# Brief summary of Waitangi Tribunal Report on Stage One of the Health Services and Outcomes Kaupapa Enquiry (“WAI 2575 Report”) and its application to Allied Health.

## Background

The Waitangi Tribunal Act 1975 established the Tribunal as a permanent commission of enquiry to hear claims bought by Māori in regards to breaches of promises made by the Crown in the Treaty of Waitangi.

A large number of claims relating to health have been bought before the Tribunal and it opted to hear these in three stages. Stage One related to systemic issues including “the way the Primary Health care system in New Zealand has been legislated, administered, funded and monitored since the passing of the New Zealand Public Health and Disability Act 2000 (“NZPHD Act”).”[[1]](#footnote-1)

While Osteopathic services are regarded by the Ministry as Allied Health rather than Primary Health services, themes articulated in the WAI 2575 Report are applicable to the provision of health services more generally. Additionally, the Chief Allied Health Officer at the Ministry of Health has identifed equity as one of the most important areas for the Allied Health workforce. Within that sphere he emphasised the need for the allied health workforce to be more representative of our population, and for those working in allied health to be culturally competent and culturally safe.

## Report findings

### Inequity

In June 2019 the Tribunal released the WAI 2575 Report. In this report it noted that the persistence of Māori health inequailities was uncontested.

“As a population group, Māori have on average the poorest health status of any ethnic group in New Zealand. We also received uncontested statistical evidence demonstrating that, despite reform and readjustments, Māori health inequities have persisted in the nearly two decades since the [NZPHD Act] was introduced. All parties to stage one of this inquiry, including the Crown, consider the poor state of Māori health outcomes unacceptable.” (p xii)

The data presented to the Tribunal provided evidence that Māori life expectancy was significantly lower than non-Māori and that non-Māori life expectancy had increased without the same gains for Māori life expectancy. Māori experience higher rates of disability, higher rates of mental illness and increased health issues due to addiction. The Tribunal was presented with statistics showing Māori rates of disease over a wide range of conditions were substantially higher than non-Māori. Avoidable hospitalisations for Māori were 60% higher than non-Māori and Māori mortality due to avoidable factors was twice as high as non-Māori.

All parties accepted that a range of socio-economic factors contribute to health outcomes, and that the on-going effects of colonisation were relevant to Māori health outcomes. The Tribunal reported Professor Paparangi Reid’s views that:

“[t]he confiscation and misappropriation of Māori resources through the colonial processes impacted both by historical trauma ... and by impoverishment.”[[2]](#footnote-2)

The Tribunal also recognised the effects of colonisation as contributing to “a form of discrimination often termed institutional racism.”[[3]](#footnote-3) Institutional racism can be described 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.”[[4]](#footnote-4)

The Director General of the Ministry of Health Dr Ashley Bloomfield recognised the link between racism and health as follows:

“So socio-economic deprivation for Māori impacts on their ability to access good health but it is compounded by other factors including racism. The impact of personal and institutional racism is significant on both the determinants of health and on access to and outcome from health care itself. Racism is associated with poorer health, including poorer mental health.”

The response of the Tribunal to this evidence was to investigate whether these poor health outcomes were due to breaches of the Treaty/Tiriti and to recommend an urgent review of the legislative and policy framework of the primary care system. The Tribunal found a failure by the Crown to design the system in partnership with Māori (and with mana whenua in particular). It found that tino rangatiratanga was not recognised in regards to Māori health and that the current framework required review at all levels due to the poor health outcomes experienced by Māori.

### Principles applied in regards to Te Tiriti

Over the years the courts and the executive arm of government promoted the application of principles as being important to guide decision making in regards to honoring the Treaty. These principles of partnership, protection and participation have become known as the “3 P’s”, and have been applied in many different contexts.

In the WAI 2575 Report the Tribunal declared the application of these 3 principles to be outdated and insufficient to ensure the honoring of Te Tiriti. The need for more than the 3 P’s principles was also accepted by the Crown.

Instead, the Tribunal recommended the adoption of 5 principles to assist in endeavours to honor Te Tiriti in regards to the Primary Health Care Sector, namely[[5]](#footnote-5):

1. The guarantee of **tino rangatiratanga**, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of primary health care.
2. The principle of **equity**, which requires the Crown to commit to achieving equitable health outcomes for Māori.
3. The principle of **active protection**, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.
4. The principle of **options**, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.
5. The principle of **partnership**, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of primary health services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

## Other WAI 2575 Recommendations

The WAI 2575 Report made conclusions in regards to a range of factors including the Tiriti/Treaty compliance of the strategies and policies of the Primary Healthcare Sector, the funding of the Sector, the monitoring of the Sector to assess whether it was delivering equitable health outcomes for Māori and whether the partnership envisaged in the Treaty operates in practice in the Sector providing health services.

## Conclusion

While osteopaths, as Allied Health providers, are not directly governed by the NZPHD Act and are not the focus of the WAI 2575 Report, it nevertheless provides useful guidance as to how to work towards honouring the Tiriti on the road to equitable health outcomes for Māori.

1. WAI 2575 Report, p xii. [↑](#footnote-ref-1)
2. WAI 2575 Report, p 20. [↑](#footnote-ref-2)
3. WAI 2575 Report, p 21. [↑](#footnote-ref-3)
4. WAI 2575 Report p 21 quoting Ministerial Advisory Committee. (1988). *Puaote atatu (Day break)*. Wellington, New Zealand: Department of Social Welfare (p19). [↑](#footnote-ref-4)
5. WAI 2575, p 163. [↑](#footnote-ref-5)