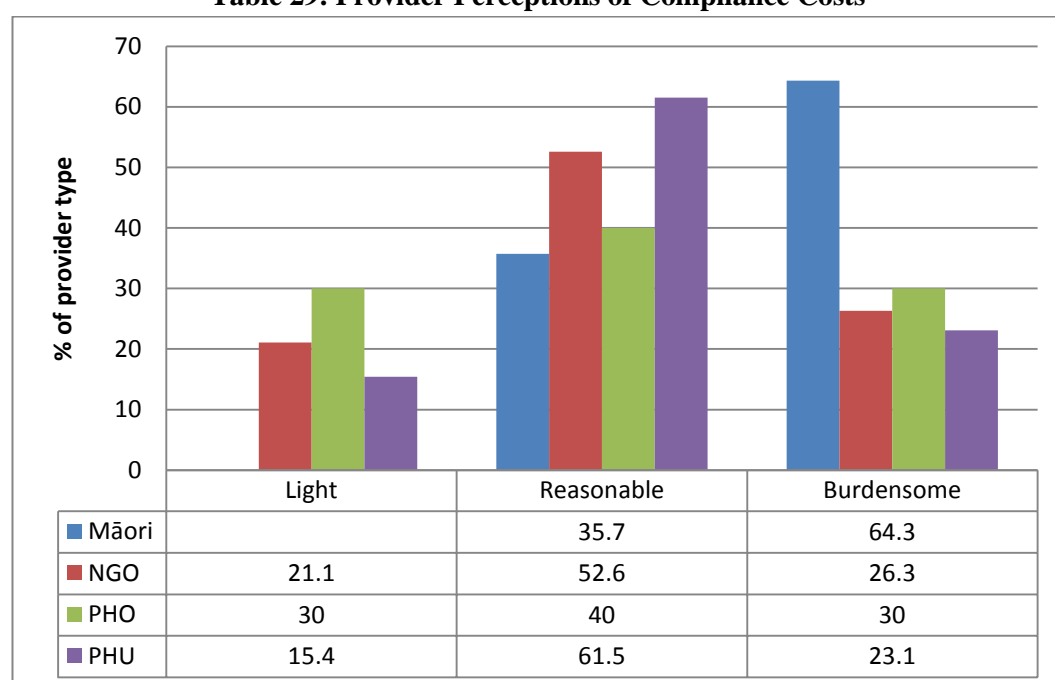
	Light	Reasonable	Burdensome
Māori		35.7	64.3
NGO	21.1	52.6	26.3
PHO	30	40	30
PHU	15.4	61.5	23.1

Note. This table is adapted from the findings of my public health provider telephone survey. This table shows providers perceptions of compliance costs of their public health contracts.

One NGO provider explains the challenges faced by smaller providers:

> ...we often have multiple funders for one programme or service, we have to scramble and scrap for funding from here there and everywhere. Sometimes we have to report for that one programme to those four different funders, some require monthly, some require quarterly, some require six monthly reporting all with different reporting templates and that is a nightmare to manage and a huge burden for a small organisation like ours and we don't get funded for administration costs, it becomes a real problem.

These concerns were echoed in accounts from some Māori providers who noted the compliance costs do not seem proportional, with small contracts incurred similar compliance costs to medium and large contracts. Ideally, compliance costs should be proportionate to funding received. Until this occurs, smaller providers such as Māori providers will continue to carry a disproportionate amount of compliance costs, thus creating a structural disadvantage.

10.5 Summary

> I think they [PHU] are treated differently and they are favoured, I think they have to fight less hard for the funding and it is a cyclical thing... There is a limited pool of funding and I think that they have been privileged to have easier access to funding than other people. Why is that, because they are the extension of the centre, they are exactly what the centre wants. Because they do, exactly what the centre wants them to do
> (Berghan, 2010, October 18, p. 6).

This chapter based on counter narratives of experienced Māori managers with decades of experience in the sector, co-funding field notes and a survey of public health providers examined the differential treatment Māori providers receive in their dealings with Crown officials. Figure 21 shows the sites of racism that privilege non-Māori providers, that were identified through this analysis.
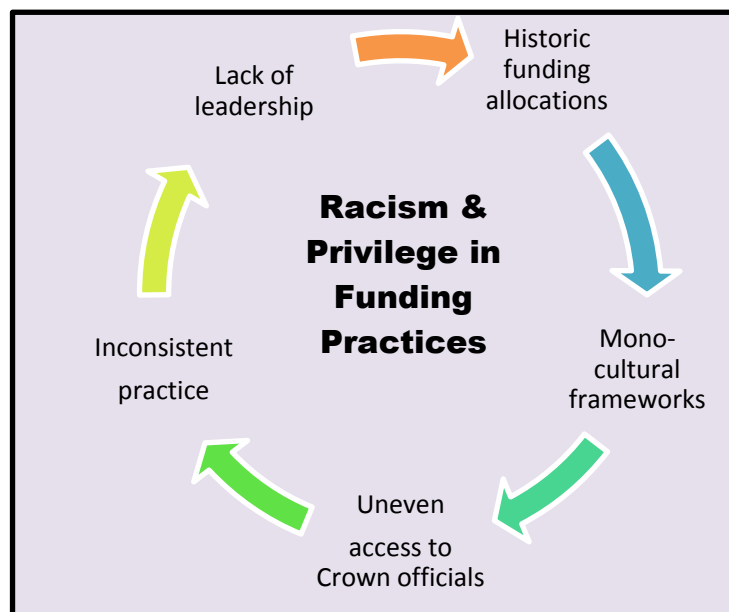
Figure 21: **Racism and Privilege in Funding Practices**
This table summarises key themes from this chapter showing how institutional racism and privilege manifest within Crown funding practices.

Before Māori health providers were developed public health, funding was allocated to generic providers to deliver health services to the entire population. Despite significant changes in the operating environment, those protected allocations have never been retendered or systematically reviewed to ensure the robustness of their service delivery to Māori. Furthermore as outlined in chapter nine operational practices due to capacity issues means generic providers are not currently monitored for their service delivery to Māori.

The public health service specifications, which form the basis of current Crown public health contracting processes, have a strong mono-cultural western bio-medical focus. These specifications do not reflect Māori ontological understandings of hauora, nor Māori public health traditions in either their structure or substantive content.

Relationships lie at the heart of funding and planning practices. Counter-narrative and the findings of the public health survey indicate that Māori providers do not report the same level of access and influence as NGO, PHO and PHU providers to health funders and decision-makers. Counter-narratives suggest prioritisation processes also seem to disadvantage Māori providers while privileging other groupings of providers.

The survey findings indicate that funders are less likely to provide Māori providers with either a cost of living adjustment or discretionary one-off funding than other providers. Crown officials are likely to subject Māori providers to greater levels of financial accountability and thereby impose proportionally higher compliance costs. Māori providers report more difficult experiences of contract

negotiation, more frequent auditing than those of other groupings of providers do and they are subject to poorer contract conditions.

These inconsistencies in Crown practice and cultural blindness enable a system that systematically disadvantages Māori providers and privileges generic providers. I assert this differential treatment across funding and planning practices is a strong indication of institutional racism and its counterpart privilege. Senior Crown managers are responsible for administering this system to detect, prevent and minimise bias and systemic discrimination ensure the robustness of funding and planning processes. Under the NZPHDA, these senior officials have clear responsibilities to reduce health inequities and uphold the Crown's Treaty responsibilities, which I suggest they are currently failing to fulfil.

In the following chapter drawing on the overall findings of this study and informed by anti-racism literature I, outline pathways forward to transform institutional racism.

CHAPTER ELEVEN: TRANSFORMING INSTITUTIONAL RACISM & PRIVILEGE

11.0 Introduction

> It is our responsibility to ensure that our grandchildren and their children will enjoy good health and long lives. As citizens of the world, it is their rightful legacy. But if that legacy is to be fully realised we are going to have to make some changes
>
> (Te Rōpū Kai Hapai o Hauora o Te Tai Tokerau, 2008, p. viii).

Although there is a wealth of research describing and quantifying racism as practiced against various target populations and its associated effects, there has been relatively little research examining how to eliminate or reduce it (Duckitt, 2001; D. Jones, 1992; Pederson, Walker, & Wise, 2005). There is even less literature documenting interventions to counter racism as practiced, condoned or tolerated by the state. This seems to coincide with Lentins' (2008, p. 311) assessment that it is far easier to review racism, than offer plausible solutions or credible pathways to transform it. Having established how institutional racism and privilege manifest within public health policy development and funding practices, the challenge remains about how to transform it.

Psychologists, Pederson, Walker and Wise (2005) advocate for both social justice and social science reasons it would seem beneficial that anti-racist interventions are robustly evaluated and documented so future strategies can be strengthened. In parallel Gillborn (2006, p. 18), calls for the development of a clear and accessible conceptual map to enable the movement to build on the successes, failures and frustrations of previous work.

An overview of some of the theoretical considerations and emerging directions from anti-racism literature applicable to countering institutional racism are explored in this chapter. I examine pathways for transforming institutional racism at structural and organisational levels through strengthening controls on state parties and Crown officials, and strategies that enhance racial climate. I examine the implications from this study in relation to remedies to transform racism and privilege in policymaking and funding practices, so that they are fairer and more inclusive.

11.1 Theorising Anti-Racism

> Those who make peaceful revolution impossible will make violent revolution inevitable (Kennedy, 1963, p. 226).

Anti-racist strategies generally aim to modify and eliminate racist beliefs, behaviours and outcomes. Berman and Paradies (2010, p. 221) in their review of anti-racism praxis, hold it is an approach to preventing or redressing the disadvantages caused by racism in social, cultural, economic and political life. C. Jones (2003, p. 9) sees racism as a waste of human potential and anti-racism as a mechanism to attempt to remedy this. For Anthias and Lloyd (2002) anti-racism action is their contribution to creating a society in which people can live together in harmony and mutual respect. Paradies (2005, p. 12) warns that anti-racism processes can arouse feelings of sadness, anxiety, hopelessness, anger, shame, and guilt. I can confirm such processes also raise feelings of rage, something Freire and Freire (1992/2004) call 'righteous anger'.

Interpretation of the origins and dynamics of racism and direct experiences and/or witnessing of racism can influence and shape the selection of approaches to counter it. Barnes-Josiah and Fitzgerald (2004, p. 11) in their review of anti-racism praxis have identified five distinct approaches to transforming it (see Table 30). Their analysis outlines different ontological understandings of why racism exists, how it can be transformed from that paradigm and the limitations of those approaches. I maintain their analysis privileges psychological approaches and personally mediated racism, overlooking rights-based approaches. From their framework, a social change approach appears the best fit for addressing institutional racism, as it attempts to deal with racism as a system.

Table 30: World Views and Approaches to Countering Racism

Approach	Prejudice reduction	Healing & reconciliation	Anti-racism	Diversity & multiculturalism	Democracy building
World view	The world is filled with wounded people who are doing the best they can with the resources they have available to them. Once people understand their own oppression and are supported they cease acting out of prejudice.	The world is filled with groups that have been traumatised by historic events. When the dominant group acknowledges & apologies for these injustices healing, reconciliation & transformation can occur.	The world is controlled by powerful systems with historically traceable roots. Once people learn how they benefit from or are battered by those systems, they can work together to affect change.	The world is filled with multitude of complex cultures, constantly intersecting & shaping each other. As people grow to understand & appreciate their own cultures around them, they will be better able to cooperate and overcome mutual problems.	The world is filled with diverse perspectives on complex issues such as race. When people have appropriate public forums processes and skills for dialoguing about these issues, they will recognise their interdependence & find cooperative ways to address common concerns.
Intended	Personal awareness & healing.	Individual transformation.	Social change.	Tolerance, awareness of cultural differences.	Engaged citizenry.
Key	Focus exclusively on personal transformation.	Focus transformation of individuals.	Limited opportunities for people to gain critical consciousness.	Often fails to recognise indigenous peoples' rights.	Indigenous voices marginalised within democracy.

Note. Adapted from *Undoing racism in public health: A blueprint for action in urban maternal and child health*, by D. Barnes-Josiah & M. Fitzgerald, 2004, p.11. Omaha, NE: University of Nebraska Medical Centre.

Racism is the product of particular socio-historical contexts but as emerging evidence, suggests (see Dunn, Gandhi, Burley, & Forrest, 2003; Dunn & Geeraert, 2003) it also has a particular geographic specificity. This understanding of racism implies effective anti-racism interventions may need to be both localised and flexible enough to address emerging issues and debate (Gillborn, 2006, p. 26). For instance, the strategies needed prior to the 11 September 2001 twin tower bombings within the United States to counter racism differ from those required after this period. McKenzie (1999, p. 616) concurs that racism changes over time and he maintains it frequently transforms from overt to more covert or subtle racism after an anti-racism intervention. This shift from overt to covert racism as outlined in chapter three is observable within Aotearoa in relation to the move from overtly racist colonisation and assimilation policies to more subtle manifestations within contemporary policy platforms.

Focus of much anti-racism activity internationally is on both increasing awareness and understandings of racism and developing cultural competence to enable its transformation. These interventions variously increase knowledge levels about racism and enhance participants' skill base and ability to provide professional services to minorities (see M. Hill & Augoustinos, 2001). Barnes-Josiah and Fitzgerald (2004, p. 6) and activist scholars, Nelson, Harris, Valenzuela and Ciske

(2009, p. 6) assert this type of approach in isolation does not address the scope or quality of programs available to minorities, nor does it address structural elements of institutional racism. Pederson, Walker and Wise (2005, p. 28) emphasise that major structural or legislative change needs supportive anti-racism educational programmes alongside them to address personally-mediated racism in order to create culture change.

Berman and Paradies (2010) and C. Jones (1999) argue racial disadvantage in social, cultural, economic and political life appears to be interrelated to experiences of institutional and personally mediated racism. They hold that despite this inter-connectedness, distinct endeavours in both policy and practice are required to counter racism and to redress racial disadvantage regardless of its contemporary and/or historical causes. Effective interventions to address racial disadvantage may be the provision of translation services, improved access to affordable housing and welfare support for new migrants. On the other hand interventions to address systemic racism require a specific focus on institutional structures rather than a cultural deficit approach which focuses on 'fixing' the very communities who are the targets of racism.

Another pathway to countering systemic racism is improving overall service delivery through implementing robust quality assurance systems and the use of evidence-based practice. Psychologists, Ceci and Papierno (2005) and public policy specialist, Callister (2007) warn such an approach can have the unintended effect of perpetuating existing ethnic inequalities. These findings suggest tailored interventions are most likely to enhance equity of outcomes and address systemic disadvantage and/or racism.

Paradies (2005, p. 5) identifies two primary approaches to anti-racism. The first individual human rights approach promotes equal treatment of all as a means to prevent racism, while the second advocates for differential treatment to enable equality of opportunity and ultimately equality of outcome. The later 'equality with difference' analysis accommodates collective human rights claims and attempts to address the structural advantage/disadvantages particular ethnic groups experience through being beneficiaries/targets of colonisation and/or slavery. The 'equality with difference' approach is the philosophy utilised within this study due to its recognition of collective indigenous peoples' rights claims.

In my review of anti-racism literature I identified several broad approaches to transforming institutional racism (see Table 31 below). These include structural pathways, strengthening controls, systemic organisational change and enhancing racial climate. The interventions listed range from aspirational advocacy goals identified by activist scholars, requiring the support of the international community, to approaches that have been implemented, evaluated, and documented within academic literature. Later in this chapter, I outline the

particular insights arising from this study directly related to policy making and funding practices which are informed by but not included in this table.

Table 31: Interventions to Counter Institutional Racism

	Type of intervention	Specific strategies	Source
Pathways to structural change	Recognition of indigenous sovereignty	Establish honourable kāwanatanga arrangements, inclusive of both local and central government governance arrangements. Enable and resource hapū/iwi tino rangatiratanga and kaitiakitanga. Establish transitional arrangements around power and resource sharing. Review democracy as decision-making mechanism when indigenous people are minority within own country.	Kāwanatanga Network, 1996; Ratima & Ratima, 2003.
	Redress for historic racism	Treaty settlements/reparations; strengthened and resourced hapū & whānau development. State acknowledge systemic racism is ongoing problem, issue public statements condemning racism, apologise as appropriate and resource an inclusive reconciliation processes. Maintain and strengthen affirmative action programs, use of both incentives and sanctions.	Harrison, Kravitz, Mayer, Leslie & Lev-Arey, 2006; Jones, 1999; Paradies, 2005; Sanson et al., 1998, Williams & Collins, 2004, Paradies et al, 2009.
Strengthen controls	International human rights instruments	Active engage in ICERD reporting and monitoring processes to allow scrutiny of performance. Advocate for *United Nations Declaration on the Rights of Indigenous Peoples* to become a binding convention with reporting and monitored processes and ensure it is embedded into domestic legislation. Support sanctions against those state parties that are non-complaint.	Daes, 2009.
	Independent monitoring agency	Strengthen and adequately resource an independent agency to rigorously monitor Crown activity and encourage evidence based anti-racism praxis. Strengthen evidence base about prevalence and dynamics of institutional racism, including reviewing effectiveness of anti-racism activity to inform praxis. Crown agencies routinely and systematically collect ethnicity data to enable ethnic specific analysis. Establish equity targets to monitor progress of indigenous peoples and anti-racism initiatives across health, education and employment outcomes. Maintain a domestic human rights system, which accepts complaints about systemic racism from either individuals or groups of citizens and remove government exemptions.	McKenzie, 1999; Paradies, 2005; Ratima & Ratima, 2003; Sanson, et al., 1998, Scotland, 2009, September, Paradies et al., 2009.
Systemic organisational change	Systems change approaches	A systems change approach involves is a planned change management process. It involves a number of key steps a) assessing organisational readiness, b) making the case for an intervention and securing organisational commitment c) recruiting a change management team d) undertaking research to inform plan and define further the intervention e) implementing the intervention and mobilising support f) ongoing process of reflection and evaluation.	Barnes-Josiah & Fitzgerald, 2004; Griffith, Childs, Eng & Jeffries, 2007.
	Strengthen core cultural and political competencies	Invest in range of professional development programs that strengthen cultural and political competencies of practitioners, managers and decision-makers. These programs will: • challenge false (ideological) beliefs about indigenous peoples and colonial history, • nurture critical thinking about structural power dynamics and encourage critical questioning about how racism is operating here? • enable participants to consistently name racism and keep it on political agenda.	Barnes-Josiah & Fitzgerald 2004; Denson, 2009; Jones, 2003; Macpherson, 1999; Paradies, 2005; Sanson et al., 1998, Paradies et al. 2009.
Enhancing racial climate	Mobilising communities	Increase informed community dialogue on racism through public forums and adult education. Develop targeted social marketing campaigns that challenge personally-mediated and institutional racism e.g. similar to the successful Like Minds Like Mine campaign; motivate local leaders to become anti-racism champions. Build cross-cultural relationships through pathways like multi-cultural festivals.	Donovan & Leivers, 1993; Jones, 2003; Paradies, 2005; Pettigrew & Tropp, 2006; Ratima & Ratima, 2003; Sanson et al., 1998; Donovan & Valias, 2006, Paradies et al. 2009.

11.2 Pathways for Structure Change

> It has been suggested that fundamental reform of racialized systems is necessarily accompanied by struggles that reach the point of overt protest and that, although this need not be in the form of violent, racially based revolution, social systems must be shaken if fundamental transformation is to take place
>
> (Gilroy cited in Paradies, 2005, p. 2).

The magnitude of institutional racism and its devastating reach requires more than the reforming of state apparatus or appeals to human rights bodies to remedy. It requires substantive structural change and transformation as significant populations of people directly and indirectly benefit from racism. Radical structural change has been pursued across colonial Africa and elsewhere as indigenous peoples assert their independence from their former colonial rulers and redefine governance arrangements. Such transformation can take the form of a violent and/or peaceful revolution and collective action.

