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The Waitangi Tribunal's WAI 2575 Report: Implications for Decolonizing Health Systems

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Abstract

Te Tiriti o Waitangi, a treaty negotiated between Māori (the Indigenous peoples of Aotearoa) and the British Crown, affirmed Māori sovereignty and guaranteed the protection of *hauora* (health). The Waitangi Tribunal, established in 1975 to investigate alleged breaches of the agreement, released a major report in 2019 (registered as WAI 2575) about breaches of *te Tiriti* within the health sector in relation to primary care, legislation, and health policy. This article explores the implications of this report for the New Zealand health sector and the decolonial transformation of health systems. The tribunal found that the Crown has systematically contravened obligations under *te Tiriti* across the health sector. We complement the tribunal's findings, through critical analysis, to make five substantive recommendations: (1) the adoption of *Tiriti*-compliant legislation and policy; (2) recognition of extant Māori political authority (*tino rangatiratanga*); (3) strengthening of accountability mechanisms; (4) investment in Māori health; and (5) embedding equity and anti-racism within the health sector. These recommendations are critical for upholding *te Tiriti* obligations. We see these requirements as making significant contributions to decolonizing health systems and policy in Aotearoa and thereby contributing to aspirations for health equity as a transformative concept.

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Introduction

Māori have challenged breaches of *te Tiriti o Waitangi* (*te Tiriti*) since shortly after its signing in 1840.[1] *Te Tiriti* is the Māori text of a short but far-reaching agreement that allowed the British Crown to establish government over its settlers in New Zealand, affirmed Māori *rangatiratanga* (sovereignty) over their own affairs, including natural resources, and granted them the rights and privileges of British subjects.[2] An English text, which differed significantly, was also drafted, but it was the Māori version that was presented and signed by most *rangatira* (leaders) and the version we argue should therefore take precedence. While First Nations' treaty rights to health are recognized in Canada and may be negotiated into treaties being contemplated in Australia, Aotearoa New Zealand is a single jurisdiction with a single treaty, giving its experiences the particular context that we demonstrate in this article.

Māori have pursued diplomatic, legal, and political channels to address breaches through, for example, delegations to British monarchs, the League of Nations, and, later, the United Nations. Military action, as well as peaceful measures such as land occupations, have been used to resist the alienation of *whenua Māori* (land).[3] Petitions continue to be presented to Parliament.[4] Since the election of the first Māori members of Parliament in 1867, members have introduced legislation and otherwise lobbied for measures to give effect to the agreement and remedy its breaches by the Crown.[5]

In 1975, after much Māori (and some non-Māori) political agitation and lobbying, a legal process to support the enduring *mana* (prestige and authority) and place of *te Tiriti* in public life was agreed. The Treaty of Waitangi Act 1975 was passed to establish the Waitangi Tribunal and other mechanisms for hearing, researching, and settling grievances.[6] The tribunal influences reconciliation efforts between Māori and the Crown through recommendations to remedy Crown breaches. The tribunal has a mandate to investigate alleged breaches of either the Māori text (*te Tiriti o Waitangi*) or the English version (the Treaty of Waitangi). Over recent decades, it has produced a significant body of work assessing evidence presented by thousands of Māori claimants about *te Tiriti* breaches and Crown defenses of government action and inaction.[7]

Issues surrounding Māori health fall within the remit of the Waitangi Tribunal, and in 2016 the claim WAI 2575 was opened to hear grievances about the health system, including health equity, health care, disability, and substance use. Neglect of Māori health, and state undermining of Māori efforts to exercise authority over their own health, have distinguished public health policy at least since 1907, when the Tohunga Suppression Act was passed. This Act criminalized certain Indigenous health practices and removed the centrality of culture to health policy.[8] By this time, the silencing of Māori voice in both policy and clinical practice was entrenched, though consistently resisted by Māori health professionals and political actors. By the 1980s, the Treaty of Waitangi Act was beginning to influence policy thinking. Scope was emerging for more effective Māori assertion of their rights under *te Tiriti,* particularly the guarantees of *tino rangatiratanga* in article 2 and of social equity in article 3. For example, in 1988, the director-general of health under the newly established neoliberal regime, George Salmond, directed the health sector to authentically engage with its treaty obligations through the mechanism of partnership and acknowledgment of health as a *taonga* (treasure).[9]

Since 1988, the health sector has attempted to engage with these responsibilities. However, despite some examples of success, the tribunal found profound colonial system failure that has resulted in major, persistent health disparities across all conditions between Māori and other New Zealanders.[10] Over 200 grievance claims were filed with the tribunal specifically in relation to the administration of the health system. The complexity, breadth, and depth of the health claim led the tribunal to hear the evidence in three stages. Stage one focused on systemic issues and the primary health care sector. The tribunal's stage one report was released in 2019 and is the subject of this article. Stage two (yet to be concluded) will address mental health, disabilities, alcohol, tobacco, and substance abuse. Stage three

(also yet to be concluded) will work with any remaining issues of national significance and eligible historical matters.

