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TE WHARE WĀNANGA O TE KURAHUNA
MAHI A ATUA
TĒNEI TE PŌ NAU MAI TE AO- TRANSFORMATION IN ACTION
Mahi a Atua:
Committed to developing indigenous systems for positive community outcomes.

Tēnei te Po Nau Mai Te Ao - Transformation in Action: Equity and Institutional Racism

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Be brave, be bold, be curious, and embrace the potential of Mahi a Atua and Te Kurahuna!

The pūrākau of Mataora, tells the story of an ariki (high chief) who had believed he was not accountable to anybody. However, guided by the love he had for his wife, Niwareka, Mataora became a kaitiaki for changing attitudes, beliefs and behaviour; firstly his own and then actively influencing changes in those around him. Guided by the knowledge embedded in the pūrākau of Mataora, Te Whare Wānanga o Te Kurahuna understands genuinely addressing equity for Māori requires an uniquely transformative Indigenous approach. Te Kurahuna is the kaitiaki of Mahi a Atua: a 'way of being' which privileges Indigenous knowledge and practice as the basis for addressing institutional racism, strengthening best practice, and realising equitable outcomes for Māori.[1]

Directly responding to evidence presented across multiple reports, inquiries and reviews that institutional racism must be addressed in order to realise equitable outcomes for Māori[2], alongside overtly operationalising the necessary paradigm shift to whānau ora and whānau-centred practice, Te Kurahuna and Mahi a Atua are centrally positioned to realise the systemic innovation and transformation across sectors which has long been called for. This paper, part of the *Tēnei te Po Nau Mai Te Ao - Transformation in Action Series*[3], examines equity and institutional racism.

Introduction

Health systems in Aotearoa have long been evidenced as supporting non-Māori to live longer healthier lives than Māori, with inequities clearly evident from before birth, through childhood and youth, to adulthood and into old age.[4] The 2020 Health & Disability Systems Review (HDSR) concluded there was significant evidence that not only had universal health systems failed to improve health outcomes for Māori, existing health service design, purchasing and contracting approaches had in fact served to *increase* inequities for Māori.

Equity

Health equity can be described as "the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or

geographically"[5], with this definition focusing attention on how resources, including services, are distributed to the community.[6] Equity of outcomes for Māori across the health system are influenced by three factors: inequity in *access* whereby services are less accessible for Māori; inequity in *quality* whereby services are not providing the same benefits for Māori; and inequity in *improvement* whereby efforts to improve service quality do not always result in improved equity for Māori.[7] An extensive literature base has, and continues to document, the impacts of differential access and quality for Māori at all levels of health care services, including primary care.[8]

Specifically in relation to mental health, access to services is a priority issue, with key recommendations from the 2018 Government Inquiry into Mental Health & Addiction focused on significantly enhancing service accessibility.[9] However, the evidence also shows that even when barriers to service access are absent, inequity for Māori in relation to the quality of services and treatments received remains. That is, even if Māori are able to access health services, optimal quality of care is not always received, and this negatively affects outcomes: increased access does not automatically equate with equitable outcomes.[10]

Furthermore, alongside the wider social and economic determinants of health which create a level of disadvantage for Māori even before engagement with the health system, not only do services fail to provide the same benefits to Māori, in some cases engagement with those services actually serves to increase inequity.[11] Included within this is that even when gains have been made through overall changes in policy or service quality, structural inequities mean Māori are not benefiting proportionately from those gains[12]: overall improvements in service quality do not equate with enhanced equity for Māori. Combined, these factors not only result in disadvantage and inequity accumulating for Māori, they also result in an accumulation of advantage for non- Māori.[13] Evidence of such cumulative inequity is widely reported across numerous areas, for example suboptimal and over-prescribing to Māori; delays in treatment and surgical interventions; and longer hospital bed stays after acute admissions.[14]

Indicators of inequity manifesting beyond service access is also evident in mental health data. Māori have differential experiences of, and are not well served by, current mental health services and approaches, with this seen in poorer outcomes across a variety of measures.[15] The 2018 Government Inquiry into Mental Health & Addiction reported that while the prevalence of mental distress among Māori is almost 50% higher than among non-Māori, Māori are 30% more likely than other ethnic groups to have their mental illness undiagnosed. With regard to secondary care, Māori are more likely to be admitted to mental health facilities; readmitted after discharge; secluded during admission; and compulsorily treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992.[16] Seclusion is experienced by Māori as being punitive in nature, with many losing faith in the mental health system and its processes.[17]

The Health and Disability Services Review concluded there was significant evidence that universal health systems had not only failed to improve health outcomes for Māori, existing health service design, purchasing and contracting approaches had in fact served to increase inequities.[18] The evidence is unequivocal: more of the same will not address the disadvantage and inequity which accumulate for Māori.