Although some would contend structural change is an extreme response to institutional racism, others such as activist scholar Malcolm X (1970) would contend that there are situations where change needs to occur "by any means necessary". As an activist scholar, I hold structural change is critical to wider processes of decolonisation and rebalancing inequitable power differentials. I however recognise that there is a multiplicity of ways of enabling positive lasting transformation.

Within this section, I review a range of structural responses to institutional racism as contributions to antiracism praxis. Specifically I examine efforts to dismantle the apartheid regime in South Africa, the tino rangatiratanga movement in Aotearoa and attempts to achieve redress for historic racism.

Dismantling Apartheid

> …the long struggle against apartheid, show[ed] that while no one knew when the monstrous regime would fall, its opponents gradually came to know its historical, systemic, visual, discursive and emotive structure, slowly piecing together a counter-machinery to wear it down through many inventions of boycott, subversion, protest, strike, reform, ridicule and defiance
>
> (Amin, 2010, p. 17).

The election of the National Party in 1948 in South Africa saw the formal introduction of the apartheid regime, which aimed to maintain white domination through a tiered racial segregation system. The entire population was required to register based on race as white, black or coloured. This categorisation reinforced by legislation formed the basis of segregated public facilities, access to education and employment, established a pass system that controlled movement and prohibited sex and marriage between races (Mandela, 1994). Land reform was practiced to the

benefit of the white minority and territorial segregation imposed upon the indigenous majority whom for all practical purposes were disenfranchised.

Apartheid was actively resisted through the mobilisation of millions[160] of people through strikes, boycotts, demonstrations and acts of sabotage to destabilise the apartheid regime, supported through international solidarity action. Regional allies from the 'front-line states' provided military bases, training and diplomatic support. Internationally, political, economic, sporting, academic and cultural sanctions were activated and resolutions condemning apartheid passed by the United Nations. Media coverage of incidents such as the Sharpeville massacre[161] raised the issue and kept it in the public eye, galvanising international support for the anti-apartheid movement. The private sector also contributed to the movement through submitting to a voluntary code of conduct (the Sullivan Principles)[162] for affiliates or subsidiaries operating in South Africa (Seidman, 2003, p. 386).

The South African government response through to mobilisation was extreme. Opposition groups and anti-apartheid leaders were forced into exile or underground while others became long-term political prisoners (Tutu, 1994). In the final years before the fall of the regime a series of states of emergency were declared which strengthened the powers of the military. Violence was also extensively used to suppress dissent. Thousands[163] were killed at the government's hands. As a result of prolonged activist pressure by the early 1990s, the government began to make concessions to the black majority and the apartheid system slowly unravelled. In 1994, South Africa held its first democratically based elections, with the African National Congress under the leadership of Mandela securing power. Soon after legislation was passed to establish a formal truth and reconciliation process as a mechanism for South Africans to confront the realities of the apartheid system and begin the process healing. In 1996, the newly elected government endorsed a new constitution built on a foundation of civil rights for all.

There are several elements within the anti-apartheid story, which are potentially applicable to countering state racism within Aotearoa. The first is the need to mobilise allies from across the political spectrum. This could involve engagement with unions as potential change agents already on site within the public service, professional bodies within the sector, advocacy and indigenous groups and/or political parties. Strategic exposure of institutionally racist policies and practices to the domestic, and if necessary the international community through the media and/or

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[160] For instance 2.5 million people participated in co-ordinated actions after the assassination of anti-apartheid leader Hani (Tutu, 1994, p. 251).
[161] The Sharpeville massacre occurred on 21st March 1960 in the Transvaal province when South African police opened fire on a crowd of black protestors killing 69 people.
[162] The implementation of the code included independent monitoring and public reporting.
[163] Johnson (2009, p. 578) conservatively estimates 30,000 people were on the apartheid casualty list.

the United Nations may contribute to modifying racist policy and practice. The use of independently monitored standards of conduct may also be an effective tool. The enduring racial inequities within South Africa warn that the transforming of institutional racism is a long-term process and is more complex than changing the political party in power.

Tino Rangatiratanga Movement

Ngā iwi e! Ngā iwi e!	All you people! All you people!
Kia kotahi ra Te Moananui a Kiwa	Be united as one, like the Pacific Ocean
E i a i e	(Cries of joy)
Kia mau ra! Kia mau ra!	Hold on firmly! Hold on firmly
Ki te mana motuhake me te aroha	To your inheritance, and to compassion
E i a i e	(Cries of joy)
Wahine ma! Wahine ma!	All you young women! All you young women
Maranga mai, maranga mai. Kia kaha	
E i a i e	Rise up, rise up, be strong
	(Cries of joy)

(Melbourne, 1976).

According to Walker (1990) Māori resistance to colonisation and institutional racism has been ongoing) since 1840. Direct action tactics utilised by Māori throughout the nineteenth and twentieth century's included the occupation of land, protest hikoi (march), demonstrations, acts of civil disobedience and petitions and deputations to parliament and the British Crown. The late 1960s and early 1970s marked the emergence of a new militancy in Māori resistance. Groups such as Ngā Tamatoa in the 1970s and 1980s challenged successive governments to fulfil their treaty responsibilities to Māori. They successfully created a ground swell of treaty conscientisation amongst Māori and some Pākehā. Awatere (1984), one of many Māori leaders to emerge, called on Māori to engage in radical action and for Pākehā to understand the violent legacy of colonisation, which Pākehā were benefiting from.

This perpetual struggle is the response to the ongoing failure of successive governments to recognise Māori sovereignty, resolve historical injustices and address contemporary racism perpetuated by the state. The enduring cornerstones of this movement include efforts to secure the return of traditional lands, securing Crown accountability to Te Tiriti obligations, alongside pro-active attempts to revitalise Te Reo me ōna tikanga, hapū and marae, strengthening tino rangatiratanga.

This body of activism has resulted in advancing Māori aspirations in the realms of, official recognition of Te Reo, the introduction of the Waitangi Tribunal to address historical injustices, and the emergence of boutique autonomy through devolvement of services to Māori providers. Out of this conscientisation also emerged reports such as *Puao Te Ata tu* (Ministerial Advisory Committee, 1988) and *He Whaipānga Hou* (M. Jackson, 1988) documenting institutional racism within government departments policy making, service delivery and structures. The consistent call from both reports

was for the Crown to share power, authority and resources, for Māori to control and deliver Māori programmes to Māori.

Alongside these efforts to make the Crown more responsive to Māori, there has been a considerable intellectual, emotional, financial investment by Māori into growing and strengthening Māori institutions. A major triumph of the last twenty years has been the revitalisation of Te Reo me ōna tikanga through the development of kōhanga reo, kura kaupapa and whare wānanga (Māori universities). Cram and Pipi (2001, p. 9) argue the Māori education movement was developed as resistance to a mainstream Pākehā centred system that failed to address key needs of Māori. Similarly the development of Māori media both radio and television reflects the failure of 'mainstream' media and a commitment to developing by Māori for Māori interventions.

Tauiwi Tiriti workers are part of the wider struggle to see the recognition of Māori sovereignty and the commitments of Te Tiriti honoured within Aotearoa. Our work comes from an activist tradition of mobilising communities to reduce inequities in power by increasing collective power to hold those in authority accountable to principles of justice and equity. Central to this approach has been the feminist tradition of consciousness raising and informing other Tauiwi about the "non-standard" version of New Zealand history to encourage reflection and ultimately action. Interventions often occur jointly with Māori through ad hoc and semi-permanent coalitions and partnerships, while other activity is more independent but with accountability mechanisms to Māori embedded.

The Nelson Action Group's (1973, February) study on legal representation for Māori and Pacific offenders was one of the earliest local responses to institutional racism involving Pākehā. Walker (1990, p. 278) contends through the 1970s and 1980s Pākehā organisations like ACORD[164] "mounted a systematic, unremitting, and uncompromising attack on institutional racism". Amongst their campaigns were critiques of social policy, lobbying for interpreters, exposure of racist portrayal of Māori in the souvenir industry and facilitating an inquiry into treatment of Māori children in social welfare homes. This work was strengthened by the emergence of alternative re-examinations of New Zealand history through the work of Simpson (1979) and Scott (1981) and understandings were further strengthened through Pākehā involvement in the 1981 anti-Springbok tour campaigns (R. Black, 2010).

Other attempts to challenge institutional racism include a discussion paper meticulously developed by the Kāwanatanga Network (1996) surrounding constitutional change. It proposed a transitional pathway for the recognition of

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[164] ACORD stands for Auckland Committee on Racism and Discrimination.

indigenous sovereignty and redefined kāwanatanga arrangements to be approved by hapū and iwi. The Network recognised for this transfer of power to occur it will require Pākehā to transform essentially our systems and ourselves, with reconfigured understandings of property rights and decision-making.

Tauiwi Tiriti workers remain few in number and the interventions undertaken are largely voluntary in nature, squeezed in around paid work and raising families. Despite this, Pākehā and Tauiwi Tiriti work has cumulatively conscientised thousands of New Zealanders, through treaty education workshops and other interventions (Huygens, 2007; D. Jones, 1992). It is unclear however, without formal evaluation, what long-term impact this exposure has on participants in their personal, professional or political lives. Regular surveys carried out by the HRC (2007, p. 11) indicate that many New Zealanders remain ill informed about the history of Aotearoa and Te Tiriti. Furthermore, Kelsey (1990) asserts Pākehā resistance and opposition to power-sharing as promised within Te Tiriti and the recognition of tino rangatiratanga remains ongoing for many.

Reflecting on the achievements of the tino rangatiratanga movement and aligned Tauiwi Tiriti work shows mixed results, over shadowed by the enduring assumption of unitary Pākehā sovereignty. Where gains have been made with a changed racial climate and variable levels of political will, these gains have had to be revisited and consolidated. This slow progress highlights the need for interventions to be enduring to withstand changing racial climates such as constitutional change and the recognition of indigenous sovereignty. It also suggests there needs to be strengthened base-line understandings of Te Tiriti and colonial history within the Tauiwi population and more specifically the public service.

Redress for Historical Racism

As discussed in chapters three and four, various governments around the world are in the process of reconciling with their historic ongoing racist policies of colonisation and assimilation. For instance, these processes have involved the issuing of an apology by the Australian government and in the case of South Africa formal truth and reconciliation hearings for citizens to share their experiences and be held to account. In Aotearoa, this response involves the redistribution of assets wrongly appropriated from indigenous peoples by the state. In the United States and elsewhere affirmative action programs have been used to redress structural inequalities generated from Jim Crow laws (Harrison et al., 2006).

As part of wider decolonisation processes, I suggest these attempts at power and resource sharing are critical if institutional racism is going to be unravelled and racial disparities addressed. Both C. Jones (1999) and sociologists, Williams and Collins (2004) have written papers exploring reparations and/or treaty settlements processes

as structural responses to historical racism. This redistribution of resources holds potential to enable the repositioning of uneven power differentials the neutralising of white privilege. Such proposals however remain in sharp contradiction to the currently favoured neo-liberal ideologies.

11.3 Strengthen Controls on State Parties and Crown Officials

As examined in chapter five there are various controls on the behaviour of both state parties and Crown officials to prevent direct and indirect racism. The newest international control on state parties is the *United Nations Declaration on the Rights of Indigenous Peoples*. The next step in its progression is its negotiated transition into a formal convention with a monitored reporting system. Such a transition Daes (2009, p. 59) Chair of the Working Group on Indigenous Peoples contends, could significantly strengthen the position of indigenous peoples' rights within the United Nations system and potentially within signatory states. Sanctions against non-compliance state parties could further consolidate this position.

Although agencies such as the Australian and New Zealand Human Rights Commissions have responsibilities to protect and promote human rights domestically, across the literature (see Paradies, 2005; Sanson et al., 1998) there are calls to strengthen and appropriately resource such independent monitoring agencies. In order to address adequately institutional racism it has been suggested that the scope of practice for these agencies would need to be altered. Specifically government exemptions would need to be removed and both systemic and/or collective complaints allowed.

Paradies (2005) calls for such an independent agency to nurture evidence-based anti-racism praxis and potentially act as a clearing-house for research into racism. Others call for the development of equity targets to monitor progress of indigenous peoples and anti-racism interventions across key areas such as health, education and employment. Such monitoring would be reliant on improved ethnicity data collection and the resolving of complex ethnicity data problems in Aotearoa created by the problematic introduction of New Zealander as an ethnic category (Callister, Didham, Potter, & Blakely, 2007). Certainly successful monitoring is dependent on standards and targets for Crown activity to be assessed against (McKenzie, 1999; Scotland, 2009).

11.4 Systemic Organisational Change

> Systemic problems are rooted in institutions, making institutional oppression an important concept to consider when addressing any form of organizational, institutional or community change (Griffith, Mason, et al., 2007, p. 390).

Organisations and public institutions can have a powerful influence over people's lives, particularly for those within vulnerable populations. Morgan (1997) argues organisations can act as conduits to resources and critical services that can either enhance or impede a community's power and agency. Organisations exist within socio-political contexts shaped by funding sources, government mandates and/or directives and staff levels of professionalism, competence and integrity. As racism occurs within society, it is manifested and reflected within the workings of institutions and organisations.

There are two primary approaches to addressing institutional racism within organisations and/or institutions: i) those driven politically, usually because of a crisis or complaint; ii) those more community and value-driven, which utilise a range of intervention logics. These approaches are examined in more detail in the following subsections drawing on formal evaluations and critical commentary alongside official accounts.

Political Driven Interventions

> In fact, the political landscape in Australia is littered with the wrecks of reports and inquiries in Indigenous affairs whose recommendations remain partially or completely unimplemented
> (Jonas cited in Paradies, 2005, p. 23).

The web of relationships between Crown Ministers and senior public servants, Crown Ministers and their coalition's partners, between government departments, are overlaid by the agenda of the media and aspirations of voters. This creates a complex and multi-layered dynamic. Through their study of public administration, Adams and Balfour (2009) assert that some government departments, often unintentionally, function as tools of oppression, reproducing and reinforcing the very marginalisation that they are ideologically committed to undoing. Adams and Balfour name this "administrative evil". They suggest it is entirely possible to adhere to the tenets of public service and professional ethics, participate in a great evil, and not be aware of it until it is too late. They contend the prevailing hegemony relies on the participation of ordinary citizens to fulfil their 'morally neutral' professional roles and act in socially normal and appropriate manner to assert its powerbase.

As introduced in chapter three *Puao Te Ata Tu* and the Lawrence inquiry (which examined the police response to the murder of Stephen Lawrence) are both attempts to address institutional racism resulting from a crisis in terms of service delivery to minority populations. The public debate surrounding these reports and their high-level political endorsement generated strong political imperatives within the public service in Aotearoa and England respectively. The impacts of these reports are assessed in the following subsections.

Puao Te Ata Tu Revisited

> *Puao Te Ata Tu* went much further than encouraging a bicultural perspective within the department. The goal, in terms of the report, is a proper engagement between Crown and Maori, a sharing of power and control over resources, a mutual accountability, where the relationship harnesses the potential of all Maori in the most effective manner (Waitangi Tribunal, 1998, p. 128).

Puao Te Ata Tu, the review into the responsiveness of the DSW to Māori in the 1980s was a landmark report within Aotearoa. It documented institutional racism through a robust consultation process (Turia, 2000).[165] The key recommendations of the report centred on the need for the department to function in a bicultural manner and to share responsibility and authority for decisions with Māori (see Table 32). These recommendations were all accepted by the then Minister of Social Welfare and became a benchmark for best practice across the public service (Tennant, 2005).[166]

Table 32: Summary Recommendations from Puao te Ata Tu

Note. Adapted from *Puao Te Ata Tu (Daybreak)* by Ministerial Advisory Committee, 1988, p.9-14. Wellington, New Zealand: Department of Social Welfare. Reprinted with permission.

The DSW in *Te Punga* (1994, p. 13) their bicultural strategy for the 1990s, credit reforms to income support policies and practices, staff recruitment, training and positive culture change within DSW as part of the *Puao te Ata tu* impact. Consultation mechanisms were established with Māori communities and efforts made to strengthen traditional Māori structures through the devolvement of 'power and

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[165] It is also significant due to its use of hui as a research framework (L. Smith & Reid, 2000, p. 29).
[166] This new bicultural thinking was reinforced in the State Sector Act 1988 within which departments and Chief Executives within the public service were expected to be held accountable around both delivering culturally appropriate services and achieving concrete outcomes for Māori.

resources' through service delivery contracts to Māori providers. DSW officials also argue the shape and scope of the Children and Young Persons and their Family Act 1989 (which reformed the social welfare sector) was significantly influenced by the thinking of *Puao Te Ata Tu*.

Unfortunately initial commitment to the implementation of *Puao Te Ata Tu* rapidly waned with what child health advocate, Kiro (2000, p. 368) speculates as the increasing influence of neoliberal ideologies and frustration experienced by those trying to transform large government departments. The Waitangi Tribunal (1998, p. 107) found in the Te Whānau o Waipareira claim that an informed commitment to the implementation of *Puao Te Ata Tu* was absent through the 1990s. Their detailed analysis of implementation efforts, demonstrated the failure of the department to honour its Treaty obligations.

The Tribunal report authors (1998, p. 112) quote the then Director-General of the department, Grant, explaining why District Executive Committees[167] were disbanded. He maintains they were:

> ...unable to perform its functions adequately and it has simply not fulfilled expectations. It is not altogether surprising, given the complexity of the policy area surrounding social welfare that members appointed on a representative (and political) basis have difficulty in coming to grips with the high level policy issues involved.

Rather than acknowledge any deficiencies within the department and/or a lack of political will Grant suggests, the failure of the reforms were due to alleged Māori incompetence.[168] In giving evidence to the Tribunal Grant's successor Bazley, confirmed that the structural changes that had been implemented in the wake of *Puao Te Ata Tu* had not endured even a decade. She conceded (1998, p. 120): "…the early impetus given by Puao-Te-Ata-Tu had gone and many Maori staff were very angry and bitter about the failure to follow through".

Over twenty years since its release *Puao Te Ata Tu* remains an enduring part of contemporary social policy and political discourses in Aotearoa.[169] Māori party Member of Parliament Hon. Rahui Katene (2009, p. 5749) recently called for the Auditor-General to critically revisit the recommendations from *Puao Te Ata Tu* in

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[167] District executive committees were one of the ways local Māori communities got input into decision-making.

[168] Other commentators suggest Māori engagement was abandoned as a cost-cutting measure (Waitangi Tribunal, 1998, p. 114)

[169] A search of New Zealand parliamentary debates for the period from October 2003 through to March 2011 identified multiple references to *Puao te Ata tu* (Flavell, 2007a, 2007b, 2008; Harawira, 2009, 2010; Sharples, 2006, 2007, 2008).

order to assess the ongoing presence of institutional racism in agencies of the state. The Public Service Association (PSA) (2009, p. 6) in their submission on the Whānau Ora Taskforce report, also called for an analysis of the extent to which the recommendations of *Puao Te Ata Tu* were implemented. The PSA suggest *Puao Te Ata Tu* continues to contain potential levers for affecting change, such as the use of letters of expectation to Chief Executives and specific equity requirements in senior managers' performance agreements.

Re-examining the Lawrence Inquiry

As introduced in chapter four, the Macpherson report into the death of Stephen Lawrence has had far-reaching impact on both understandings of racism and approaches to countering racism in England. Admed (2004) credits the well-publicised report with introducing the term institutional racism into local policy discourse. While McKenzie (1999) contends the report shifted policy, emphasis from equality of access for minority groups, to the more potent equity of outcome. The Lawrence inquiry also led to the then Labour government drafting the Race Relations (Amendment) Act 2000 (UK), indeed Gillborn (2006, p. 15) argues this is the major outcome of the inquiry. This Act placed an enforceable duty on all public authorities in England and Wales to promote positive race relations, which affected some 45,000 public institutions.[170]

The Home Office (2009, p. 2) asserts that 67 out of 70 of the Macpherson recommendations have now been actioned. Bourne (2001, p. 13) maintains the Macpherson report has been a watershed for race relations in England:

> A multitude of bodies, from national ones like the NHS [National Health Service] to small voluntary groups, have held conferences to discuss the post-Macpherson agenda, instituted internal reviews and carried out audits of institutional racism. Never in British race relations history has there been so much interest in exposing and combating racism.