On its own, the stage one report is a substantive scholarly contribution to Māori health policy development.[11] It makes an important contribution to the monitoring of the effectiveness of the Crown's policy in Māori health by defining the Crown's responsibilities and obligations under *te Tiriti* and evaluating its successes and failures in relation to these responsibilities and obligations.

The tribunal found that the Crown was responsible for ensuring equitable policy outcomes and for the active protection of Māori health and well-being.[12] Inequities in the burden of disease and inaccess to effective primary health care show that these outcomes remain elusive for Māori.

The WAI 2575 report argues that the Crown has failed to deliver equitable health outcomes for Māori and is therefore in breach of *te Tiriti*.[13] In response, we argue that there are at least five key implications for all health-related legislative and policy instruments. These instruments should (1) be compliant with *te Tiriti*; (2) recognize *tino rangatiratanga*; (3) ensure accountability to Māori; (4) ensure that investment in Māori health is commensurate with equitable outcomes; and (5) embed equitable and non-racist practices in policy development, delivery, and evaluation. These requirements are vital to the decolonization of the hegemonic health system of Aotearoa in pursuit of health equity and social justice.

Primary health care is strategically important for achieving improvements in Māori health and is, as noted by the World Health Organization in its Declaration of Alma-Ata,

> *essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation … It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work and constitutes the first elements of a continuing health care process.*[14]

Methodology

This article is written from a critical perspective, as the authors are invested in understanding where power resides and the ways it can be located to maximize justice and human rights.[15] Feminist and Indigenous scholars alike have long argued that privilege and lived experiences shape how we see the world.[16] As researchers, who we are influences our research questions and what we hear and see when we collect and analyze data. By way of *whanaungatanga* (relationship building), we take the unusual position of introducing ourselves so our standpoints are transparent to the reader.[17]

Heather Came is a Pākehā (of settler descent, *Tangata Tiriti*) activist-scholar with expertise in *Tiriti* application, institutional racism, and critical policy analysis. Her professional background lies in health promotion and public health, as well as the dynamics of institutional racism. Heather Came and Timothy McCreanor were both expert witnesses on behalf of claimants to the stage one Waitangi Tribunal WAI 2575 hearings.

Dominic O'Sullivan belongs to the Te Rarawa and Ngāti Kahu *iwi* (tribes). He is a political scientist interested in Indigenous self-determination. He writes from a liberal theoretical perspective to examine the recognition *te Tiriti* has under New Zealand's prevailing liberal democratic arrangements.

Jacquie Kidd is Māori, belonging to the Ngāpuhi *iwi*. Her professional background is in nursing, and her current work involves community-based research to identify and address health inequities at the local level. Her focus is on amplifying the strengths and solutions found within *whānau* (family), *hapū* (family groupings or subtribes), and *iwi* through co-designing research and associated health messages.

Timothy McCreanor is a Pākehā public health researcher with a longstanding interest in the ways in which language shapes and reflects relations among Māori and Pākehā. Health as a key domain in such discursive relations is a current focus of his contributions to research and action for social justice.

Overview: WAI 2575 report

The stage one WAI 2575 hearings saw evidence presented by Māori health providers and other interested parties relating to the period from the enactment of the New Zealand Public Health and Disability Act (NZPHDA) in 2000 to the present. The tribunal agreed to an urgent hearing because of the seriousness of the issues raised and the extent of the health inequities that the claimants described. All parties agreed that the legacies of colonization had an impact on health inequities.[18]

Systemic issues in the legislative and policy framework

The tribunal found that the policy and legislative framework failed to consistently state a commitment to achieving health equity for Māori and that the treaty clause in the NZPHDA was reductionist: "it simply does not go far enough in ensuring that the whole health system complies with the Treaty."[19] It also found that the principles of participation, protection, and partnership that inform Māori approaches to health policy were "outdated and need to be reformed."[20] For example, despite structural mechanisms in place for Māori participation in the health sector, the tribunal found that Māori were not afforded "Treaty-consistent control of decision-making in relation to health design and delivery."[21] The tribunal was concerned by the omission of reference to the treaty in lower-level policy documents and recommended the development of a new treaty clause for the NZPHDA to give greater authority to the requirement to achieve equitable health outcomes for Māori.