Māori voices to the 2018 Government Inquiry into Mental Health & Addiction characterised optimal access as whānau receiving the right support, at the right time, clearly expressing a desire for substantially improved access to culturally-aligned services and tools.[19] As was highlighted in 2018 to Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575), if health services are delivered inadequately or inappropriately, then the delivery method of those services itself can become a negative determinant of health outcomes.[20]

Supporting this, a recurring theme consistently identified over the past 30 years is that reliance on Western knowledge has led to a lack of recognition and understanding of te ao Māori, Māori concepts and Māori models of practice.[21] Research focused on primary care identifies that although Primary Health Organisations (PHOs) have attempted to tailor their responses to the specific access barriers faced by Māori, this has not necessarily resulted in improved health outcomes for Māori. Whilst economic and geographic barriers to access are considered relatively easily identified and solved by PHOs, a disconnect between Māori models of health and wellbeing and the dominant disease-oriented models of health utilised by PHOs has not been addressed.[22]

Equity and Institutional Racism

Despite high levels of health inequity for Māori being well documented and widely discussed for several decades, this inequity has persisted. It has also been long demonstrated that these persistent inequities are structural, and are underpinned by institutional racism.[23] Described as critical to address if long term change was to be achieved in Aotearoa, recommendation one of Puao-Te-Ata-Tu in 1988 explicitly called for an attack on "all forms of cultural racism in New Zealand that result in the values and lifestyles of the dominant group being regarded as superior to those of other groups, especially Māori".[24]

Over thirty years later, institutional racism continues to be positioned as central in addressing health inequity for Māori. In Stage One of the Health Services and Outcomes Kaupapa Inquiry (WAI 2575), consistent with the established evidence base, all parties, including the Crown, accepted institutional racism was a known determinant of health and wellbeing. Senior Māori health researchers have consistently called for entrenched institutional racism to be addressed; and for racism to be declared a public health crisis.[25] The HDSR stressed the impacts of racism must be addressed[26]; and the need to eliminate systemic racism within mental health and addiction services was highlighted in the 2018 Government Inquiry into Mental Health & Addiction.[27]

Addressing health inequity requires those with the highest levels of need receive attention and resources proportionate to that need.[28] Expert evidence presented to WAI2575 defined institutional racism as 'inaction in the face of need'.[29] Again, all parties to the WAI 2575 Claim, including the Crown, agreed that the severity and persistence of health inequity Māori continued to experience was an indicator that the health system was institutionally racist. The Waitangi Tribunal also concluded that the framework for the primary health system in New Zealand was institutionally racist in that Māori, as those with the highest levels of need, were not receiving resources proportionate to that need.[30]

Repeated failure by the health system to respond to the significant inequities in Māori health outcomes; higher exposure by Māori to determinants of ill health and disease; and the ongoing under-representation of Māori across the health workforce[31] is all evidence of the extent to which persistent inequity for Māori has become 'normalised'. Far from generating a sense of urgency, inequity for Māori has come to be almost routine, an expected and accepted feature of our national landscape.[32]

Sustaining much of this normalisation is the dominance of individualised deficit theory,

language and indicators which sustain the stereotype that inequity results from the individual failings of Māori, as opposed to systemic structural bias.[33] The normalisation of this stereotype then serves as justification for the continued existence of ongoing inequitable service delivery, in the process endorsing ongoing structural racism.[34] For example, the deficit-oriented term 'hard to reach', often used by policy makers and health professionals when attempting a focus on Māori communities, is acknowledged as masking the failure of health care service delivery, and the wider complexities for whānau which arise from the social determinants of health.[35]

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Institutional racism manifests across majoritarian decision-making systems.[37] Health systems are comprised of decision-making individuals, including those who determine health priorities, funding, and health workforce development. It has been argued that public policy decisions and processes are not ideologically neutral, instead heavily influenced by the normative cultural expectations of those designing them.[38] The ideology of 'equality' which positions Indigenous models and services as undesirable for central government, results in prescriptive contracts, short contracting periods and onerous accountability requirements, all of which have been identified as symptomatic of a deeper desire on the part of the state to maintain control over Indigenous development.[39]