As the focus of the Lawrence inquiry, the criminal justice sector implemented a variety of reforms. These reforms included putting formal support in place for victims and witnesses of crime, the overturning of the double jeopardy legal principle, building a shared definition of hate crime, and enhanced monitoring of racial incidents. Detailed performance indicators were introduced in the sector covering

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[170] Across the public service targets were set for the recruitment of a more representative workforce, improved ethnic data collection, completion of race equality plans by government agencies and initiatives to secure back the confidence of the community. Some public institutions appointed Equality and Diversity Champions to oversee change management, while others commissioned equity and diversity impact assessment reviews of decision-making to build evidence based responses (Scotland, 2009).

inter-agency collaboration, community satisfaction levels, cultural awareness training, recruitment, retention and progression of minority recruits.

Foster, Newburn and Souhami's (2009, p. 47) mixed method evaluation of the impact of the Macpherson reforms on police practice found improved relationships and consultation with minorities, enhanced handling of hate crimes and some change in police culture particular around displays of overt racism amongst individual officers. The authors speculated this change might have resulted from increased scrutiny on police behaviour. They reported (2009, p. 48) that minority officers believed this "…cultural change was largely 'cosmetic' and that more fundamental expressions of discrimination continued largely unchecked". It was noted (2009, p. 77) that some officers found it difficult to shift from an equal opportunity approach to policing where everyone was treated the same to considering culturally appropriate policing.

Benetto's (2009, p. 37) assessment of police implementation of the Macpherson recommendations for the Equality and Human Rights Commission found that in some areas clear progress was being achieved while racial equality was not taken seriously in others. Stop and search figures indicate black men continue to be disproportionately targeted.[171] Employment data also shows black police officers continue to resign or are sacked proportionately more than their white colleagues and there has only been a two percent increase in black minority ethnic officers in London against the Home Office's target of a 25% increase.

Stone (2009, p. 6), who was part of the Lawrence inquiry team, notes some positive changes around the introduction of robust emergency life support training for officers and improved training for officers generally, in would benefit the entire community. However he maintains (2009, p. 7) that in areas of policing in minority communities, "…nothing has changed in ten years". Stone (2009, p. 7) suggests the issue of institutional racism has continued to slip off the agenda of police leadership: "…being left for the next commissioners, the next chief constable or the next government Minister". As part of his assessment Stone suggested dealing with institutional racism was part of being a professional, 'you see what needs to be done and you get on with it'. The pathway to professionalism he asserted was higher education. He emphasised that enduring leadership from the top condemning institutional racism strengthens anti-racism efforts. He also called for structural change in the form of a Royal Commission of Inquiry, looking into the structure of policing with a view to realigning the force to fit current realities.

Rollock (2009) based on a systematic examination of research reports, reviews and articles from across government and academic and voluntary sectors identified

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[171] As of 2008 you are seven times more likely to be stopped for a stop and search intervention if you are black than white (R. Stone, 2009, p. 6)

ongoing areas of systemic concern. These related to, recording, monitoring and sharing of racist incidents and racially motivated crime, transparency around inquiry processes, sharing implementation progress, progression and retention of minority staff and the effectiveness of stop and search procedures. Rollock (2009, p. 6) concluded that there was still significant progress to be made and given the outlined concerns it was difficult to argue that the charge of institutional racism no longer applied in the context of policing.

The significant response to the Macpherson report is such that it is difficult to assess critically what specific elements are potential lessons for the Aotearoa context. The literature shows much has been done and more is still to be done. Annual reports assessing progress against an inquiry inspired action plan provide a strong level of accountability and transparency. Such actions were clearly lacking in the processes following the release of *Puao Te Ata Tu*. Likewise, the performance targets and requirements around race equality planning outlined within the Race Relations (Amendment) Act 1990 appear to have been powerful levers to create a more responsive criminal justice system and public service. Media and academic scrutiny and the campaign for justice led by the Lawrence family have kept the issue of institutional racism in the public eye and effectively on the policy agenda.

Community/Professional Driven Interventions

> Institutional racism in any organisation is, almost by definition, invisible. To detect and therefore counteract it, the institution or profession must carefully examine its own practices, both in the past and in the present. Each professional and organisation, then, needs to examine and acknowledge its own place within the social and political structures and systems that give rise to, and perpetuate racism
>
> (Sanson et al., 1998, pp. 174-175).

For many individuals, professional groupings and organisations the racial inequities that permeate education, health and criminal justice systems are unacceptable. This realisation has inspired and motivated various models and approaches to countering racism and attempts to address racial disparities. These community and professionally driven interventions often come from a social justice value base. Organisations might value being accessible to all within the communities they serve, be committed to eliminating racial inequities or see tackling racism as ethical business practice. External 'un-doing' racism consultants or in-house change management teams often lead interventions within this context. Both forms are guided by particular theoretical approaches.

Systems change theory and the traditions of community action often underpin community and/or professionally driven anti-racism interventions. Systems change approaches are used when change agents are seeking to achieve sweeping and

sustained transformative impact. This approach is recommended when organisations and institutions face complex problems that require systematic, multi-level change (Midgley, 2006). When applied to racism this suggests the necessity of multi-level strategies. A sole emphasis on a particular element of a system is usually insufficient for sustained transformation.

Community action approaches usually involve relatively simple action/reflection intervention logic. When applied to countering racism they focus on reducing inequities in power and promote collaborative action, to increase collective power and affect change. Griffith et al. (2007) maintain this method relies on increasing accountability of individuals and systems for monitoring the reduction of inequities/racism, and the reorganising of both formal and informal power. In this context, power is exercised through overt decision-making, agenda setting, prioritisation, shaping meaning, ideology and worldviews.
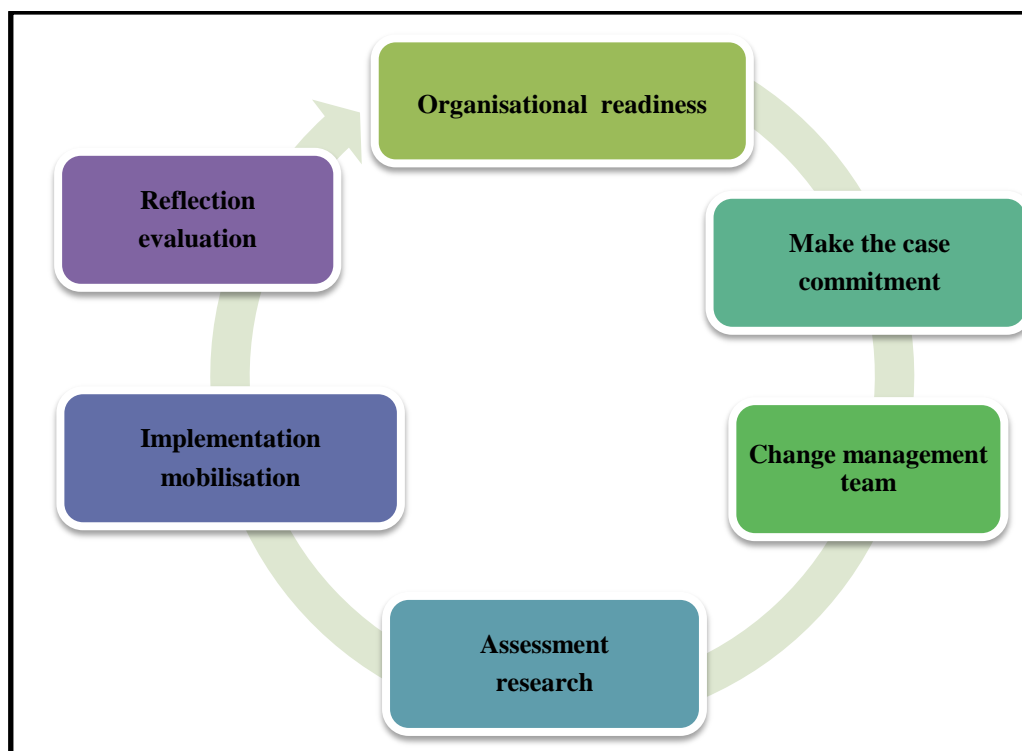
Figure 22: **Systems Change and Community Action Anti-Racism Framework**
This figure synthesises the elements of a systems change/community action anti racism framework.[172]

Figure 22 depicts a conceptual framework based on systems change and community action potentially suitable for interventions to address systemic racism. Although the diagram presents the stages as distinct they can be overlapping and occur simultaneously. Underlying this approach is emphasis on constructive problem

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[172] This figure is developed from the writings of Barnes-Josiah and Fitzgerald (2004), Griffin et al (2007), Huygens (2007), C. Jones (2003), Paradies (2005), Pederson, Walker and Wise (2005), Sanson et al (1998) and Speer and Hughey (2008).

solving and a process Watts, Williams and Jagers (2003) call socio-political development. The later being a process where there is deliberate investment into strengthening workforce capacity and critical competencies throughout the intervention.

The first step of the framework occurs before making the decision to commence an intervention. Griffith et al. (2007), C. Jones (2003) and Barnes-Josiah and Fitzgerald (2004) all recommend undertaking a racial climate test[173] to examine elements of the existing social environment related to racial classification. Part of this process is to examine an organisations' institutional readiness, which is their ability to take on the body of work necessary to affect change. C. Jones (2003, p. 13) makes the point that "fish swimming in water may be unaware of the water, but the water in which they swim can be clean or polluted… I propose we try to see the water in which we swim". Undertaking a comprehensive analysis, she argues, will collectively enable more targeted and effective interventions to counter racism. If institutional readiness is not, yet present Barnes-Josiah and Fitzgerald (2004) recommend investing in awareness raising as a launching pad to achieve institutional readiness so systemic change can be attempted.

The second stage of the intervention is building a firm foundation, by making an enduring case to achieve official recognition of the problem within an organisation and commitment to remedying the situation. This process is likely to take time and often occurs as two sequential developmental steps. Barnes-Josiah and Fitzgerald (2004) hold that the success of any anti-racism intervention is dependent on securing this organisational commitment to affect change. Pedersen Walker and Wise (2005, p. 26) and Paradies (2005, p. 22) also emphasise the importance of engendering political will. They argue that the existing racist power relations privilege some at the expense of others; therefore, attempts to address racism are likely to be met with resistance by those that believe they stand to lose something. Resistance therefore needs to be actively managed throughout any intervention.

The third stage is bringing together an effective change management team to champion the intervention. Griffith et al. (2007) emphasise the importance of this team being multi-cultural and multi-disciplinary in make-up and inclusive of diverse points of view. Relationship building, involvement, and engagement with all affected and interested stakeholders to define the broad parameters of the intervention are critical to success. Sanson et al. (1998) holds it is fundamental to engage actively specifically with communities targeted by racism. This relationship building is also seen as key by Huygens (2007) who analysed Pākehā anti-racism work as an accountability mechanism.

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[173] Various racial climate testing tools have been developed and utilised for this purpose in a variety of contexts (see Chavous, 2005; Pike, 2002)

The fourth stage as emphasised by community psychologists, Speer and Hughey (2008) involves assessment that is identifying the layers of issues contributing to the situation or system. Griffith et al. (2007) emphasise the assessment needs to build a common critical analysis of institutional racism and power which helps the smooth operation of the change team. This can be aided by the utilisation of structural analysis and/or soft systems methodology, which helps get to the root cause of an issue. The later tool also provides a rationale and process for deciding how and where to intervene in an organisation or institution. Throughout this period, the detail of the intervention is refined and agreed upon by the change management team. Within this planning process, understanding is needed of both the dynamics of racism and the culture of the organisation where that intervention will take place.

During the assessment stage, C. Jones (2003) calls for robust documentation of differential service delivery issues by race and the identification of the structural factors that perpetuate these differentials. She champions both monitoring outcomes for institutional racism and examining structures, policies, practices and norms to identify the mechanisms of institutional racism. Specifically within policy analysis, C. Jones draws our attention to four types of policies that serve as structural factors that perpetuate institutional racism (see Table 33).

Table 33: Contemporary Structural Factors Affecting Institutional Racism

Types of Policies	Detail of Policy
Policies that allow segregation of resources and risks.	Toxic dump sitting policies. Zoning of schools.
Policies that favour differential valuation of human life by race.	Curriculum policies that favour certain histories. Societal blindness to racism.
Policies creating inherited group disadvantage (or advantage).	Lack of reparations for historical injustices. Intergeneration transfer of wealth through estate inheritance.
Policies that limit self-determination.	Policies led disproportionate incarceration. Majority rules as only mode of decision-making when there is a fixed minority.

Note. Adapted from Confronting institutionalized racism by C. Jones, 2003, Phylon, 50(1/2), p.18.

The fifth stage focuses on implementation. It is about securing resources and mobilising allies to engage in collaborative action. The sixth stage focuses on active reflection and the embedding of evaluation learnings into future planning. At this point, it is hoped the desired changes have become effectively institutionalised within the organisation. The longevity of racism, Pederson, Walker and Wise (2005, p. 28) contend, suggests that multiple strategies implemented over time may be necessary to address it. They sensibly speculate that substantive social change takes time, sometimes a generation, sometimes several.

Limitations and challenges of this proposed process is the difficulties of getting unanimous support for facilitating change within an organisation. Griffith and team concede it is labour intensive, complex and at times difficult, requiring a range of competencies amongst change agents. Barnes-Josiah and Fitzgerald warn the work may be difficult and painful for some and there is risk change achieved may be cosmetic, superficial and temporary. They emphasise the importance of change agents doing what is feasible as any action can be a platform for future work.

11.5 Enhancing Racial Climate

All anti-racism interventions take place within a particular socio-political context or racial climate. This climate can be conducive to an intervention or hostile to it, regardless of the thought and effort gone into planning. Anti-racism activities attempting to enhance both levels of understanding of historical and contemporary manifestations of racism are amongst the most evaluated anti-racism activity and the most commonplace. The efficacy of various approaches to interventions falling broadly under anti-racism education are reviewed extensively elsewhere (see Bennett, 2006; Chipps & Simpson, 2008; Gillborn, 2006; Haggie, 1990; M. Hill & Augoustinos, 2001; Pedersen & Barlow, 2008; Sonn, 2008).

The literature indicates it seems a reasonable assumption that education will enhance racial climate. The detail of how to do this best remains contested. The softening of hostile attitudes or reinforcing the resolve of those already sympathetic will support other systemic anti-racism interventions, making anti-racism education a building block of challenging systemic racism and privilege.

In the following section, I address more specifically the recommendations arising from this study and the specific context of addressing racism within policymaking and funding practices.

11.6 Insights from this Study

In this study, I argue that the origins of institutional racism and Pākehā privilege in Aotearoa resides in the taken-for-granted colonial policies and practices of colonisation and assimilation and the assumption of unitary Pākehā sovereignty. Although this history cannot be changed, a greater acknowledgement of its implications is a key step towards transforming racism and privilege. At a macro level, processes of decolonisation need to be undertaken to support the recognition of indigenous sovereignty, while actively managing Pākehā resistance and discomfort. Strengthened United Nations controls on state parties' compliance with human rights instruments and the consolidation of the *United Nations Declaration on the Rights of Indigenous Peoples* into a convention could strengthen efforts to resist systemic racism against indigenous peoples.

The success of any anti-racism intervention can be undermined or strengthened by a favourable or unfavourable racial climate. Racial climate and/or political will can be influenced and bent into a favourable position depending on both the application of resources and imagination. The assumption of anti-racism activists that a well informed public, knowledgeable in colonial history and critical thinking are more likely to want to transform racism seems a reasonable justification to continue to invest time in teaching New Zealand history and consciousness raising. As identified in the writings of the Kāwanatanga Network (1996), much needs to be done to prepare Pākehā for structural change, to move into a society where Pākehā are no longer the beneficiaries of racism. Improving racial climate is however not a substitute for structural change.

The following subsections isolate an emerging framework about how to transform racism within public health policy making and funding practices. These suggestions are the synthesis of the collective wisdom of the counter storytellers, public health providers and other activist scholars. Although the recommendations are represented separately for policymaking and funding practices, they are at times both over-lapping and complimentary.

Public Health Policy Making

As described in chapter eight, institutional racism and privilege can be represented as a continuous loop, which marginalises Māori input and influence through the development of public health policy and normalises western bio-medical discourses. Within this section, I revisit the elements of this loop that is tyranny of the majority, incomplete evidence base, lack of cultural competence, flawed consultation and impact of Crown filters. I identify possible remedies to these manifestations of racism and privilege.

The first point of this loop and site for possible intervention is what Berghan (2010, October 18) calls the tyranny of democracy (see Figure 23). This structural manifestation of institutional racism/privilege is the outcome of Pākehā population growth and Māori becoming a numerical minority within Aotearoa and the subsequent Pākehā imposition of majoritarian decision-making. As discussed elsewhere, democracy is upheld as being a fair and equitable system in that everyone gets a voice. In practice, a decision-making mechanism swamps minority concerns in favour of meeting the needs of the majority. Counter storytellers confirmed that decisions within both senior management teams within Crown agencies and within advisory/steering groups are often made based on majority support for a decisions and/or a unilateral decision by the most senior official.
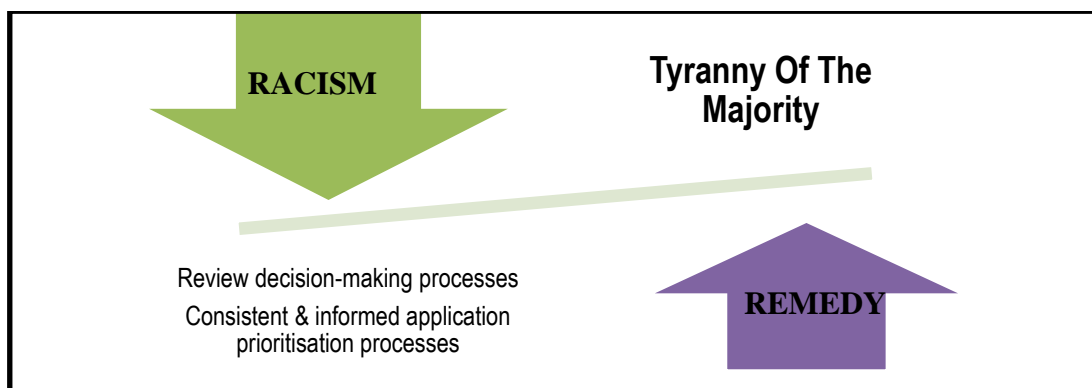
Figure 23: **Disrupting the Tyranny of the Majority**
This figure outlines of site of racism in this instance majoritarian decision-making. It offers some pathways to remedy racism within this context.

There is however various methods available for Crown officials to make decisions at both senior management and operational levels in relation to policy, which could be used instead of majoritarian decision-making. Mandela (1994, p. 23) in his autobiography explains the decision-making processes of the Thembus people in South Africa:

> The meeting would continue until some kind of consensus was reached. They ended in unanimity or not at all. Unanimity however, might be an agreement to disagree to wait for another more propitious time to propose a solution. Democracy [in that context] meant all men were to be heard and decision was taken together as a people; majority role was a foreign action. A minority was not to be crushed by the majority.

Māori traditionally used variations of consensus decision-making. As with the Thembus example, strategic withdrawal might occur and leave the issue on the floor for another time. Silence did not mean consent. Work commissioned by the United Nations (2004) is investigating how to deepen democracy for indigenous peoples. Suggested models include enhanced consultation and participation processes and consensus as a decision making approach.