The tribunal found that the primary health care framework under the NZPHDA was not designed in partnership with *mana whenua* (local Māori) or other Māori communities. It found that the primary health framework did not "recognise and properly provide for *tino rangatiratanga* [sovereignty] and *mana motuhake* [autonomy] of *hauora Māori* [Māori health]."[22] It argued that the current partnership arrangements need to be reviewed at all levels.

With concern, the tribunal noted the underrepresentation of Māori within the health workforce and the disestablishment of *Te Kete Hauora* (the Māori group within the Ministry of Health). It noted that Māori health managers within district health boards (DHBs) were "hamstrung by the ambit of their role and the very minimal budget holding functions they often hold."[23] In these respects, the Crown was in breach of *te Tiriti*. The tribunal also recommended exploring the establishment of an independent Māori Primary Health Authority.

Primary health care funding

The tribunal found that Māori primary health organizations "were underfunded from the outset."[24] Funding arrangements disadvantage primary health organizations that serve high-needs (often Māori) communities. In addition, it found that the "Crown has been aware of these failings for well over a decade but has failed to adequately amend or replace the current funding arrangements."[25] Over NZ$200 billion has been spent on health since 2012, with little measurable improvement to Māori health outcomes. The tribunal noted that NZ$167 million (less than 0.1%) was allocated for the primary care of Māori patients, with only NZ$28.7 million going to Māori primary health organizations during this period.

The tribunal recommended an assessment of the extent of underfunding since 2000, and a review into the funding of the primary health system. It recommended that the claimants and Crown agree on a methodology for conducting this assessment. To reflect this matter's underlying urgency, the tribunal directed the parties to report progress by January 2020. We argue that this review is essential to improving health outcomes and should take a holistic approach to addressing the determinants of improved health outcomes, including the inter-generational impacts of sustained underfunding. Justice requires that the assessment consider that supporting equitable outcomes may necessitate an allocation to Māori health that is more than proportionate to the Māori share of the population.

Accountability

The Crown argued that the primary health care system was deliberately "permissive and semi-devolved."[26] On the one hand, this devolution, which occurred as part of public sector reforms during the 1980s, allowed the Crown to shift its direct responsibility for primary health care to private providers. On the other hand, it created opportunities for Māori entities to seek contracts with the Crown to provide primary care with greater reference to Māori epistemologies and community priorities. While devolution does provide a foundation for Māori authority (*rangatiratanga*) in health policy delivery, the tribunal found that the Crown did not collect enough qualitative or quantitative data to fully inform itself, or the public, of how the sector was performing in relation to Māori health. Māori health outcomes were not systematically measured or reported on, and *Te Puni Kōkiri*, the Ministry of Māori Development, failed to carry out its statutory duty to monitor the health sector's effectiveness for Māori.

The tribunal recommended that the Crown commit to reviewing and strengthening accountability mechanisms and processes. To this end, it proposed that the Crown, in conjunction with Māori health experts, co-design a research agenda. It recommended the reintroduction of annual Māori health plans for DHBs, the inclusion of treaty references in policy documents, and external monitoring of the Ministry of Health.

Implications of the WAI 2575 report

Our argument is that the tribunal's recommendations may be given substantive effect through reframing the ways in which the Crown uses legislative and policy instruments in relation to Māori health. The reframing that we propose is to ensure that these instruments are consistent with *te Tiriti*, recognize *rangatiratanga*, ensure accountability to Māori citizens, receive public funding sufficient to support equitable outcomes, and entrench non-racist practices at all levels of the policy process—development, implementation, and evaluation.