The 'politics of ethnicity' is a term used to describe the situation whereby not only do uniquely Indigenous Māori solutions lack state commitment and support, they also become the focus of persistent scrutiny.[40] For example, despite the substantial evidence base demonstrating the success of Whānau Ora in effecting transformative outcomes for Māori, indicative of the pervasive reach of institutional racism, Whānau Ora remains vulnerable to challenge in a political climate not receptive to policies shaped around Indigenous practices and values.[41] It appears highly contradictory that although the evidence base clearly demonstrates the effectiveness of Whānau Ora as a sustainable transformative solution, it continues to be side-lined by state agencies.[42] In addition, the constant scrutiny of Indigenous solutions starkly contrasts with a visible lack of consequences for mainstream health and social service providers in relation to the poor outcomes they produce for Māori.[43]

That fundamental Māori concepts and processes are not understood by decision makers, despite the availability of a robust evidence base to inform them, is yet another indicator of how institutional racism is embedded and sustained within systems.[44] The Waitangi Tribunal conclusion in 2019 that the Crown, despite being fully aware of the presence and ongoing impact of institutional racism across the health sector, had nevertheless failed to address that institutional racism, is further evidence of this normalisation.[45] Normalisation results in inaction[46], and inaction in the face of high need is the very definition of institutional racism.

Despite the extensive evidence base and multitude of review and inquiry recommendations compiled over several decades, the overall structural and systemic transformation necessary to genuinely address intergenerational inequity for Māori remains absent.[47] Most recently, the Initial Mental Health & Wellbeing Commission has reported a distinct lack of action in regard to the transformative systemic changes and innovation required to realise improved outcomes for Māori.[48]

Te Kurahuna, Mahi a Atua and Institutional Racism

Te Whare Wānanga o Te Kurahuna, the precious source of knowledge steeped in traditional practises consistent with a Maori worldview, is the kaitiaki of Mahi a Atua: a 'way of being' which privileges Indigenous knowledge and practice as the basis for strengthening best practice, addressing institutional racism and realising equitable outcomes for Māori.[49] Guided by the knowledge embedded in pūrākau, Te Kurahuna understands genuinely addressing equity for Māori requires an uniquely transformative Indigenous workforce development approach.

Fundamental to Te Kurahuna achieving its aspiration of growing a collective consciousness able to shift institutional racism and effect transformative systemic change is a paradigm shift. Māori health providers and communities have a long history of innovation: the past 40 years have seen the incorporation of mātauranga Māori into health service delivery; an increase in Kaupapa Māori services and the use of Indigenous models and healing practices; alongside Māori workforce development and leadership strategies.[50] However, none of these innovations have focused on transforming the wider systems underpinning healthcare service delivery in Aotearoa.[51]

As was identified by the HDSR, improving equity and wellbeing for Māori requires urgent improvements in the way the system in its entirety delivers for Māori.[52] However, genuine transformation which is centred on enhanced rangatiratanga and mana motuhake must extend beyond simply the addition of more Kaupapa Māori services. The overwhelming message provided to the 2018 Government Inquiry into Mental Health & Addiction was a new approach to mental health and addiction in Aotearoa was needed.[53]
As a deliberate multi-level response, Te Kurahuna training is grounded on the premise that systemic institutional racism can be addressed by a collective consciousness on the part of both Māori and non-Māori. Fully aligned with the underpinning principles of Kaupapa Māori theory and cultural safety, Te Kurahuna understands movement to critical consciousness as an ongoing process of examining structural variables such as power, social justice and equity, alongside active critical self-reflection and assessment of the privilege and bias of health practitioners. This includes one's own contribution to institutional racism, particularly for those trained within dominant biomedical paradigms which serve to support and sustain ingrained systemic racism.[54] In this way, Te Kurahuna contributes to what Tina Ngata describes as 'healing of the system, healing of practitioners, and healing of those who wield power'.[55]

The evidence is clear: we cannot continue to privilege ways of working which are shown to be ineffective, and still expect transformative change will occur.

Te Kurahuna understands that pathways which are able to impact inequity most effectively are those directed toward the health workforce, healthcare organisations, and the wider systems in which those workforces and organisations exist. In doing so, Te Kurahuna seeks change at both the individual and systems level, aspiring to create a collective consciousness which results in a critical mass of Mataora; a workforce of 'change agents', able to influence and embed sustainable transformative change.[56] Mahi a Atua, a 'way of being', as opposed to a therapy or technique,[57] explicitly focuses on reinstating and embedding Indigenous knowledge systems which then lays the foundations for deliberate and intentional pathways to systemic transformation across sectors, providers, iwi, and communities.[58]

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