The notion of deliberative democracy; an approach which incorporates elements of both consensus and majoritarian decision-making is also been explored by some as a means to enhance indigenous influence in decision-making (see Kahane, Weinstock, Leydet, & Williams, 2009; Van Cott, 2006). Fishkin (2010) through his comparative studies of deliberative democracy in various countries has identified several characteristics for legitimate deliberation. These include ensuring all participants have accurate and relevant data; different positions are compared based on their supporting evidence. All relevant major positions held by the public are considered, participants sincerely weigh the options based on the evidence not who is advocating a position.

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Alternatively given the normalisation of racism within the health sector and in recognition of Māori Te Tiriti rights there could be circumstances where Māori are given a right of veto in decision-making forums. Joint co-management arrangements with Crown agencies have trialled a range of partnership and decision-making processes in attempts to enable both kaitiakitanga and rangatiratanga (Taiepa et al., 1997). Prioritisation criteria utilising resources such as the HEAT tool (Signal et al., 2008) could also strengthen decision-making by introducing a more evidence-based and transparent approach. The consistent and informed application of prioritisation processes could act as a useful control to prevent racism and privileging.

The second site for intervention is in the incomplete evidence base (see Figure 24) used to frame and construct policy. With the exception of both the Health Promoting Schools program and the *Whānau Ora* policy platform, public health policy in the last ten years in Aotearoa has been dominated by a western bio-medical focus. At a profound level, this orientation denies the relationship between health and culture and indigenous ontological understandings of hauora in the shape and content of policy. Given the extent Crown officials reference the work of Durie (1994b), which clearly articulates Māori concepts of health and wellbeing; it is a reasonable assumption that this consistent mono-cultural framing of health policy is what da Silva (2010, October 31, p. 1) calls "wilful ignorance". I suggest more inclusive definitions of evidence need to be considered when developing policy.
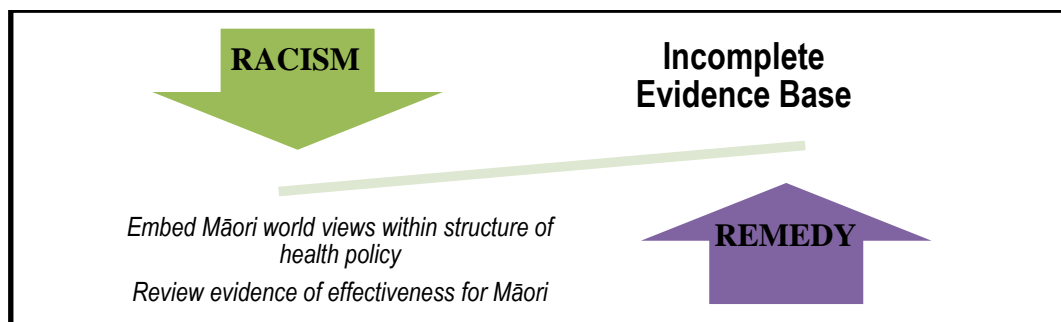
Figure 24: **Incomplete Evidence Base**
This figure outlines of site of racism in this instance utilising an incomplete evidence base in policymaking and offers some pathways to remedy racism within this context.

As outlined in chapter six there are a range of ways of examining health and wellbeing and various public health traditions, including long standing indigenous approaches. If the purpose of the health sector is to improve the health status of the entire population, it makes sense to draw on a range of evidence sources to inform policy development. Health policy could also be structured to reflect a range of worldviews and different understandings of the prerequisites and determinants of health. An approach to public health developed in Te Tai Tokerau (Te Tai Tokerau MAPO Trust & Northland DHB, 2008) endorsed by the Ministry of Health, attempts to do that through drawing on the traditions of epidemiology, kaupapa Māori

traditions and community aspirations. It would seem unlikely that a single ontological approach alone would hold the solution to all the complex challenges facing public health.

In relation to policy content, an epidemiological population level analysis provides a valuable overview of what is going on across a population and offers direction for interventions to benefit the bulk of the population. In many instances, however population level initiatives such as the promotion of seatbelts are beneficial to Māori and non-Māori alike, other times public health interventions can embed and heighten existing inequalities. Consistently ensuring policy development processes include reviews of the efficacy of interventions within Māori communities is a potential powerful control against racism. The assumption that what works for everyone will work for Māori is flawed, it seems more likely the opposite is true. Raising the health status of the most vulnerable has the effect of lifting the health status of the entire population.

The third site for intervention is that of addressing deficiencies in cultural competence (see Figure 25) amongst Crown officials. Assorted writings by Māori academics and counter narratives suggest the ability to be proficient in both Te Ao Māori and Te Ao Pākehā and translate across these worldviews is a scarce competency (certainly amongst Pākehā). Counter narratives in this study detailed a litany of mono-cultural practice in the dealings of Crown officials in relation to policy. This lack of cultural competency is a function of both recruitment strategies and workforce development planning.
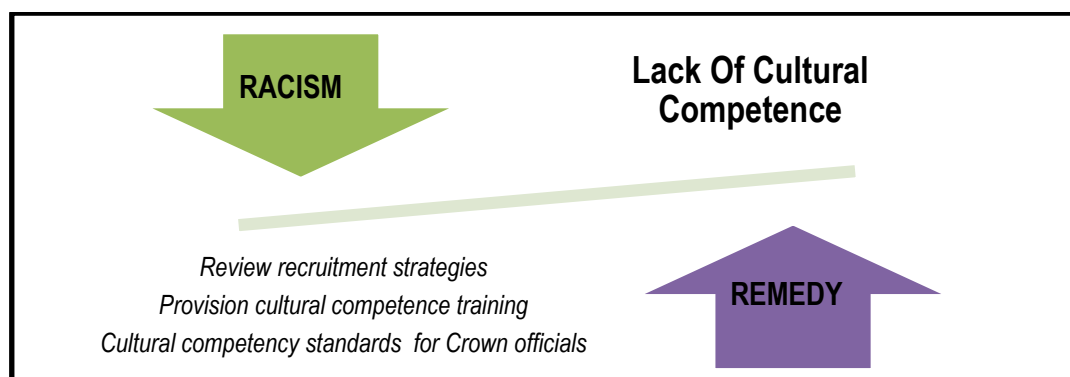
Figure 25: **Lack of Cultural Competence**
This figure outlines of site of racism in this instance lack of cultural competency amongst Crown officials and offers some pathways to remedy racism within this context.

A relatively straightforward remedy to address this enabler of racism and privileging is reviewing recruitment strategies and prioritising cultural competency within selection criteria. Staff must be provided with ongoing professional development opportunities to strengthen their existing cultural competencies. There is a range of training providers specialising in this area, servicing the multiplicity of health

professionals with competency requirements around developing and maintaining levels of cultural competences. Such competency requirements and training opportunities must also be in place or applicable to Crown officials engaging in and managing policymaking and funding activity. Once these controls and support mechanisms are in place the production of mono-cultural policy thereby could becomes managed like any performance management issue.

The fourth site of intervention relates to flawed consultation practices (see Figure 26). This occurs within the context of complex and challenging relationships between many Māori providers and Crown agencies resulting from their long-term experiences of systemic racism. Research undertaken by Te Puni Kōkiri (2000a, 2000b) amongst others has revealed the limitations of Crown practice in relation to consultation. Despite the existence of elaborate guidelines (see Ministry of Health, 2002c), to assist officials in this area counter narratives confirm a range of substantive concerns about elements of consultation practice. These concerns relate to, timing and timeframes of consultation processes, the level of information provided to enable informed participation, the cost of participation, rigid structure provided to give feedback, engaging with the wrong people and asking the wrong questions.
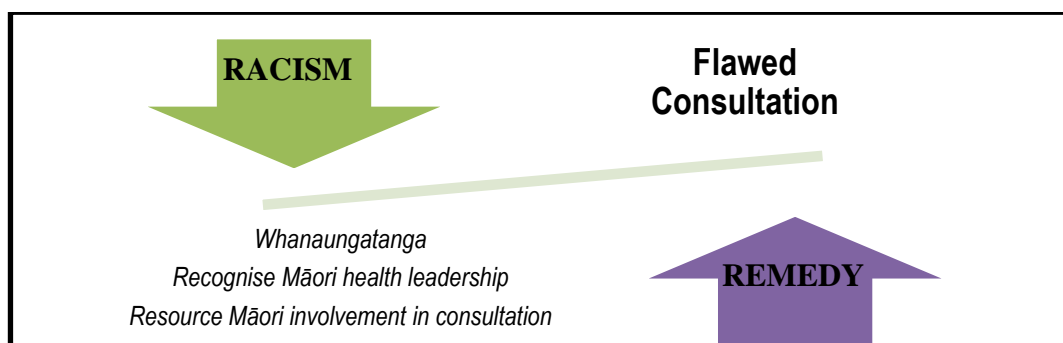
Figure 26: **Flawed Consultation**
This figure outlines of site of racism in this instance flawed consultation processes in the development of policy and offers some pathways to remedy racism within this context.

There are however remedies to minimise consultation as a site of institutional racism and strengthen Māori engagement. Firstly, trusting relationships need to be established and strengthened between Crown agencies and Māori providers. Māori are not one of many stakeholders; Māori are treaty partners and need to be engaged with accordingly. Trust is build through honesty, mutual respect, the honouring of commitments and the exercise of the culturally specific notion of "good manners". Without this base meaningful participation in consultation processes is unlikely to occur.

Māori health providers have often been specifically mandated or delegated authority by iwi or hapū to manage whānau interests in terms of health services. Māori providers are accomplished in engaging with Māori communities due to their

whakapapa and whanaungatanga links, which enable them to do their work. Crown consultation planning must recognise this and work with recognised Māori health leadership to engage at strategic not operational levels. It is for Māori CEOs not Crown officials to determine how their respective organisations might engage in a process, depending on the particular kaupapa. Given the multiplicity of demands on Māori and the opportunity cost of participation in Crown consultation processes where practical Māori should be compensated for their time and expertise.

The final site of intervention related to policy making is the impact of Crown filters (see Figure 27). As described by Berghan (2010, November 7) filters act to water down and dilute Māori content within policy as it progresses through development and sign-off processes. This manifestation of institutional racism as demonstrated by counter narratives is fuelled by lack of cultural competence, willingness to both use incomplete evidence and disregard Māori evidence altogether in favour of western bio-medical understandings. It also seems to represents a lack of political will to either power-share and/or addresses inequities between Māori and non-Māori.
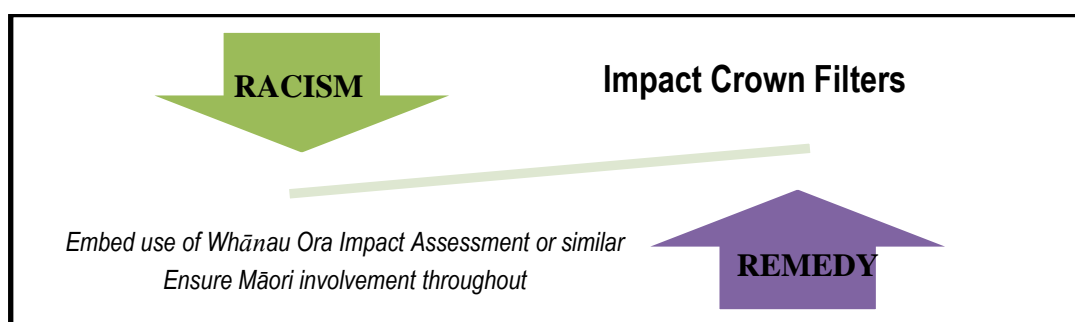
Figure 27: **Impact of Crown Filters**
This figure outlines of site of racism in this instance the impact of Crown filters on policy and offers some pathways to remedy racism within this context.

The Ministry of Health have commissioned a range of audit and assessment tools that could alleviate this manifestation of racism if they chose to apply them within their own practice. Among those that might be applicable are the WOIA (Ministry of Health, 2007e), the HEAT tool (Signal et al., 2008) and *He Taura Tieke* (C. Cunningham, 1995). These tools would need to be applied by culturally competent officials during the development of policy and after any major revisions. Based on the collected counter narratives it is during the revision stages that policy is often radically altered and both internal and external Māori input is minimised. Inclusive policy is developed when Māori are involved from conception, through development, implementation and evaluation.

Transforming racism and privilege within policymaking will be an iterative process of re-orientation and reconfigured power-relations. It will involve revamped decision-making and recruitment processes, embracing Māori worldviews and public health traditions, valuing whanaungatanga and respecting Māori leadership. It will involve

investing in cultural competency training, applying new standards of practice and ensuring internal and external Māori involvement throughout the policy cycle.

Funding Practices

As described in chapter nine, racism and privilege are quantifiable across Crown funding practices and can be represented as a continuous loop. Within this section, I outline remedies to the elements of this loop, historic funding allocations, mono-cultural funding frameworks, uneven access to and the inconsistent practice of Crown officials and lack of leadership.

Funding and planning activity requires Crown officials to maintain relationships across a range of providers (see Figure 28). This study demonstrated that groupings of public health providers reported the perception of variable levels of access to Crown officials and considerable variation in the reported quality of their respective relationships. This variation in levels of influence and trust is visible in the representation levels of groupings of public health providers in both Ministry and DHB advisory and steering groups. As highlighted by one public health manager in this study, the strength of relationships appears to be a critical determining factor in relation to providers' experiences of Crown officials.
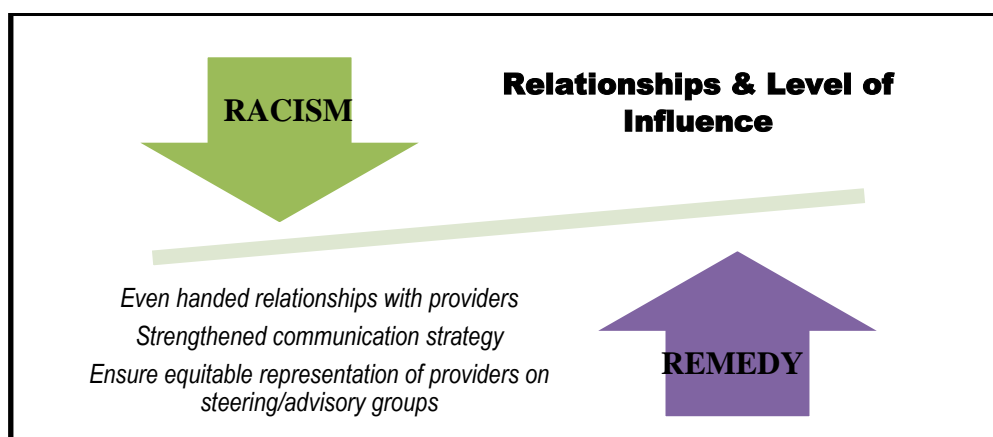
Figure 28: **Relationships and Levels of Influence**
This figure outlines of site of racism in this instance provider/funder relationships and levels of influence and offers some pathways to remedy racism within this context.

Strong relationship management by Crown officials and their even-handed treatment of providers seems central to alleviating racism. As a small sector, most Crown officials working in public health have a web of existing relationships with public health providers across the sector. The challenge for Crown officials is to build relationships with all providers and ensure equitable formal and informal access to information, advice and support. Enhanced transparency through a strengthened sector wide communication strategy and proportional engagement with providers could minimise the likelihood of inconsistencies in practice. Equitable representation

of groupings of public health providers on steering and references groups would also remedy uneven representation levels and improve policy input.

This study demonstrated a number of inconsistencies in relation to Crown contracting practices across groupings of public health providers, primarily disadvantaging Māori providers (see Figure 29). These inconsistencies included contract terms, auditing practices, negotiation processes and the mono-cultural content of the current public health service specifications. To date neither the Ministry of Health (2003f) nor local DHB quality assurance planning appears to have addressed these systemic problems. I contend such failings in practice could have been picked up by risk management processes and addressed through quality assurance mechanisms.
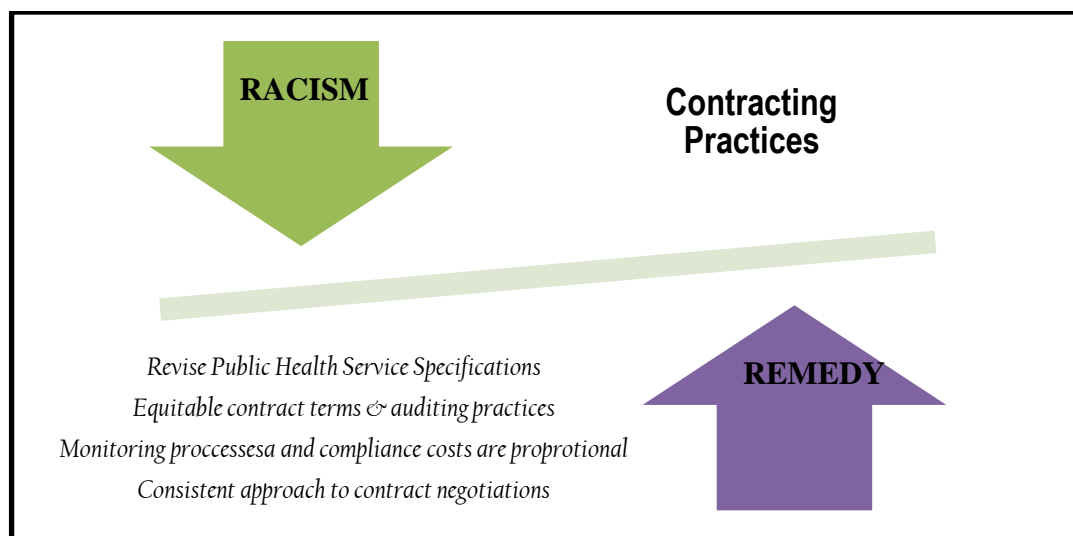
Figure 29: **Contracting Practices**
This figure outlines of site of racism in this instance the operational contracting practices of Crown agencies and offers some pathways to remedy racism within this context.

Given the central place of public health service specifications as the basis of public health contracting, to alleviate racism this document needs to be redrafted to be inclusive of both Māori worldviews and Māori public health approaches. Contract timeframes for providers should be standardised, unless a performance management process is currently underway, or the particular funding stream for a program is one-off. Auditing practices need to be adapted so they are proportional to contract size and the over-auditing of Māori providers must cease. Likewise monitoring practices (unless a performance management process is currently underway) also need to be proportional to contract size to even out compliance costs. Monitoring processes need to ensure providers are effectively delivering to Māori communities. Providers should also be able to expect a consistent level of flexibility and good will from Crown officials when entering into contract negotiations.

This study identified inconsistencies in Crown practice in relation to funding practices (see Figure 30). These included inequitable access to cost of living adjustments and discretionary funding, inconsistencies in allowable financial reporting and prioritisation processes. Alongside these practices is the privileging of some groupings of providers through the historic investing the bulk of public health monies. This has occurred without a review process and regardless of provider performance. Once more, many of these flaws in funding practices reflect a failure of quality assurances processes.
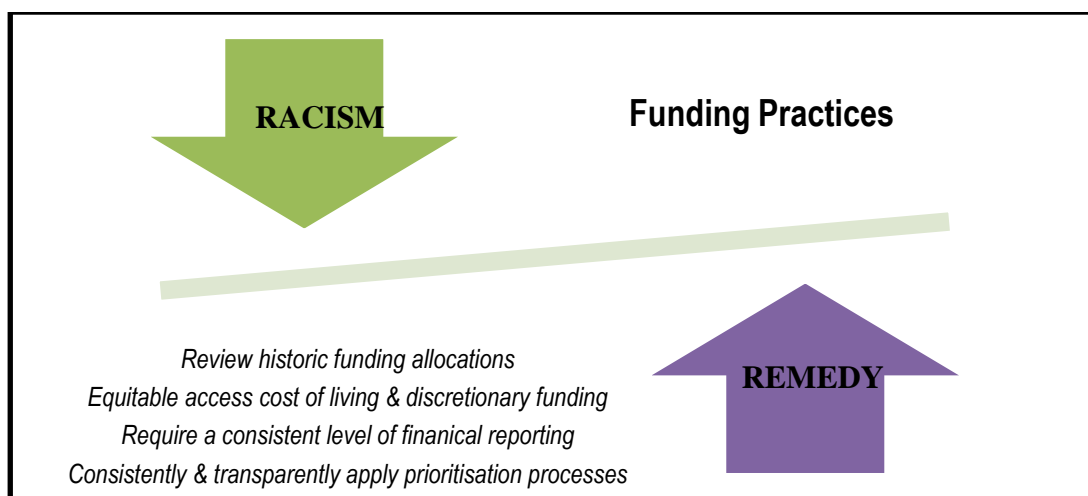
Figure 30: **Funding Practices**
This figure outlines of site of racism in this instance the funding practices of Crown agencies and offers some pathways to remedy racism within this context.