Tiriti-compliant legislation and policy

The tribunal's findings and recommendations for amending the NZPHDA and for reforms to policy administration are based on the conceptual perspective that policy decisions are not ideologically neutral. Rather, such decisions are both the product of the dominant culture in which they are formed and a political compromise among competing stakeholders. This means that equitable outcomes are more likely, and the policy process is more just, if Māori aspirations, values, and epistemologies are guaranteed influence at every stage of the policy process.[27] However, government discourses often privilege the Treaty of Waitangi (the English version) and guiding treaty principles (developed by the executive and judicial branches of government) over *te Tiriti o Waitangi* (the Māori text). Use of the English text reinforces the government's assertion that Māori ceded sovereignty to the British Crown, an argument that the tribunal found against in 2014.[28]

Privileging the English text over the Māori—when the Māori text was the instrument that most *rangatira* signed and when the international legal doctrine of *contra proferentem* maintains that in the event of dispute, the instrument should be interpreted against the drafting party—justifies a diminished regard for substantive Māori presence and leadership in the policy process.[29] It also justifies diminished space for Māori to exercise independent authority over their own affairs. If, however, the Māori text is privileged and the instrument is not upheld as a cession of sovereignty, a different political dynamic is created in which Māori, as citizens, are shareholders in public sovereignty and, at the same time, holders of an independent authority that should be recognized in public policy.[30]

We therefore argue that the Māori text is the definitive text. Correspondingly, there is an argument for legislation and policy development to occur with exclusive reference to the Māori text. Research into what it may mean for the Treaty of Waitangi Act 1975 to be amended to ensure that the tribunal conducts its inquiries with exclusive reference to the Māori text is also justified as a way of admitting that Māori did not cede sovereignty to the British Crown.

Critical policy analysis on these themes could be developed through scholarly attention to the role of ideology in health policy, especially on the implications that sovereignty was not ceded and that, instead, Māori retain the rights of *rangatiratanga* and citizenship.[31] The nature of sovereignty in a liberal democracy, as distinct from the authority that the concept implied in 1840, and how this is both distinct from and related to *rangatiratanga*, is an important question for how policy decisions are made, who makes them, and whom they are made for. In this respect, Heather Came et al. have developed a new methodology specific to analyzing health policy entitled "critical *Tiriti* analysis."[32] This methodology outlines a five-phase process to review policy in relation to the Māori text of *te Tiriti o Waitangi*. With the finding that contemporary health policy is not consistent with *te Tiriti*, we argue that this methodology will become standard operational practice and ensure that Māori participate and lead future policy development as a matter of course.

One of the inherent features of critical *Tiriti* analysis is that policy development is transparent—that is, who is claiming to make policy, whom are they making it for, and which philosophical aspirations and epistemological preferences are being used. This does not mean that individuals writing on behalf of governments must be named, but it does mean that the processes being used and their justifications should be explicit. Critical *Tiriti* analysis assumes that published policy documents will include a methodological description showing that there has been Māori leadership in the development process. For instance, was there Māori participation in policy writing, was there wider Māori consultation, was there an advisory committee, and, if so, who was on it? Reference lists should be included so the quality of the evidence can be reviewed by Māori and other interested parties. Evidence of academic and other forms of Māori scholarship should be present to demonstrate engagement with Māori perspectives of what works and why in health policy.

Currently, Māori epistemologies are not consistently present in policy design and implementation. The WAI 2575 report implies that their inclusion would require a fundamental shift in policymaking, implementation, and evaluation. However, there is a gap between what policy might want to achieve (or know that it needs to achieve) and the ability to do so. This is why the tribunal recommended that the Crown and Māori co-design a responsive research agenda.

There are several different ways to approach co-design, ranging from including Māori representatives on policy and planning committees, to consulting with stakeholder communities, to a power-sharing community engagement process.[33] A *Tiriti*-focused co-design approach to service development and delivery involves the latter, beginning with building relationships between the employees of Crown agencies and traditional *hapū* as well as urban-based Māori communities. *Tikanga* (customary protocols), including Māori practices such as *pōwhiri* (welcome ceremony) and *whanaungatanga* (relationships with people, land, and ancestors), provide mechanisms for establishing relationships, which is fundamental to co-design.

Recognizing tino rangatiratanga

In colonial contexts, the nation-state imposes and assumes unitary political sovereignty. Indigenous sovereignty is contested by the colonial state despite prior incumbency, natural justice, and even the Crown's acknowledgement of prior Māori sovereignty as a precondition for the conclusion of a treaty.[34] The United Nations Declaration on the Rights of Indigenous Peoples recognizes extant Indigenous political authorities that remain in spite of the erection of colonial government.[35] Within *te Ao Māori* (the Māori world), *rangatiratanga* is a power subordinate to no other, so it cannot be ceded. The concept itself encompasses terms such as authority, control, and the right of Māori to make decisions for Māori.[36]

Liberal democracy, which was not the prevailing political arrangement in 1840, but is in 2020, means that sovereignty is not held by the state, Crown, or Parliament in its own right. Nor is it an authority over and above the people. It is, instead, a repository of citizens' collective authority, and it

is exercised by governments only through citizens' consent.[37]

Citizenship belongs to Māori as much as it belongs to anybody, but it does not supersede or diminish *rangatiratanga*. *Te Tiriti* is explicit. The two co-exist as interrelated spheres of political authority and have implications for health policy's form, purposes, development, and implementation. This gives the sovereignty that Māori did not cede a heterogenous nature, meaning that Māori are simultaneously part of the nation-state while also standing outside of it. Therefore, *tino rangatiratanga* and the collective public sovereignty that Māori share with other citizens needs to be expressed within public agencies, as well as through *hapū* and other Māori entities. For Māori health, equity, community thriving, and personal health and well-being are legitimate aspirations that public budgets must fund.[38] One of the critical enablers of these aspirations and of just service provision is the fact that Māori leaders are present in senior management positions within Crown agencies and on DHBs. To this end, it is significant (but insufficient) that in 2019 the minister of health appointed Māori people to chair four of the country's nineteen DHBs, compared with none in previous years.[39] While it is not possible to establish a causal link between an exact number of Māori people holding office in the administration of the public health system and equitable outcomes, it is fair to say that the system must ensure sufficient substantive Māori participation for Māori to be able to recognize that their values and priorities influence the provision of primary health care and that they are able to make meaningful decisions about how, by whom, and to what end that care is delivered.

Recognizing *tino rangatiratanga* means that it must be evident to Māori citizens that every substantive decision about the design of the health sector, the prioritization of resources (see later section on funding), and the setting of policy directions needs to have been made with equitable and empowered Māori leadership. This leadership needs to be nurtured and developed, without constraint or interference from the Crown. Administrative reforms ought to be made to ensure that the practice of making policy decisions without reference to Māori cannot occur. Given the depth and urgency of addressing health disparities, public decisions need to systematically consider and prioritize measures that advance Māori aspirations to deliver improved holistic Māori health outcomes. Critical *Tiriti* analysis has been developed to support this objective and support the implementation of structural mechanisms at all levels that are monitored and strengthened over time as part of ongoing sector-wide quality assurance efforts. Māori leadership of these mechanisms needs to be resourced so as not to overburden Māori. Health sector leadership needs to embrace Māori leaders and leadership styles.[40]

An independent Māori Primary Health Authority was proposed by the tribunal.[41] However, this potentially underplays the magnitude of the challenge, and it would make more sense to have an overarching Māori-led and -governed holistic authority that rejects the current siloing. Such a broad configuration would bring together a critical collective mass of Māori knowledge and leadership. In a recent *whaikōrero* (speech), Professor Sir Mason Durie articulated his vision for an independent Māori health and well-being authority (Te Rūnanga Whakapiki Mauri). This authority

> *would be defined by the norms of te ao Māori. It would favour Māori decision-making at all levels and would foster an integrated approach that saw all Kaupapa Māori Organisations working towards the same goals and with the same values. It would bring together mental health, child health, health generally, kōhanga reo [language nest], kura kaupapa [Māori primary school], whare kura [Māori school], housing and other aspects of wellness.*[42]

Durie has called for collective Māori endorsement of his proposal, though this does leave unresolved the question of generic health funding that currently resources existing health services. One model that could be re-introduced and integrated into Durie's proposal is the Māori co-purchasing organizations (MAPOs) that were formed in the 1990s under the Northern Regional Health Authority and operated in the Te Tai Tokerau and Auckland regions. The

MAPO strategy was a structural co-funding mechanism to enable *iwi* input into all health service purchasing decisions.[43] If integrated into Durie's proposal, a nationwide localized MAPO system could consolidate Māori control and authority in relation to health funding.

Strengthening accountability

The tribunal report explained at length the lack of public accountability in relation to Māori health outcomes.[44] Existing structural mechanisms need to be consistently applied. For instance, the tribunal reported that the Crown has never withheld money through the Crown funding agreement, nor sacked a DHB board, nor rejected an annual plan, in relation to poor performance in relation to Māori health. Critically, Te Puni Kōkiri (Ministry of Māori Development) needs to resourced to a level where it can fulfill its statutory responsibility to monitor the health sector. Existing Ministry of Health and DHB monitoring of health providers' delivery of Māori health outcomes also need to be strengthened.