Remedies in relation to funding practices involve developing a consistent approach in the allocation of cost of living adjustors and enforcing a standard level of financial reporting across providers. Prioritisation processes also need to be consistently applied and providers given equitable opportunities to apply for discretionary funding.

To transform historic privileging in Crown funding practices I suggest it is necessary to revisit historical funding allocations. These allocations were made prior to a raft of major developments within the sector including the emergence of Māori health providers. A robust and transparent re-tendering process would ensure the most effective existing public health providers would secure this funding pool. Central to such a tendering process would be criteria to ensure who ever won the tender could demonstratively prove their ability to deliver successfully to Māori communities.

Many of the inconsistencies around funding and planning practices could easily be addressed through the strengthening of operational policies and protocols, with appropriate workforce development strategies. Pro-active line management of Crown officials would help ensure compliance with these revamped organisational

requirements. Greater transparency around these practices would enable providers to hold Crown officials accountable for fair treatment. Historic funding allocations would also need to be revisited to complete this transformation.

11.7 Summary

Findings from this study and reviews of relevant anti-racism literature offer a range of potential fruitful pathways to transform institutional racism and its counterpoint privilege.

Structural change has seen the transformation of the apartheid regime in South Africa and assorted indigenous peoples gain measures of self-government. I maintain within a colonial context a key structural pathway to address institutional racism against indigenous peoples is to enter into a process of decolonisation with the purpose of revitalising indigenous sovereignty. Within the context of Aotearoa Te Tiriti offers a platform for this transition. Critical to that transition there needs to be historical redress and resource redistributed to minimise the structural advantages gained by white people through historical racism. Treaty settlements, however modest given what was alienated by Crown actions, have been central to such processes in Aotearoa.

Anti-racism activists have welcomed the endorsement of the *United Nations Declaration on the Rights of Indigenous Peoples* after twenty years in development. The protection of indigenous rights would be greatly enhanced by the successful transition of this Declaration into a binding convention with monitored reporting processes. Likewise given the enduring nature of expressions of state racism it seems prudent to strengthen independent domestic human rights agencies to more effectively monitor Crown activity and broaden evidence-based anti-racism praxis.

Politically and community driven organisational change offer a range of insights into how to transform racism. The contrasting outcomes of the Macpherson and *Puao Te Ata Tu* investigations into institutional racism illustrate the importance of maintaining political will, setting targets and actively monitoring Crown activity. Community driven approaches emphasise the important of planned systemic approaches, where progress can be measured and barriers identified and problem-solved.

This study identifies a range of strategies to transform racism and privilege in the specific context of policy making and funding activity. These included strengthening Crown operational protocols and practices and the monitoring of these through quality assurance processes and by relevant line managers. Proposed remedies included embracing Māori world-views and public health traditions, valuing whanaungatanga and investing in cultural competency training. Remedies also

included ensuring Crown officials consistently apply policy, the reconfiguring of the public health service specifications and reviewing historical funding allocations.

Central to all these approaches is the importance of creating a supportive racial climate to affect change. Anti-racism education focussing on increasing awareness of contemporary and historic manifestations of racism can be seen as a building block and enabler of all anti-racism activity. This includes structural, organisational or professional practice levels.

The final chapter will summarise the contributions of this study to local and international understandings of institutional racism, privilege and activist scholarship.

CHAPTER TWELVE: LOOKING BACK (INTO) AND LOOKING FORWARD (FROM THIS RESEARCH)

12.0 Introduction

> Available health statistics raise serious concerns that Māori are not receiving the standard of health services received by other groups in New Zealand. The Special Rapporteur [of the United Nations] encourages the Government to continue to work with whānau, iwi and Māori leaders to assess the causes of the discrepancy in health conditions and identify possible culturally appropriate solutions (Anaya, 2011, p. 24).

This research emerged out of passionate dialogue with Māori working within public health, a cluster of powerful reports (see Berridge et al., 1984; M. Jackson, 1988; Ministerial Advisory Committee, 1988) written in the 1980s about institutional racism in the public sector, and a strong personal intuition based on many years working in the sector that Māori providers were not receiving a fair deal from the Crown. That racism was prevalent in government activities was taken as a starting point for my research. I set out to verify, identify, describe and strategise how to challenge this racism and its counterpoint privilege.

Informed by local and international studies institutional racism is defined in this research as a pattern of differential access to material resources and power determined by race. Racism and privilege are thereby interlinked concepts, when one group of people are being structurally disadvantaged, another is privileged. The intentions and motivations of individuals involved are not the defining characteristic of such racism rather the racial disparities that are generated. Emerging from structural analysis traditions the construct of institutional racism has proven an effective lens to gain a deeper understanding of racial power dynamics in Aotearoa.

Institutional racism is notoriously difficult to identify because it is not usually a conspicuous act, rather it is a pattern of behaviour. Within this study, through analysis of a range of data sources, I have contributed to understandings of how racism and privilege manifest within Crown policy making and funding practices, substantially informed by the significant experience of Māori counter storytellers. My mixed-method approach; included counter storytelling, a desktop review of Crown documents, an historical analysis, co-funding field notes, literature review, a survey

of public health providers and a quantitative funding analysis. Cumulatively these methods provided strong validation for the claim that systemic discrimination in the administration of the public health sector is widespread.

As well as expose racism through this research, I also aimed to contribute to scholarship that is activist in orientation. Within this final chapter, I reiterate the major findings of this study, drawing out contributions to local and international scholarship. I also examine the implications of this work for theory, research and practice and outline its limitations.

12.1 Contributions to Local Understandings

Institutional racism has been a small but consistent part of both activist and parliamentary[174] discourses since the 1980s and remains a frequent theme in Waitangi Tribunal reports. Local academic scholarship has however been largely silent on institutional racism and Pākehā privilege with limited debate within the public health sector locally.[175] Academic analysis of racism within the health sector has instead focussed on disparities in health outcomes between Māori and non-Māori (see Ajwani, Blakely, Robson, Tobias, & Bonne, 2003; T. Blakely et al., 2004; Ministry of Health and University of Otago, 2006; Robson, 2007; Robson & Harris, 2007) and quantifying self-reported racism and its impact on health (see Harris et al., 2006a; Harris et al., 2006b). I maintain the dissemination of these findings through activist and academic networks will provide opportunities to revitalise debate about institutional racism and privilege and open it out to a wider audience.

My comprehensive findings affirm the views of Waitangi Tribunal claimants and others who allege discrimination occurs in the administration of the health sector. This study provides a detailed description of how institutional racism manifests within public health policy making and funding practices. It also identifies concrete strategies and pathways that hold potential to minimise, disrupt and transform state racism. This analysis draws on the work of C. Jones (2001, 2003), Paradies, Harris and Anderson (2006a; 2008) and Griffith et al, (2007). It is also informed by my recognition of the Crown's Te Tiriti responsibilities to protect the interests of Māori.

Within this section I summarise some of my key findings. Specifically I outline how racism become normalised Crown practice, how racism manifests in Crown policy and funding practices, insights from working with activist scholarships and my contributions to anti-racism praxis.

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[174] A search of New Zealand parliamentary debates for the period May 2003 through to March 2011 identified 176 references to institutional racism.

[175] Among the exceptions includes work by Borell, Gregory, McCreanor, Jensen, and Moewaka-Barnes (2009), C. Jones (2010), Kearns, Moewaka-Barnes and McCreanor (2009) and my own work (Came 2011a).

Racism as Normalised Crown Practice

There have been a range of important contemporary commentaries and revisionist histories of Aotearoa examining the relationships between Māori and the Crown (see Fleras & Spoonley, 1999; D. O'Sullivan, 2007; Orange, 1987; Walker, 1990). This body of work is complemented by Waitangi Tribunal reports, which provide respected independent accounts of New Zealand history. These robust reports utilise a range of sources from historic government documents through to oral testimony from kaumātua.

Drawing on these sources, I argued that the Crown's failure to accept that Māori never ceded sovereignty remains the single most critical factor (illustration of institutional racism) in Māori – Crown relations since 1840. This racist denial led to the imposition of unitary parliamentary sovereignty, the transfer of economic assets to Pākehā and the marginalisation of Māori communal cultural practices and ways of life. Māori resistance to this has been both steadfast and enduring.

My historical analysis of Crown engagement with Māori since 1840 in chapter three was framed under the macro themes of; colonisation, assimilation, biculturalism and neo-liberalism. This analysis revisited and revisited key themes from *Puao Te Ata Tu* (Ministerial Advisory Committee, 1988) and updated them into a contemporary context. This examination traced the continuity of systemic racism against Māori across major race relation policy platforms of successive governments (Came, 2010, June). Based on this evidence I maintain whether consciously or unconsciously institutional racism and the privileging of Pākehā has become normalised Crown practice. This making of racism "ordinary" has been so successful it renders it near invisible for those working within or in close quarters to Crown agencies.

Quantifying Racism in Crown Practice

> There is plenty of information within the [health] system to demonstrate that the system is not working as well as it could. It is not a difficult exercise for this information to be put to good use... the system should be held accountable for performance particularly failure
> (Wano, 2011, July 22, p. 2).

Institutional racism is difficult to identify because it is not usually a conspicuous act, rather it is a pattern of behaviour privileging one group while systematically disadvantaging another. Within this study through analysis of a range of data sources I contributed to understandings of how racism and privilege manifest within both Crown policy and funding practices informed by the significant experience of counter storytellers such as Wano.

Public policy is written to address the needs and aspirations of the entire population and is critical to the effective working of government. Policy guides Crown officials in their determinations of what interventions to fund and where to invest resources. Within this study I argue that a policy cycle with embedded racism will generate policy that privileges one group of people and disadvantages another. The marginalisation of Māori viewpoints across all the stages of policy development was a major theme of this study, supported from a variety of data sources. How this cycle takes effect is represented as a continuous loop of racism and privilege (see Figure 31) as discussed in both chapters eight and eleven.
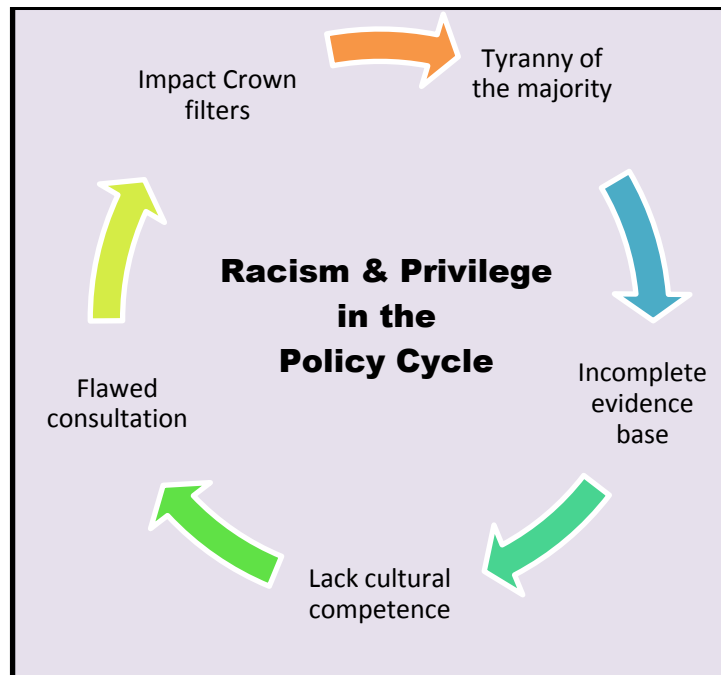
Figure 31: **Racism within the Policy Cycle**
As introduced earlier this figure depicts how the dynamics of privilege and racism, as identified in this study, manifest within the policy cycle.

Counter narratives within this study spoke of the structural challenges facing Māori as a minority voice within a system driven by majoritarian decision-making (see 8.1). Public health policy was seen as dominated by bio-medical perspectives and epidemiological analysis (see 8.2), consciously or unconsciously disregarding Māori understandings of the dynamics of wellbeing. This is reflected in both the structure and content of policy. Concerns about the level of cultural competence (see 8.2) amongst Crown officials were outlined by many parties as a source of mono-cultural analysis. Policy developed using flawed consultation processes (see 8.3) and elaborate Crown filters (see 8.3) further silence Māori.

How institutional racism and privilege manifest in Crown funding practices can also be represented as a continuous loop (see Figure 32), as discussed in chapter ten and eleven. The starting point of this cycle is a set of historical funding allocations (see

10.4) which transferred the bulk of public health investment into NGOs and PHUs. These seemingly incontestable allocations appear to have been awarded regardless of the [in]effectiveness of ongoing service delivery. Mono-cultural policy in the form of the current public health service specifications (see 10.3) forms the basis of Crown public health contracting. These specifications are strongly influenced by a bio-medical framework marginalising Māori worldviews and therefore Māori public health approaches.
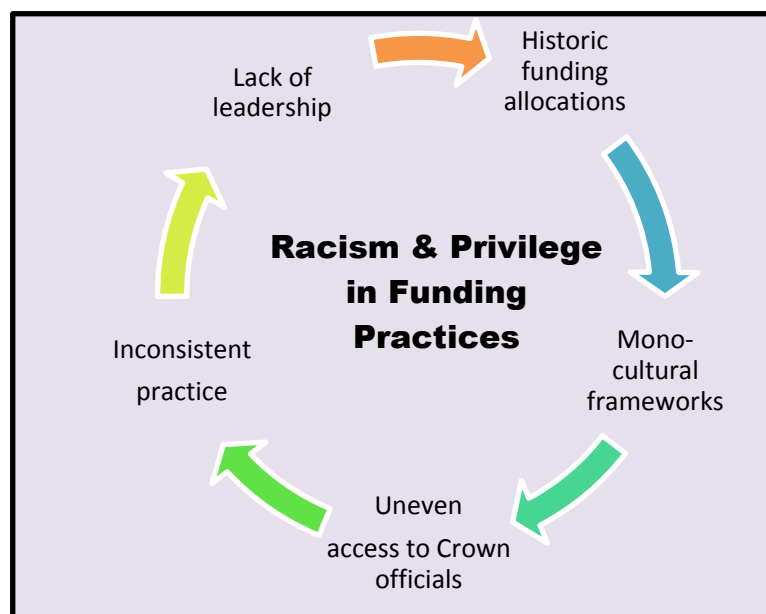
Figure 32: **Racism & Privilege in Funding Practices**
As introduced earlier this figure depicts how the dynamics of privilege and racism, as identified in this study, manifest within funding practices.

Whether perpetuated consciously or unconsciously, this study exposed differential treatment of public health providers by Crown officials. This is reflected in groupings of providers' uneven access to Crown officials and decision-makers (see 10.2) and in differential representation on steering and advisory groups. Inconsistencies were also quantified in relation to Crown contracting and funding practices (10.3 and 10.4). Māori providers reported least access to cost of living adjustments and discretionary funding, greater levels of scrutiny, higher proportional compliance costs and less favourable contract terms.

I suggest this differential treatment across funding and planning practices is a strong indication of institutional racism. These examples of racism were enabled by the failure of quality assurance systems and deficiencies in both management processes and leadership generally. These deficiencies are evident in their failure to either detect or address systemic racism, despite formalised mandates such as those articulated within CERD to eliminate racial discrimination.

Doing Political Research: Activist Scholarship

Activist scholarship is about exposing injustice and working collaboratively with others to effect change. As a piece of activist scholarship, this study has exposing injustice and identifying a series of pathways to transform this. The findings of this study represent both a shared opportunity and a shared responsibility. Planning around their ongoing dissemination (see appendix D) and implementation remain a primary focus for those of us associated with this research. We are committed that the findings of this research reaching a wide audience to inform both activist and academic discussions around antiracism praxis.

At the heart of my activist method is dual accountability to my research whānau and to Pākehā Tiriti workers active in the struggle to support Māori tino rangatiratanga (Came, 2010). I maintain these governance arrangements can be credited with the political relevance and cultural competency of this work. Briefly described in chapter two my approach involved an active management of power dynamics, strong relationships, and a base-line of cultural competence honed through years of community and activist work. The complexity of why and how this collaborative process worked is still unfolding and a source of personal and professional reflection (see Came & da Silva, 2011).

Also critical to my activist method was my engagement with a kaupapa Māori ethical framework – *Te Ara Tika* - developed by the Pūtaiora Writing Group (Hudson et al., 2010). This framework required me to actively engage with the concepts of whakapapa, mana, tika and manaakitanga within the context of activist scholarship. I maintain this ethical reflection process contributed to my understandings about co-intentional relationships and collaboration between Māori and Pākehā, and the interface between kaupapa Māori theory and Pākehā Tiriti work. I believe it would be of benefit to other Tauiwi researchers writing in the context of Aotearoa to consider how our work sits with such indigenous frameworks to strengthen our ethical bicultural practice.

Not unexpectedly the political nature of this work led to some difficulties accessing information through usual collegial professional channels. This led me to utilise the Official Information Act 1982 and the Ombudsman's office to compel Crown agencies to release information about their funding practices. Likewise, the inflammatory nature of some of the counter narratives collected during this research led me to review and expand data collection strategies to test transparently the trustworthiness of these passionate accounts. This flexibility and resourcefulness lies at the heart of an activist scholarship approach, which I maintain is uniquely suited as a methodological approach when investigating issues of power.

Contributions to Anti-racism Praxis

Within this study I outlined strategies to transform state racism at macro, meso and micro levels. These strategies can be used in isolation or woven together into a comprehensive intervention framework. This study affirms the notion that anti-racism interventions are more likely to succeed within a supportive racial climate. Although aspects of the contemporary racial climate within the public health sector are assessed quantitatively within this study, I utilised a qualitative approach to elevate indigenous voice and experience (Came, 2011b). Anti-racism education focussing on increasing awareness of contemporary and historic manifestations of racism (which positively impact on racial climate) can therefore be seen as a building block for anti-racism praxis.

There is an intricate web of controls in place to moderate the behaviour of state parties and Crown officials intended to minimise and/or prevent systemic racism. At a state party level this includes legally binding human rights instruments administered by the United Nations. At a Crown official level this includes various procedures, legislation and regulations. The regular finding of CERD reports confirms the New Zealand government does not consistently meet its international obligations. Furthermore this study demonstrates that controls within public health are failing to prevent systemic discrimination.

These findings suggest there is a need to strengthen controls and prioritise meeting international obligations (see chapters five and eleven). In the first instance I advocate for the progression of *United Nations Declaration on the Rights of Indigenous Peoples* into a full-fledging convention with a monitored reporting process as a way to strengthen the position of indigenous peoples. Given the persistent nature of state racism a strengthened independent domestic human rights agency might also prove beneficial to more effectively monitor Crown activity and broaden evidence-based anti-racism praxis.

At a structural level I suggest the most effective way to address institutional racism against indigenous peoples within a colonial context is to enter into a process of decolonisation (see 11.2) as advocated by Fanon (1961/2004), S. Jackson (1989) and others. The purpose of this strategy is to restore indigenous sovereignty. Within Aotearoa, *Te Tiriti o Waitangi* is an imperative to sanction this transition. Examples such as the collapse of apartheid in South Africa are powerful reminders that radical transformation is possible. Central to such change is historical redress and resource redistribution to minimise the structural advantages gained by white people through historical racism. Treaty settlements have been central to such processes in Aotearoa.

Both politically and community driven organisational change (see 11.4) offer a range of insights into how to transform racism. The contrasting outcomes of the Lawrence

and *Puao Te Ata Tu* investigations into state racism highlight the importance of maintaining political will, setting targets and actively monitoring Crown activity. Community driven approaches emphasise the importance of planned systemic approaches, where progress can be measured and barriers identified and problem-solved. Common across both traditions is the importance of incremental measurable progress.

Through this study I have identified a range of options to transform racism within the specific context of policy making and funding activity as outlined in chapter eleven. These include strengthening Crown operational protocols and practices, the monitoring through quality assurance processes and effective line management. Proposed remedies included embracing Māori world-views and public health traditions, valuing whanaungatanga and investing in cultural competency training. Remedies also included ensuring Crown officials consistently apply policy, the reconfiguring of public health service specifications and reviewing historical funding allocations. Some of these actions could be implemented tomorrow; others would require change management processes and resource redistribution.

12.2 Contribution to International Understandings

> Not enough has been written about institutional practices that are covertly racist, and often concealed. To understand the potency or power of institutional racism, one must first understand the function of American institutions
> (Better, 2008, p. 37).

C. Jones (2003) writing in the context of the United States, advocates for an informed national conversation on institutional racism. This study contributes various insights to an extended international debate. For instance, through tracing the policy origins of institutional racism within Aotearoa, I suggest racism in colonial contexts appears to be intrinsically connected to historic and ongoing processes of colonisation and assimilation. Such racism in Aotearoa and potentially elsewhere has become a normalised part of Crown practice regardless of the policy platforms of successive governments. In this study, this is exposed through the careful demonstration of the dynamics that result in enduring racial inequities across a range of social indicators. While noting the local specificities of both colonisation and institutional racism, I suggest this analysis is a contribution to literature on decolonisation.

The mechanisms of government, health policy making and funding practices differ across the world but hold some common elements. Despite the geographic specificity of racism (see Dunn & Geeraert, 2003; P. Jackson, 1987) this study provides a practical illustration of how to quantify racism within Crown activity. This analysis may also provide markers for others attempting to identify the sites of racism within the administration of their respective health services/public sector. If health sectors

across countries have enough common components, expanded data from this study could be utilised to enable comparative studies and benchmarking of state performance.

In relation to activist scholarship, this study provided an exemplar of a collaborative approach of co-intentional relationships between indigenous and non-indigenous peoples which may be of interest to others undertaking political research. At the heart of that collaboration was the application of an indigenous ethical framework (Hudson et al., 2010) applying the elements of mana, whakapapa, tika and manaakitanga. This served to locate the study in a given place, while as a researcher I was vigilant of the complexity of the power dynamic of being a privileged beneficiary of racism working with those targeted by racism. My approach also demonstrates a potentially powerful dual accountability to both a predominately indigenous research whānau and a dominant group activist network. This governance structure kept this study focussed and political relevant.

In a practical sense, this study addresses various elements of the Cooperative Centre for Aboriginal Health's (Paradies et al., 2008, p. 1) research agenda, as summarised in Table 34. This research agenda was developed primarily by key researchers and policy-makers from Australia and Aotearoa with expertise in racism and indigenous health "...to advance our understandings of, and our ability to combat, racism as a threat to indigenous health in Australia and Aotearoa".

Table 34: Cooperative Centre for Aboriginal Health Research Agenda

Research Question	Suggestions from this Research
How can an understanding of the ways in which societal systems produce advantage and positive health outcomes for white Australians and Pākehā New Zealanders help improve indigenous health?	My study deliberately exposed Crown practices perpetuating racism and its counter-point white privilege. This analysis led to the development of an intervention framework that may enable consistent funding practices and policy making inclusive of indigenous world views in both structure and content. Such a transformed environment could allow indigenous health providers to focus on what they do best, delivering quality health services to indigenous peoples and likewise it could result in a much needed reallocation of resources. The logical but yet unproven outcome of this shift of focus and improved operating environment could be improved health outcomes for indigenous peoples through enhanced service delivery.
What is the best way to measure systemic racism against indigenous peoples?	My study recommends the use of both qualitative and quantitative analysis to measure racism. Intricate to such a method is strong engagement with indigenous peoples and the use of a multi-pronged data collection strategy, inclusive of an historical component to maximise the trustworthiness of findings.
What are the best approaches to addressing systemic racism against indigenous peoples?	My study advocates for a comprehensive intervention framework with multi-points of entry reflecting both the historical context of racism and the current racial climate. Such an approach might include addressing systemic racism through structural and

Research Question	Suggestions from this Research
	organisational change, strengthening controls on state parties and Crown officials, improving the racial climate and specific interventions related to policy making and funding activity in the health sector.
What racist elements of institutions/systems are most amenable to change and how should the fostering of anti-racist cultures and environments be measured?	An examination of racial climate is a both a useful planning tool to identify points of leverage to facilitate change with a racist system and also if repeated a vehicle to evaluate progress in transforming it. A qualitative racial climate check if developed sufficiently could stand alone to identify points of intervention or depending on the resource available be supplemented by a quantitative-based racial climate check as favored in the United States. Within the intervention framework proposed in this study a range of audit/evaluation tools could be developed and utilised to measure behavior change as a marker of systemic change. There is a wealth of evaluation literature that could advance understanding of this research question.
What are the costs of racism and the savings from anti-racism policy and practices?	My study contends the most powerful measure of the failure of the health system to address the needs of indigenous peoples is through the life expectancy gap between indigenous and non-indigenous peoples. However else these costs and savings are quantified I contend life expectancy needs to be central.
How can we improve health system performance as a way of combating systemic racism against indigenous peoples in heath care?	My study outlines a comprehensive intervention framework to transform institutional racism and enhance policy making and funding practices within the New Zealand health system. Implementation of individual components and/or the entirety of the framework could improve health system performance and ultimately improve health outcomes for indigenous peoples.

Note. Adapted from *The impact of racism on indigenous health in Australia and Aotearoa: Towards a research agenda* by Y. Paradies, R. Harris, I. Anderson, 2003, Darwin, Australia: Cooperative Research Centre for Aboriginal Health. Reprinted with permission.

My use of critical race theory, particularly the juxtaposition of master and counter narratives may also be of interest to others undertaking political research. A desktop review of dominant discourses allows the rhetoric of the powerful to speak for itself without the immediate clutter of interpretation and justification and the same respect is accorded to counter narratives. This parallel process allows competing discourses to stand together as different viewpoints of the same phenomenon, exposing sites of discord and conflicting interpretations. This method could be applied powerfully for instance, to mainstream media discourse on sport and the experiences of female athletes or to state discourses on education and the experiences of new migrants accessing them.

12.3 Implications for Policy, Practice and Future Research
Crown agencies should be able to detect and address systemic racism through their routine administration of the public service. Indeed, they are entrusted and resourced to do this important work on behalf of all New Zealanders. I suggest executive

management teams are responsible for this failing and need to be held accountable for rectifying the situation. Allowing systemic racism could be grounds for activating performance management processes or be considered serious misconduct. Given the endemic failings of Crown agencies to be consistent in their administration of the health sector, I contend change management efforts need to be transparent so progress can be monitored independently.

In terms of future research, this study offers a variety of potentially useful directions. In the first I welcome the practical application and evaluation of the intervention framework outlined in chapter eleven. Throughout the study, I have pondered whether the methodology and method utilised in this study would be applicable in other areas of Crown activity to detect and transform institutional racism, particularly within primary healthcare and elsewhere within the public sector. Likewise, I wonder what resonance this analysis and intervention framework might have for indigenous peoples and allies attempting to decolonise in other colonial contexts. The potential for a collaborative, comparative study may offer rich insights for resourced research in the future.

Given the breadth of this study, various elements are addressed only briefly and would benefit from greater examination. For instance, the application of racial climate to anti-racism praxis, a critical assessment of the effectiveness of controls on Crown officials to prevent racism, the gap between Crown rhetoric (in this instance policy) and operational practice and the merits and risks of engaging in activist scholarship would all benefit from further investigation and reflection.

As a non-indigenous researcher working with issues of racism and privilege I found it invaluable to work with a research whānau. This direct accountability mechanism enabled me access to direct and clear political and cultural guidance. This method may be a fruitful approach for other activist scholars working with systemic issues of power and oppression.

Although not explored within this study many counter storytellers raised concerns about both the negative and positive contribution of Māori Crown officials in transforming and reinforcing institutional racism. A closer examination of this complex dynamic offers another line of enquiry for future research.

12.4 Limits of Present Research

This study grew out of my time working within Māori health for a distinctive Māori co-funding organisation. While working for them I was able to witness Crown officials in their dealings with a range of public health providers. Despite my background in anti-racism work, I was shocked by what I perceived as inconsistency in Crown practice in their dealing with providers and other behaviours I considered

racist. When the Ministry and Northland DHB unilaterally withdraw from their co-funding partnerships with MAPO in 2010, this unique site for observing/monitoring Crown behaviour was relegated to history. The access I experienced and exposure to overt and covert racism has in many ways driven this piece of work and influenced my perceptions of Crown agencies.

Throughout the research process, it was a perpetual dilemma about how and when to engage formally with Crown officials. I carried with me the notion that good collaborative practice involves early engagement with all stakeholders. I chose not to follow that convention in this study as I wished to hear clearly from those targeted by institutional racism. This sat uncomfortably with me because of the professional and personal relationships I have with a range of Crown officials and my suspicion that the later I engaged the less interested they would be in these findings. Ultimately, I engaged relatively late in the research process but in balancing that I also deliberately sought out counter storytellers with experience working within Crown agencies.

Before this study I had had never carried out OIRs. After being passed around by a range of Crown officials, it seemed the path of least resistance. Through over forty OIRs, I obtained a range of useful and sometimes irrelevant material that I analysed to stitch together into a funding analysis. The primary limitation of this analysis is that the Ministry of Health do not track Māori health expenditure, nor do they track Māori public health expenditure. Despite retaining administrative responsibility for the bulk of public health expenditure the Ministry of Health do not have a complete overview of public health investment. The same is true for most DHBs. The lack of this tracking compromised my funding analysis and raises questions as to why this information is not systematically collected and/or fed into planning.

I remain strongly interested in the extent to which the dynamics of racism and privilege as documented in this study are echoed or different from the experiences of indigenous peoples in other colonial contexts. I utilised published indigenous analysis, particularly Māori analysis, where possible but found it increasingly difficult to source material around the specifics of public health policy making and funding practices as the study advanced. This study would have been strengthened by expanding it into a comparative study with Australia, Canada or both. The logistics of establishing the trusting relationships with indigenous collaborators in another country were beyond the resources of this study.

Whānau ora is embedded within Māori tikanga. Since 2002, it has been the major Māori health platform of successive governments. Under the National-led government, increased emphasis has been placed on whānau ora through the work of the Whānau Ora Taskforce. Many remain optimistic that a well-resourced *Whānau Ora* program could revolutionise service delivery to Māori communities. Due to the

timing of this study, I believe it was premature to assess the impact of this program. As a result, it has only made a fleeting appearance in this study. I maintain the existence of the *Whānau Ora* program does not invalidate the systemic racism I have documented in this study.

12.5 Concluding Comments

> Surely if you are acting for what is tika and pono than the consequences of that even if they might seem harsh or bad there has to be some sort of ethical line you are working from here, some sense of ethics. People just need to have some courage and do what is right
>
> (Kuraia, 2010, September 23, p. 4).

On average, every week in Te Tai Tokerau there is a tangi. Frequently that death is both premature and preventable. Access to appropriate health services could have improved both the quality of that person's life and its length. These deaths are a tragic cultural, social and economic loss to the people of Te Tai Tokerau and Aotearoa.

This study documented the systemic failure of Crown agencies, under different governments to develop inclusive policy and undertake consistent funding practices within the public health sector. Furthermore, it revealed the failure of Crown agencies to detect institutional racism within their own organisation practices. The controls in place to prevent this within both the public service, and the international community administered by the United Nations, have not prevented this failing. I suggest the outcome of these failings is reflected in reduced service delivery to Māori communities, which thereby contributes to poorer health outcomes and premature death.

The intervention framework within this study proposes a multi-entry systems approach to transforming racism. It outlines structural and organisational pathways, emphasises the importance of strengthening controls and deliberately improving racial climate. It also offers particular remedies to address systemic racism within Crown policy making and funding practices. The recognition of indigenous sovereignty and the honouring of *Te Tiriti o Waitangi* lie at the heart of this framework.

I hope the insights gleaned from this study are utilised to achieve transformative collective action and the demise of institutional racism as part of a wider social movement for change. Once this takes place I suggest Māori health and potential will flourish, and Crown officials administering the health system will act with more care, integrity and fairness.

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Appendices

Appendix A: Log of Official Information Request Correspondence with Ministry of Health

Date	In/Out	From	To	Description
6/12/2010	OUT	Heather Came	Ministry of Health	Initial OIR Health Funding
13/12/2010	IN	MOH	Heather Came	Confirmation of OIR [Ref H201004824]
13/12/2010	IN	Richard Morris, MOH	Heather Came	Clarifying OIR
13/12/2010	OUT	Heather Came	Richard Morris, MOH	Clarifying OIR
17/12/2010	IN	Phone appointment	Richard Morris	Response to OIR
14/2/2011	OUT	Heather Came	Richard Morris, MOH	Clarifying OIR
14/2/2011	IN	Richard Morris, MOH	Heather Came	Clarifying OIR
14/2/2011	OUT	Heather Came	Richard Morris, MOH	Clarifying OIR
9/3/2011	OUT	Heather Came	Richard Morris, MOH	Request update on OIR
22/3/2011	OUT	Heather Came	Kevin Woods, MOH Richard Morris, MOH	Request update on OIR
1/4/2011	OUT	Heather Came	Richard Morris, MOH	Request update on OIR
1/4/2011	IN	Phillip Berghan-Whyman	Heather Came	Acknowledge receipt OIR
1/4/2011	OUT	Heather Came	Phillip Berghan-Whyman, MOH	Dialogue re extension
28/4/2011	IN	Richard Morris, MOH	Heather Came	Response to OIR
16/5/2011	OUT	Heather Came	Richard Morris, MOH	Clarification of OIR response
17/5/2011	IN	Callum Sutherland, MOH	Heather Came	Confirmation of OIR [Ref H201101422]
13/6/2011	IN	Richard Morris, MOH	Heather Came	Response to OIR
17/6/2011	OUT	Heather Came	Richard Morris, MOH	Request update on OIR
17/6/2011	IN	Callum Sutherland, MOH	Heather Came	Acknowledge receipt OIR
24/8/2011	OUT	Heather Came	Richard Morris	Clarification to OIR
29/8/2011	IN	MOH	Heather Came	Acknowledge receipt of OIR [Ref H201102640]
6/9/2011	IN	Richard Morris, MOH	Heather Came	Response to OIR

Appendix B: Log of Official Information Request Correspondence with DHBs

Date	In/Out	From	To	Description
14/02 2011	OUT	Heather Came	ALL DHB CEOS	Official Information Request about their public health investment
	IN	Phil Cammish, Bay of Plenty DHB Jim Green, Tairawhiti DHB	Heather Came	Email clarification exchange
	IN	Lyn Butler, Counties Manukau DHB Chris Flemming, South Canterbury DHB Brian Rousseau, Southern DHB	Heather Came	Confirmation of receipt of OIR
15/02/2 011	IN	Dave Davies, Waitemata DHB Donna Straiton, Waikato DHB Gary Smith, Auckland DHB Tricia Wells, Whanganui DHB Tracy Oneale, Wairarapa DHB Maegan McIsaac, Nelson Marlborough DHB	Heather Came	Confirmation of receipt of OIR
15/02/2 011	IN	Arlene Gross, South Canterbury DHB Graham Dyer, Hutt Valley DHB Maegan McIsaac, Nelson Marlborough DHB	Heather Came	Clarification of OIR
15/11/2 011	OUT	Heather Came	Jim Green, Tairawhiti DHB Arlene Goss, South Canterbury DHB Graham Dyer, Hutt Valley DHB Maegan McIsaac, Nelson Marlborough DHB	Clarification of OIR
15/02/2 011	IN	Jim Green, Tairawhiti DHB	Heather Came	OIR Initial response
16/02/2 011	IN	Jan Adams, Waikato DHB Tim Woods, Waitemata DBH	Heather Came	Clarification of OIR
16/02/2 011	OUT	Heather Came	Jan Adams, Waikato DHB	Clarification of OIR
16/02/2 011	IN	Shan Tapsell, Lakes DHB	Heather Came	Confirmation of receipt of OIR
17/02/2 011	IN	Tricia Wells, Whanganui DHB	Heather Came	Dialogue around scope of OIR
17/02/2 011	OUT	Heather Came	Tim Woods, Waitemata DBH Tricia Wells, Whanganui DHB	Clarification of OIR
17/02/2 011	IN	Mark Bowen, West Coast DHB	Heather Came	Response to initial OIR
18/02/2 011	IN	Mike Grant, Midcentral DHB	Heather Came	Response to initial OIR
21/02/2 011	IN	Tricia Wells, Whanganui DHB	Heather Came	Dialogue around scope of OIR
22/02/2 011	IN	Shan Tapsell, Lakes DHB	Heather Came	Charging rates for OIR recovery
22/02/2 011	OUT	Heather Came	Tricia Wells, Whanganui DHB	Clarification of OIR
24/02/2 011	IN	Andrew Old, Auckland DHB	Heather Came	Clarification of OIR

Date	In/Out	From	To	Description
24/02/2011	OUT	Heather Came	Mark Bowen, Westcoast DHB	Clarification scope of OIR
24/02/2011	IN	Mark Bowen, Westcoast DHB	Heather Came	Extension of timeframe to respond OIR
25/02/2011	IN	Tricia Wells, Whanganui DHB	Heather Came	OIR initial response
28/02/2011	IN	Hiranthi Abeygonesekera, Capital Coast DHB	Heather Came	Confirmation of receipt of OIR
7/03/2011	IN	Mike Cummins, Nelson Marlborough DHB	Heather Came	Extension of timeframe to respond OIR
7/03/2011	OUT	Heather Came	Mike Cummins, Nelson Marlborough DHB	Confirmation of extension
8/03/2011	IN	Tracey Adamson, Wairarapa DHB	Heather Came	Response to OIR clarification
9/03/2011	IN	Garry Smith, Auckland DHB	Heather Came	Request for extension
10/03/2011	IN	Arlene Gross, South Canterbury DHB	Heather Came	Extension of timeframe to respond OIR
11/03/2011	OUT	Heather Came	Arlene Gross, South Canterbury DHB	Confirmation of extension
11/03/2011	IN	Geraint Martin, Counties Manukau DHB Karen Roach, Northland DHB	Heather Came	OIR initial response
14/03/2011	IN	Karina Thomson, Bay of Plenty DHB	Heather Came	Update on OIR response
14/03/2011	IN	Cherie Wills, Southern DHB	Heather Came	OIR initial response
14/03/2011	IN	Dave Davies, Waitemata DHB	Heather Came	OIR initial response
18/03/2011	IN	Brett Paradine, Waikato DHB	Heather Came	OIR initial response
25/03/2011	IN	Garry Smith, Auckland DHB	Heather Came	OIR initial response
29/03/2011	IN	Karin Thomson, Bay of Plenty DHB	Heather Came	OIR initial response
30/03/2011	IN	Shan Tapsell, Lakes DHB	Heather Came	Update on OIR response
30/03/2011	IN	Sandra Boardman, Taranaki DHB	Heather Came	Partial response to OIR clarification
31/03/2011	IN	Arlene Gross, South Canterbury DHB Maegan McIsaac, Nelson Marlborough Sandra Williams, Capital Coast DHB	Heather Came	OIR initial response
4/04/2011	IN	Kevin Snee, Hawkes Bay DHB	Heather Came	Initial OIR response
7/04/2011	IN	Graham Dyer, Hutt Valley DHB	Heather Came	Response to initial OIR
12/04/2011	IN	Cathy Cooney, Lakes DHB	Heather Came	Charging rates for OIR response
11/05/2011	IN	Greg Bogden, Canterbury DHB	Heather Came	Initial response to OIR
16/05/2011	OUT	Heather Came	Mike Grant, Midcentral DHB	Follow up re OIR response
23/06/2011	OUT	Heather Came	Kevin Snee, Hawkesbay DHB	Clarification of OIR response

Date	In/Out	From	To	Description
27/06/2011	OUT	Heather Came	Donne Winnard, Counties Manukau DHB Tracey Adamson, Wairarapa DHB Sandra Boardman, Taranaki DHB Nicolette Pomana, Hutt Valley DHB Karen Roach, Northland DHB Sandra Williams, Capital Coast DHB Paul Bohmer, Auckland DHB Tricia Wells, Whanganui DHB Dave Davies, Waitemata DHB John Peters, Nelson Marlborough DHB Brett Paradine, Waikato DHB Jim Green, Tairawhiti DHB Arlene Gross, South Canterbury DHB Robert Mackway-Jones, Southern DHB Greg Brogden, Canterbury DHB Mike Grant, Midcentral DBH Karina Thomson, Bay of Plenty DHB	Clarification of OIR response
27/6/2011	OUT	Heather Came	Cathy Cooney, Lakes DHB	Appeal re OIR charges
27/06/2011	IN	Tricia Wells, Whanganui DHB Uaine Akari, Waitemata DHB Robert Mackway-Jones, Southern DHB	Heather Came	Clarification of OIR response
28/06/2011	IN	Arlene Gross, South Canterbury DHB	Heather Came	Update re OIR clarification
29/06/2011	IN	Karina Thomson, Bay of Plenty DHB	Heather Came	Update on OIR clarification
29/06/2011	IN	Shona McLeod, West Coast DHB	Heather Came	Clarification of initial OIR
30/06/2011	OUT	Heather Came	Shona McLeod, Westcoast DHB	
30/07/2011	IN	Paul Bohmer, Auckland DHB Donne Winnard, Counties Manukau DHB	Heather Came	Update on OIR clarification
30/07/2011	IN	Karina Thomson, Bay of Plenty DHB Mike Cummins, Nelson Marlborough DHB	Heather Came	Complete OIR clarification
1/07/2011	OUT	Heather Came	Doone Winward, Counties Manukau DHB	Confirmation of OIR extension
12/07/2011	IN	Brett Paradine, Waikato DHB	Heather Came	Update on OIR clarification
13/07/2011	IN	Garry Smith, Auckland DHB	Heather Came	Response to OIR clarification
14/07/2011	IN	Brett Paradine, Waikato DHB	Heather Came	Complete OIR clarification

Date	In/Out	From	To	Description
15/07/2011	IN	Geraint Martin, Counties Manukau DHB	Heather Came	Response to OIR clarification
18/07/2011	IN	Steve Perry, Taranaki DHB Mark Bowen, West Coast DHB	Heather Came	Update on OIR clarification
19/07/2011	IN	Shan Tapsell, Lakes DHB	Heather Came	Partial response to OIR
19/07/2011	IN	Mark Bowen, West Coast DHB	Heather Came	Complete OIR
22/07/2011	IN	Tracey Oneale, Wairarapa DHB	Heather Came	Complete OIR clarification
22/07/2011	IN	Sandra Boardman, Taranaki DHB	Heather Came	Partial clarification of OIR
25/07/2011	IN	Dale Bramley, Waitemata DHB	Heather Came	Complete OIR clarification
25/07/2011	IN	Karen Roach, Northland DHB	Heather Came	Partial response to OIR
29/07/2011	IN	Jim Green, Tairawhiti DHB	Heather Came	Response to OIR clarification
5/08/2011	IN	Kevin Snee, Hawkesbay DHB	Heather Came	Complete OIR clarification
12/08/2011	OUT	Heather Came	Greg Brogden, Canterbury DHB Paul Bohmer, Auckland DHB Sandra Williams, Capital Coast DHB	Follow up OIR
25/08/2011	OUT	Heather Came	Arlene Gross, South Canterbury DHB Sandra Boardman, Taranaki DHB Sandra Williams, Capital Coast DHB Mike Grant, Midcentral DHB	Follow up OIR
25/08/2011	IN	Sandra Williams, Capital Coast DHB	Heather Came	Confirmation of OIR clarification
25/08/2011	IN	Arlene Gross, South Canterbury DHB	Heather Came	Update on OIR clarification
26/08/2011	OUT	Heather Came	Greg Brodgen, Canterbury DHB Tricia Wells, Whanganui DHB Uaine Akari, Waitemata DHB Tracy Oneale, Wairarapa DHB Nicolette Pomana, Hutt Valley DHB Kathryn Leydon, Northland DHB Paul Bohmer, Auckland DHB	Follow up OIR
26/10/2011	IN	Nicholette Pomana, Hutt Valley DHB Uaine, Akari, Waitemata DHB	Heather Came	Update on OIR
29/08/2011	IN	Sandra Williams, Capital Coast DHB	Heather Came	Request for extension on OIR
3/08/2011	IN	Greg Brogden, Canterbury DHB	Heather Came	Update on OIR
31/08/2011	IN	Tricia Wells, Whanganui DHB Garry Smith, Auckland DHB	Heather Came	Response to OIR clarification

Date	In/Out	From	To	Description
1/9/2011	IN	Arlene Gross, South Canterbury DHB	Heather Came	Response to OIR clarification
9/10/2011	OUT	Heather Came	Tammy Taylor, Taranaki DHB	Clarification on OIR
15/10/2011	OUT	Heather Came	Sandra Williams, Capital Coast DHB	Clarification on OIR
15/9/2011	IN	Tracy Oneale, Wairarapa DHB Sandra Williams, Capital Coast DHB	Heather Came	Response to OIR clarification
2/10/2011	OUT	Heather Came	Karen Roach, Northland DBH Arlene Gross, South Canterbury DHB Sandra Boardman, Taranaki DHB Tricia Wells, Whanganui DHB Nicolette Pomana, Hutt Valley DHB Robert Mackway-Jones, Southern DHB	Clarification of OIR response
3/10/2011	OUT	Heather Came	Mike Grant, Midcentral DHB Cathy Cooney, Lakes DHB	Chase up OIR response
3/10/2011	IN	Robert Mackway-Jones, Southern DHB	Heather Came	Responses to OIR clarification
4/10/2011	IN	Arlene Gross, South Canterbury DHB	Heather Came	Confirmation of clarification
4/10/2011	IN	Josie Boland, Canterbury DHB	Heather Came	Response to OIR clarification
5/10/2011	IN	Nicolette Pomana, Hutt Valley DHB	Heather Came	Update on OIR clarification
12/10/2011	OUT	Heather Came	Tammy Taylor, Taranaki DHB	Clarifying OIR response
12/10/2011	IN	Vicki Kershaw, Taranaki DHB	Heather Came	Partial response to OIR
17/10/2011	IN	Vicki Kershaw, Taranaki DHB	Heather Came	Response to OIR clarification
17/10/2011	OUT	Heather Came	Niki Michael, Midcentral DHB	Chasing up OIR response
17/11/2011	IN	Niki Michael, Midcentral DHB	Heather Came	Confirmation of clarification of OIR
17/11/2011	IN	Craig Johnston, Midcentral DHB	Heather Came	Response to OIR clarification
18/10/2011	IN	Karen Roach, Northland DHB	Heather Came	Partial response to OIR clarification
21/10/2011	OUT	Heather Came	Fleur King, Northland DHB	Clarification OIR response
21/10/2011	IN	Nicolette Pomana, Hutt Valley DHB	Heather Came	Update on OIR clarification
26/10/2011	OUT	Heather Came	Kathryn Leydon, Northland DHB	Clarification OIR response
26/11/2011	IN	Debbie Oldham, Hutt Valley DHB	Heather Came	Response to OIR clarification
28/10/2011	IN	Shan Tapsell, Lakes DHB	Heather Came	Response to OIR
1/11/2011	IN	Joyce Donaldson, Northland DHB	Heather Came	Response to OIR

Appendix C: Public Health Provider Survey

Section A: Introduction

Do you currently or have you in the last five years held a public health contract with Ministry of Health?

Yes	No

Do you currently or have you in the last five years held a public health contract with a DHB

Yes	No

Which category applies to your organisation?

Regional PH provider	National NGO	PHO	Local NGO	Māori Provider	Other

What size is your organisation?

Small	Medium	Large

What year/decade did your organisation secure its first public health contract?

Section B: Contracts and Service Delivery

What is the usual contract time [timeframe] of your public health contracts?

1 year	2 year	3 years plus	Various	Evergreen

How frequently are your public health contracts usually monitored?

Never	Quarterly	Six Monthly	Annually	Various

Describe in a couple of sentences your experiences of contract monitoring?

To what extent do your current public health contracts fit with your organisational philosophy?

Easy Fit	Okay	Problematic	Complicated

How do you find the compliance costs of administering your public health contracts?

Light	Reasonable	Burdensome

How frequently have your public health contracts been audited in the last five years?

Not sure	Never	Once	2-5 Times	5+ times

Have any of your PH contracts been performance managed by funders in last five years?

Yes	No	Don't know

Section C: Relationships and Influence

How would you characterise your access to DHB funding and planning staff?

Limited	Complicated	Easy	Variable	Difficult

Describe in a couple of sentences your relationship with your DHB funders?

How would you characterise your access to Ministry public health funding and policy staff?

Limited	When required	Frequent	Variable

Describe in a couple of sentences your relationship with your Ministry funders?

Is/ has your team been represented on any DHB Steering/Advisory Groups in the last five years?

Never	Occasionally	Often	Constantly	Don't know

Is/has your team been represented on any Ministry Steering/Advisory Groups in the last five years?

Never	Occasionally	Often	Constantly	Don't know

Section D: Funding and Financial Accountability

Describe the extent and level of the financial reporting you are required to provide

Light	Reasonable	Burdensome

Do you get access to an annual cost of living adjustment?

Never	Occasionally	Often	Always

If you received this, did you apply or was it offered?

What success have you had in obtaining discretionary/ one-off funding in the last five years?

Never	Rarely	Occasionally	Often

What impact has the recession line-by-line review had on your organisation?

Little	Some	Extensive	Don't know yet

Section E: Te Tiriti o Waitangi

How effective do you believe your organisations service delivery is to Māori?

Limited	Developing	Developing/Strong	Strong

Please clarify how you assessed the level of effectiveness you indicated in the previous question?

What proportion of your PH resources is invested into Māori specific initiatives?

Less than 10%	About 25%	More than 50%

Appendix D: Research & Dissemination Strategy

Te Ao Māori

- Māori health providers
- Waitangi Tribunal Claimants
- Māori Media
- *Sharing evidence*
  Collaboration

Crown Agencies

- **Ministry of Health**
  Associate Minister
  He Kete Hauora
  Public Health Operations
- **District Health Boards**
  Governance
  Māori Managers
- **Other Crown Agencies**
  Human Rights Commission
- *Systems Change*
  Quality Assurance

Public Health Community

- **Public Health Association**
  National Conference
- **International PH Networks**
  Peoples Health Movement
  International Union of Health Promotion & Education
- *Professional debate*
  Conscientisation

Academic Community

- Management Studies
  Social Policy
  Political Science
  Public Health
  Womens Studies
- Conference Presentations
  Journal Articles
- *Building evidence*

Activist Community

- **Pākehā Tiriti Workers**
  National gathering
  Master classes
- **Trade Unionists**
  Combined Trade Union
  Public Service Association
- *Submission writing*
  CERD Reporting
  Targeted campaigning
  Conscientisation

Other

- **Mainstream Media**
  Interviews
- **Political Parties**
  Green Party
  Mana Party
  Māori Party
- Social Service ANGOA
- *Informed public*

Appendix E: Papers & Presentations Generated From Study

Chapter One: Introduction
Came, H and Humphries, M. (2011, July). Ongoing reach of institutional racism at *7ᵗʰ International Critical Management Studies Conference*, Naples Italy.
Chapter Two: Methodology & Method
Came, H. (2010). Activist scholarship: Doing political research In M. Campbell, C. Michelle & C. Simon-Kumar (Eds.), *Proceedings of the New Zealand Women's Studies Association Conference: Connecting Women, Celebrating Diversity* (pp. 13-24). Hamilton, New Zealand.
Chapter Three: Historical Patterns of Institutional Racism Within Crown Practice
Came, H. (2010, June). Policy origins of institutional racism at Challenging Politics: Emerging New Voices Conference (Peer reviewed paper), Brisbane Australia. http://www.polsis.uq.edu.au/docs/Challenging-Politics-Papers/Heather_Came_Policy_Origins_of_Insitutional_Racism_in_Aoteaora.pdf
Chapter Four: Theorising Racism & Privilege
Came, H. (2010, December). Theorising racism and privilege at *Annual New Zealand Political Science Association Conference*, Hamilton New Zealand.
Chapter Eight: Counter Narratives: Racism Within the Policy Cycle
Came, H. (2011). Racial climate in recent health policy and practice in Aotearoa. In A. Dickson & C. Prichard (Eds.), *Proceedings of Organization, Identify and Locality (OIL) V11* (pp. 42-50). Palmerston North, New Zealand.   Came, H (2011, November). How Crown agencies discriminate against Māori Public Health Providers at the *Waikato University Health and Social Science Research Colloquia*, Hamilton, New Zealand.
Chapter Ten: Counter Narratives: Differential Treatment of Public Health Providers
Came, H. (2011, September). Benchmarking Crown practice: Findings of a public health provider survey at the *Annual Public Health Association Conference: Creating Our Future Now*, Christchurch New Zealand.
Chapter Eleven: Transforming Institutional Racism & Privilege
Came, H. (2011, July). Disrupting institutional racism within health policy in Aotearoa New Zealand at *Australian Social Policy Conference: Social Policy in a Complex World*, Sydney Australia.   Came, H and da Silva, S. (2011). Building political competencies for the transformation of racism in Aotearoa. *Kotuitui*, vol 6(1), 113-123. doi: 10.1080/1177083X.2011.615332   Came, H and da Silva, S (2011, December). *Political competencies for antiracism workers* at Australian Critical Race Theory and Whiteness Conference: *Directions and Intersections*, Surfers Paradise, Australia.
Chapter Twelve: Looking Backward (Into) Looking Back (From The Research)
Came, H (2011, December). Transforming institutional racism in healthcare management in Aotearoa New Zealand In *Proceedings of 25ᵗʰ Anniversary Australia New Zealand Academy of Management Conference*, Wellington, New Zealand.

Waikato Management School
Te Raupapa

THE UNIVERSITY OF
WAIKATO
Te Whare Wānanga o Waikato

Participant Information Sheet

There is compelling evidence to support the existence of contemporary institutional racism and demonstrable inequities between Māori and Pākehā health outcomes. Through this research, I intend to make a contribution to the transformation of institutional racism and privilege. My focus is on the Crown through their funding, planning and policy making processes and practices in the provision of public health. I will work with a research whānau/reference group (made up of Māori health leadership and a Pākehā crone) constituted for the purpose of guiding, monitoring and advising through-out the research process.

The research aims to answer the following questions:
- To what extent and how is institutional racism and [majority] Pākehā privilege manifested within public health policy and funding frameworks and practices?
- What are the emerging directions to dismantling and preventing institutional racism within public health policy and funding?

This PhD research is being led by Heather Came who is being supervised by Dr Maria Humphries at the Waikato Management School, Waikato University. Heather has received a scholarship from the Tindall Foundation [2009] and a University of Waikato Doctoral Scholarship [2010] and will apply for other scholarships through the course of this study.

Informants are being asked to engage in a collaborative Storytelling process, this is likely to involve two or three 45 min to 60 min conversations. These mutually agreed conversations will be recorded and transcribed and sent back to participants to amend, add any further thoughts that may have since occurred, and sign-off on the mutually agreed themes. Central to this method is ongoing negotiations of themes as the basis for subsequent conversations that are agreed between Heather and the informants.

All material collected will be stored securely at Heather's home office in Onerahi, Whangarei. Heather's academic supervisors will have access to this material as requested to support the research process. Non-identifiable data will also potentially be shared with Heather's reference group to enable informed advice and support during data analysis.

The material gathered will be used to undertake analysis about the extent of institutional racism/privilege within public health funding and policy making. As part of the research process, there are plans for a gathering of all informants to review the draft findings before these are confirmed in the final document and to work towards building a consensus on future action.

Heather is happy to provide presentations to the organisations of informants throughout the research process. Heathers intention is to publish learnings from this research and findings in academic articles and present at relevant conferences. This dissemination will be discussed with the research whānau/reference group and other informants as appropriate.

The focus of this research is on institutional racism not personally mediated racism. Those that request confidentiality will be protected particularly those that are working within Crown organisations. Informants can opt in to the research through completion of the consent form and opt out of the research process up until the end of 2011 (or later by negotiation) by notifying Heather or Maria. If informants opt out there, transcripts and other documentation will be returned.

More information about the research can be obtained from:

Researcher's Name and contact information:
Heather Came, 1732 Pakiri Road, RD2 Wellsford 0972,   021 279 063,
heather.came@yahoo.co.nz

Supervisor's Name and contact information:
Dr Maria Humphries, Waikato School of Management, Waikato University, 027 292 8809, mariah@mngt.waikato.ac.nz

Consent Form for Participants

I have read the Information Sheet for Participants for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I also understand that I am free to withdraw from the study at any time, or to decline to answer any particular questions in the study. I agree to provide information to the researchers under the conditions of confidentiality set out on the Information Sheet.

Informants can opt out of the research process or withdraw particular material up until the end of 2011 (or later by negotiation) when data analysis is expected to be well underway by notifying Heather or Maria.

I agree to participate in this study under the conditions set out in the Information Sheet form.
I do/do not wish to be identified in the final thesis or publications.

Signed: _____
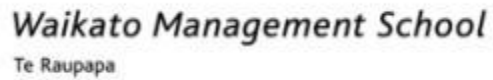Name: _____

Date: _____

Researcher's Name and contact information:
Heather Came, 1732 Pakiri Road, RD2 Wellsford 0972,   021 279 063, heather.came@yahoo.co.nz

Supervisor's Name and contact information:
Dr Maria Humphries, Waikato School of Management, Waikato University, 027 292 8809, mariah@mngt.waikato.ac.nz

Appendix H: Crown-Defined Treaty Principles

High Court Ruling: NZ Māori Council v Attorney-General 1987	Waitangi Tribunal Reports 1983-87	Royal Commission on Social Policy 1988	Labour Government statement on Treaty Principles 1989	Waitangi Tribunal Reports 1987-95
The acquisition of sovereignty in exchange for the protection of rangatiratanga.	The treaty implies a partnership, exercised with the utmost good faith.	Partnership.	The principle of government or kāwanatanga principle.	The exchange of the rights to make laws for the obligation to protect Māori interests.
The Treaty established a partnership, and imposes on the partners the duty to act reasonably and in good faith.	The exchange of the right to make laws for the obligation to protect Māori interests.	Participation.	The principle of self-management (the rangatiratanga principle).	The Crown obligation to protect Māori treaty rights.
The freedom of the Crown to govern.	The Māori interest should be actively protected by the Crown.	Protection.	The principle of equality.	The need for compromise by Māori and the wider community.
The Crown's duty of active protection.	The needs of both Māori and the wider community must be met, which will require compromise on both sides.		The principle of reasonable co-operation.	Duty to consult.
Crown duty to remedy past breaches.	The courtesy of early consultation.		The principle of redress.	The Crown cannot divest itself of its obligations.
Māori to retain rangatiratanga over their resources and taonga and to have all the privileges of citizenship.	The Crown cannot evade its obligations under the treaty by conferring authority on some other body.			The Crown's obligation legally to recognise tribal rangatiratanga.
Duty to consult.	The treaty is an agreement that can be adapted to meet new circumstances.			The tribal right of self-regulation.
	Tino rangatiratanga includes management of resources and other taonga according to Māori cultural preferences.			The right to development.
	Taonga includes all valued resources and intangible cultural assets.			The Crown's right of pre-emption and its reciprocal rights.
				The principle of options.

Note: Adapted from "The principles of the Treaty of Waitangi" by J. Hayward in *Rangahau whanui national overview report*, A. Ward (Ed), 1997, Wellington, New Zealand: Waitangi Tribunal; *The April report*, by Royal Commission on Social Policy, 1988, Wellington, New Zealand: Author; *He tirohanga ō kawa ki te Tiriti o Waitang*i by Te Puni Kōkiri, 2002, Wellington, New Zealand: Author.

CHECKLIST – Applying the Bill of Rights Act Non-Discrimination Standard

(as set out in Part 1A of the Human Rights Act)

1. Whose actions are covered by Part 1A Human Rights Act?
a. Legislative, executive, and judicial arms of government, and
b. Any person or body in the performance of:
- Public functions, powers or duties;
- Conferred or imposed by or pursuant to law.
(Section 3)

Other Actors

Human Rights Act Part II may apply

2a. What actions (by those actors) are covered by Part 1A of the HRA?
- Legislation
- Decisions by the Crown
- Policies, practices, and services

2b. What actions (by those actors) are NOT covered by Part 1A of the HRA?
Policies, practices, and services in relation to:
- Employment
- Racial harassment
- Sexual harassment
- Victimisation

3. Is there discrimination?
1. Does the action make a distinction based on one of the prohibited grounds of discrimination?
2. If so, does the distinction involve a disadvantage to the person or group?
(Section 19(1))

NO

YES

NOT Discrimination under Bill of Rights Act and therefore NOT discrimination under Part 1A of Human Rights Act

4. Is it affirmative action?
"Measures taken in good faith for the purpose of assisting or advancing persons or groups of persons disadvantaged because of discrimination that is unlawful by virtue of Part II of the Human Rights Act 1993 do not constitute discrimination".
(Section 19(2))

YES

NO - *Prima facie* (on its face) discrimination

5. Is the discrimination justifiable?
1. Is there an important and significant objective; and
2. Is there a rational and proportionate connection between the objective and the means used to achieve it?
(Section 5)

YES

6. What to do if you find discrimination under Part 1A Human Rights Act?
Options include:
- Modify policy, etc, to achieve objective in a less or non-discriminatory manner
- Seek legal advice on compliance/Bill of Rights Act developments
- Consider whether policy necessary or can be abandoned
- Consider risks, which include:
  - negative compliance statements in Cabinet papers
  - if legislation - section 7 Bill of Rights Act report to the House
  - inquiry by/complaints to Human Rights Commission
  - cases to Tribunal/Courts - substantive remedies or, if legislation, declarations of inconsistency with Parliamentary and Government follow-up
  - review of regulations by Regulations Review Committee

Reproduced from *Checklist: Applying the Bill of Rights Act non-discrimination standard* by Ministry of Justice, 2010, p.2. Wellington, New Zealand: Author. Reprinted with permission.

Appendix J: Log of Health Related Waitangi Tribunal Claims

Date	WAI No.	Claimant	On behalf of	Health Related Claims
27/08/2008	2278 #1.1.1	Tracy Waitokia	Whanganui Iwi	Rangatira and mana of Māori women; imposition of cultural, political and social and economic systems; poor health statistics and institutional racism.
28/07/2008	1601#1.1.1	Tania Hodges, Kris MacDonald	Mana motuhake blanket claim	Mainstream health system systematically fails Māori. Removal of Treaty clauses from legislation and contracts. Impact of economic reforms of 1980s and 1990s.
31/08/2008	1819#1.1.1	Richard Paki	King Country Māori	Increased exposure to the determinants of ill health. Creation of a system which has produced severe disparities in health outcomes. Lack of accessible heath services. Underfunding Māori services. Imposition of mono-cultural western based medical system. Structural and interpersonal racism.
12/02/2009	2053#1.1.1	Mona Kupa and Hera Ferris	Ngati Ngarengare and Muaupoko	Disparities in health outcomes. Imposition of mono-cultural western based medical system. Structural and interpersonal racism.
12/08/2002	1018#1.1	Irene Apihka Mullen-Mack	Otaraua and Rāhiri hapū ki Waikanae of Atiawa ki Waikanae	Long term oppressive impact of government social, economic, health policies. Dispossession of lands, fishing rights and economic development opportunities. Poor health statistics. Institutional racism and prejudicial behaviour by key government agencies including health system.
7/07/2009	1817#1.1.1	Kalern Paki	Te Paparahi o Te Raki	Exposure to determinants of ill health. Lack of health system responsiveness. Poor quality of care and preventative education. Imposition of medical system based exclusively on western scientific models discounting traditional healing models.

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8/08/2008	2260#1.1.1	Papaarangi Reid & Ripeka Evans	Te Tai Tokerau	Rangatira and mana of Māori women; imposition of cultural, political and social and economic systems; poor health statistics and institutional racism. Exposure and effects of colonisation. Assumption of right to govern and enact laws by Crown.
8/01/1998	692#1.1	Hana Loyla Cotter, Takuta Hohepa Mei Emery & Pirika Tom Hemopo	Te Tai Whenua o Te Whanganui a Orotu & Ngati Kahungunu	Removal of hospital services from Napier and the consultation process there in. Poor health statistics. Inadequate representation Māori in health authorities in Hawkes Bay region. Failure to protect health as taonga. Institutional racism. Defective legislative framework administering health sector. Failure to monitor Māori health policies.
29/08/2008	1821#1.1.1	Wikuki Kingi Snr, Fraser Tawhai & Wikuki Kingi Jnr	Kirikiriroa Marae and community	Failure to consult, provide equitable funding and protect interests urban Māori. Detrimental impact of social policy.
29/08/2008	2164#1.1.1	Te Huia Bill Hamilton	Hamilton, Ruawai, Aperhama, Watene, Te Teira, Kiripaeahi, Ihaia, Iraia, Kereama whānau	Historic injustices. Failure of good governance and to protect rangatiratanga through assimilation laws, policies and practices.
26/08/2008	2242#1.1.1	Tracey Dalton	Te Tai Tokerau	Administration of local government and the marginalisation of Māori within resource management and conservations lands. Impact of colonisation and Crown led heath institutions. Widespread alienation of land and ensuring socio-economic deprivation. Lack of health system responsiveness. Exposure to the determinants of ill health.
29/06/2004	1184#1.1	Pat Ngata	Ngati Porou	Lack of appropriate standard of healthcare.
12/05/1995	508	Awaroa ki Manukau	Ngati te Ata	Failure to protect Māori interests in surplus Crown lands and wahi tapu. Failure to promote Māori language. North Health failure to consult.

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17/09/2002	686#1.23 A(a) & 508#1.1a	Whititera Kaihau	Ngati te Ata & Ngati Kahukoka a Hapū	Alienation of land, imprisonment of tupuna, imposition of law. Upholding the English version of the treaty.
25/10/1994	473	Tom Hemopo	Te Taiwhenua o Whanganui a Orotu	Removal of health services from Napier and lack consultation. Inconsistent implementation of policy.
27/08/2008	2106#1.1.1	David McDonald, Morehu MacDonald	Heeni Rawiri Whānau, Ngati Tokotoko hapū, Ngati Hinerangi Iwi	Alienation of lands, maladministration of education and health systems.
12/09/1991	261	T Paki and E Manukau	Ngati Whātua	Alienation of land.
10/10/2002	261#1.1.b	Hoani Neri Porter, Eriapa Maru Uruamo	Ngati Koromatua hapū, Te Taou iwi	Alienation of land. Failure to provide adequate education and health services.
18/08/2008	1739#1.1.1	Te Rau o Riwa, Marlene Jocelyn Davis	Ngati Haua, Ngaruahine iwi	Alienation of land. Health and education policies. Poor governance.
15/08/2008	2295#1.1.1	Thomas Anzac Te Rangi	Mangakāhia	Alienation of land. Health and education policies. Poor governance.
18/08/2008	1743#1.1.1	Cyril Te Rangiwaewae	Ngati Haua hapū, Ngaruahine iwi	Alienation of land. Health and education policies. Poor governance.
18/08/2008	1744#1.1.1	Marylinda Brooks, Gloria Kerehoma, Pue Barry Whakaruru, Faith Wharemate & Ngaraina Brooks	Okahu/Inuawai hapū	Alienation of land. Health and education policies. Poor governance.
18/08/2008	1748#1.1.1	Kerehoma, Hauwhenua, Reihana Ngana, Tauke and Rangiwananga Whānau	Okahu/Inuawai hapū	Alienation of land. Health and education policies. Poor governance.
15/08/2008	1755#1.1.1	Julian Ihaia Rewiti	Te Orewai hapū, Ngati Hinemaru iwi	Policies, practices and actions of the Crown. Burning of house under the Public Health Act 1900; forced relocation.
27/8/2008	1606#1.1.1	Ratapu Kaa	Te Koropatu marae, Ngati Peehi/Ngati Te Kanawa Hapū	Alienation of land. Health and education policies. Poor governance.
	844	Huhana Mihinui	NZ Māori Council	Disproportionate Māori smoking rates and deaths. Focus of tobacco education campaigns.

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29/04/1994	433	Tarati Hoheps-Birks	He Putea Atawhai & Ngati Kahu iwi	Prejudicially affected by social policy; particularly HOMES disability strategy. Should include kaupapa Māori evaluation.
4/08/1995	538#1.1	Ivy Waitangi Kapua	Ngati Whaita Hapū of Ongaroto marae	Alienation of land. Historic and contemporary Crown legislation and education, health, social services, housing, justice, employment policies.
2/08/1995	535#1.1 & 48#1.13	Rongoherehere Wetere	Ngati Maniapoto iwi	Alienation of lands. Destruction of flora, fora, indigenous industry and war. Administration of education, health, social services, housing, justice, employment policies.
10/4/1984	11	Huirangi Waikerepuru	Nga Kai Whakapumau i te reo	Failure to protect Māori language: radio, television and education. Policy regarding speaking Māori in hospitals.
23/08/2008	1818#1.1.1	Thomas Te Winitana Maniapoto, Winston Te Winitana Maniapoto & Georgina Haereroa	Ngati Paretekawa	Failure to protect traditional healing practices. Failure to provide adequate health services, particularly mental health services. Land and resource alienation.
11/08/2008	1926#1.1.1	Harold Te Pikikotukuku Maniapoto & Dana Erina Maoia_Maniapoto	Ngati Pare Te Kawa iwi	Failure to protect the health of river systems from pollution. Failure to protect spiritual health, mauri, wairua of life force. Compromised fishing practices and rangatiratanga.
7/05/2007	1415#1.1.1	Violet Sade	Te Waiariki, Ngati Kororoa & Ngati Taka	Crown allowed socio-economic deprivation. Unable to fulfil kaitiakitanga functions.
5/08/2008	2309#1.1.1	Rhoda Hohepa Cartman-Mahanga	Ngati Tautah, Ngai Tawak, Te Uri o Hua hapū, Nga Puhi iwi	Land alienation, removal of ancestral relics, denial of rangatiratanga.
26/08/2008	2158#1.1.1	Marilyn Tamakehu, Jenny Tamakehu	Atihau Nui a Paparangi & Te Iwi o Whanganui	Failed to protect customs, cultural and spiritual heritage.
19/07/2009	2173#1.1.1	Carol Murray	Muaupoko	Disparities in health outcomes, destruction of hapū structures. Land alienation, lack of healthcare responsiveness.
19/12/2009	2237#1.1.1	Lindsey Te Ata o Tu MacDonald	Ngai Tahu	Prejudicially affected by health sector policies. Poorer quality healthcare for Māori.
13/10/2004	1451#1.1.1	William Tukekeru Dansey	Tuwharetoa iwi & Rauhoto a Tia hapū	Land alienation. Poor health, sickness & mortality.

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30/08/2008	2253#1.1.1	Alison Thom	Ngati Horehia, Ngati Toki, Ngati Kororoa hapū and Nga Puhi iwi	Impact of colonisation. Lack of equitable opportunity and social disadvantage.
11/11/2005	1315#1.1.1	Taitimu Maipi, Tureiti Moxon, Elaine Tapsell & Hakopa Paul	Māori PHO coalition	Prejudicially affected by health regulations and policies in relation to establishment PHOs. Doesn't recognise inequities in health outcomes.
19/06/2009	2065#1.1.1	Patrick Tangaere	Te Tai Rawhiti	Impact on mana and rangatiratanga of Māori men. Poor health statistics.
31/08/2008	1770#1.1.1	Anthony Paki	King Country Māori	Disparities in health outcomes. Destructions of hapū structures and mechanisms of healing. Land alienation. Lack of health system responsiveness.
28/03/2001	1096#1.1.	Tunuiarangi Rangi McLean	Tamaki Makaurau Health Trust & Kotahitanga Community Trust	PHO establishment process inconsistent with *He Korowai Oranga*.
29/08/2008	17221#1.1.1	Rodney Ngawaka	Ngati Rehua & Ngati Wai ki Aotea	Disparity in health outcomes.
13/03/2009	2051#1.1.1	Whetu Kenirck	Ngati Mihiroa & Muaupoko	Maori mental health statistics and access to services. Failure of health policy.
28/05/2009	2091#1.1.1	Barbara Tangiahua	Ngati Hauiti	Disparities in Māori mental health outcomes.
12/03/2009	21212#1.1.1	Inuwai McKinnon	Ngati Tahinga & Ngati Maniapoto	Disparities in health outcomes. Destruction of hapū structures and mechanisms of healing. Land alienation. Lack of health system responsiveness.
12/08/2008	2143#1.1.1	Karen Frances Pointon & Steven Lance Wilson	Ngati Turi	Māori deaf and disabled not resourced for self-management. Crown lack of policy analysis of Māori with disability.
22/10/2009	2145#1.1.1b	Apihaka Mack, Marama Pala, Peter Tamiana & Kepas Pala	Ina Māori & South Pacific HIV/AIDS Foundation	Failure of NZAF to be inclusive of Māori in their service delivery. Disparities in infection rates due lack service provision.
1/09/2008	1701#1.1.1	Haami Piripi	Te Rarawa	Governance, water quality, undermining rangatiratanga, social and economic deprivation. Inadequate health services.
30/10/2000	888#1.1.1	Joseph Harawira, Matiaha Kohe, New Zealand Māori Council	Māori who worked at the Whakatane Sawmill and their whānau	Health impacts use of pentachlorophenate (PCP) and dioxins in Whakatane saw mill i.e. birth defects, skin diseases and terminal illnesses.

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21/08/2008	1816#1.1.1	Lance O'Sullivan	Northland Inquiry District	Exposure to the determinants of ill health.
20 May 2009	306#1.1(b) & 1017#1.1.(c)	Eru Kaukau & Kahuterangi Hamiora	Ngati Haua	Land and resource alienation. Failure to provide adequate health services.
24/03/2009	2070#1.1.1	Ratu Reihana	Hikuroa	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
28/08/2008	2097#1.1.1	John Kahui Hillman	Te Mai Koha	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
29/08/2008	1507#1.1.1	Pouri Te Wheoki Harris, Huriwaka Hare, Taite Renata, Raymond Matetawiti Harris, Tass Davis, Kauae & Hohepa Hare	Nga Uri o Taupoto, Ngati Toro and Nga Puhi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
26/08/2008	1519#1.1.1	Kaahurangi Josephs	Ngati Whatua	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
28/08/2008	1531#1.1.1	Enga Harris	Whānau	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
26/08/2008	2024#1.1.1	Taipari Munro	Tahuhunuiarangi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
27/08/2008	2025#1.1.1	Raewyn Maria Toia	Ngati Toro hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
7/04/2009	2030#1.1.1	Julian P Hati	Ngati Kurukupakiaka	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.

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29/08/2008	2034#1.1.1	Mark Anthony Turu Maipi	Te Uri o Mate hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
29/08/2008	2035#1.1.1	Joseph Nicholson Hohepa Heta	Ngati Naho & Te Paina hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
28/08/2008	2041#1.1.1	John Kahui Hillman	Te Tutanekai	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
1/09/2008	2049#1.1.1	William Peter Hatu	Whānau	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
17/08/2008	2055#1.1.1	Guy Naden	Ngai Tama	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
29/08/2008	2081#1.1.1	Ben Katipa	Ngati Amaru & Ngati Pou hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
26/08/208	2105#1.1.1	Lee Ann Martin	Ngati Ira hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
26/08/2008	2107#1.1.1	Lee Ann Martin	Ngati Ngahere & Ngati Ira hapū	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
24/08/2008	2110#1.1.1	Morehu McDonald	Ngati Hinerangi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
14/08/2008	2111#1.1.1	Yvonne Rauwhero, Matuakore McMillan Koperu & Morehu McDonald	Ngati Hinerangi, Ngati Tamapango, Ngati Tokotoko, Ngati Tangata, Ngati Kura, Ngati Whakamaungarangi, Ngati Te Riha & Ngati Tawhaki	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.

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14/08/2008	2112#1.1.1	Tukiterangi Rawiri-McDonald, Morehu McDonald	Te Ohaki marae, Ngati Tokotoko, Ngati Kura, Ngati Whakmaungarangi, Ngati Tawhaki hapū & Ngati Hinerangi iwi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga. Poor governorship.
14/08/2008	2113#1.1.1	Matuakore McMillan Koperu & Morehu McDonald	Ngati Tamapango, Ngati Tokotoko hapū, Ngati Hinerangi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga. Socio-economic hardship.
24/03/2009	2138#1.1.1	Taroi Kaka	Dorothy, Mary, Stanley, Kerry, Celia Kaka & Hokimate Taroi Kaka Whānau Trust	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga.
23/05/2001	938#1.1	Karehana Wicks	Ngai Tauwhao ki Otawhiwhi hapū Ngai Te Rangi iwi	Failure to provide adequate health services. Land alienation and development opportunities.
2/01/1985	17	MacCully Matiu	Ngati Kahu	Land alienation. Undermining traditional healing practices.
N.d.	179	Colin Malcolm	Ngati Kahu	Concerns regarding urupa (burial grounds) and wahi tapu (sacred ground).
29/08/2008	1812#1.1.1	Hoane Titahi John Wi, Tame Te Nuinga Tuwhangai, Raymond Tane, Christine Brears, Ruthe Cuthbertson, Lamia Rata, Te Aroha Hemana, Ameria Kereopa & Robert Jonathan	Ongarue, Ohura & Otunui River area	Prejudicially affected regulations and policies. Failure to protect taonga (treasures) such as rongoa (traditional medicines). Desecration of wahi tapu. Damage to spirit, wairua, mana and ihi of the claimants.
10/10/2003	973#1.1(a) & 900#1.1.27(a)	Phillip Hiroka Ripia	Te Whānau a Umuariki hapū, Ngati Uepohatu iwi	Land alienation. Maladministration of health, education. Denial of rangatiratanga and kaitiakitanga. Poor governorship.
8/04/2002	967#1.1.1	Peter Love	Wellington Tenths Trust	Land alienation. Poor mental health service delivery to Māori
16/10/1990	181	Ngawata Eliza Page & Honey Thomas	Ngati Mutunga, Ngati Tama, Te Atiawa	Sale of surplus Crown lands by local DHB.
10/04/1990	292	Awarua Karena Wiki	Whānau	Sale of surplus Crown lands by local DHB.

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6/09/1991	233	Anaru Rangiheuea	Rotomahana Parekarangi	Land alienation.