One response is to strengthen Māori health performance indicators at every level of the system, including individual and collective accountabilities. Ministerial insistence and support for specific performance indicators in all relevant Crown agencies may sharpen bureaucratic and clinical focus.

Transparency in practice and outcomes are critical to strengthening accountability to Māori. Various DHB and Ministry of Health reports are publicly available, and Māori members may question ministers in Parliament in relation to these reports. However, the data presented are usually high level and frequently not reported by ethnicity. George Gray's independent website, Trendly, offers analysis of some indicators by DHB; however, as the tribunal recommended, effective monitoring requires more comprehensive data.[45]

The Indigenous data sovereignty movement has clearly articulated the aspiration that Indigenous people should control Indigenous data.[46] Others have argued that more work needs to be done to develop and strengthen measures that are meaningful for Māori.[47]

To achieve this policy reorientation, more Māori-led production and analysis of Māori health data is needed. This requires a focused investment in health research and increased efforts at recruiting and training Māori scientists and policy makers. Māori-specific measures, alongside quality and quantity of life, should be key outcome measures for the health sector.

Investing in Māori health

The Waitangi Tribunal report noted a pattern of systemic underfunding of Māori health.[48] Funding to Māori health providers from the Ministry of Health and DHBs in 2015–16 was 1.86% of Vote Health.[49] Clair Mills and Papaarangi Reid have quantified the cost of "doing nothing" in relation to child health inequities, for example, by estimating that inaction in relation to Māori health in this one area costs between NZ$62 million and NZ$200 million per annum.[50]

Current investment levels in Māori primary services do not reflect population parity, with Māori making up 15% of the total population.[51] However, raising investment levels to 15% does not address the inter-generational effects of disparate morbidity and mortality that the tribunal attributes to colonial practices—an association corroborated by others.[52] In finding that Māori primary health care is underfunded, the tribunal recommended that the Crown and claimants cooperate to establish a methodology for working out how an appropriate level of funding is to be determined. This is a significant opportunity for Māori to influence future appropriations and policy settings.

The presumptions that would usefully inform the development of such a methodology include recognizing that although underfunding is ultimately the outcome of government budget priorities, it is also enabled by wider investment strategies, procurement policies, prioritization processes, and contracting practices. Pending the development of Te Rūnanga Whakapiki Mauri or something similar, the health sector's funding and contracting infrastructure needs to be reviewed with a focus on identified sites of institutional racism and the broader inconsistencies with *te Tiriti* that the tribu-

nal found.[53] An action research process could then be instigated by systems change teams within public entities to design and progressively implement anti-racism interventions focused on specific sites of racism that would contribute to a broadening community of anti-racism praxis.[54]

Historical trauma, entrenched disparities, and ongoing disinvestment in Māori health knowledge, human capital, and operational systems means that a larger proportion of Vote Health will be required to acknowledge both *rangatiratanga* and the substantive equality of opportunity that citizenship implies.[55]

Health equity is not simply a matter of levels of public funding. The ways in which decisions are made and implemented, by whom, and for whom are also important. *Rangatiratanga*, for example, suggests the replication of models of Indigenous-owned and -run health services that exist nationally and for Indigenous peoples elsewhere that are consistent with Māori aspirations and operate on the assumption of both clinical and cultural safety.[56]

Embedding equity and anti-racism

The intellectual debate about whether institutional racism exists in the New Zealand health system appears to have been resolved, and there is agreement that it is a major impediment to health equity.[57] This is a profound agreement and presents a unique opportunity for a transformative response from the Crown in relation to upholding *te Tiriti* within the health sector. The debate now needs to focus on how to eradicate institutional and other forms of racism long embedded in the sector and on how Māori wish to express *tino rangatiratanga*.

The achievement of health equity in Aotearoa will require a significant political commitment at the policy, systems, and individual levels. While *rangatiratanga* in the form of Te Rūnanga Whakapiki Mauri or similar may be some years away, it is important that change occurs immediately.[58] This can be achieved by engaging in action research as outlined above, but also through adopting a *kaupapa Māori* methodology to address inequity.

Came et al. have consistently argued for a systems change approach that embraces a relational, holistic, and intergenerational analysis to eliminate institutional racism and secure active engagement with *te Tiriti o Waitangi*.[59] These works maintain that anti-racism efforts need to be planned, sustained, systematic, and multi-leveled to be successful. Short-term effects are otherwise produced when what is needed is long-term sustained change. There needs to be high-level political will, a commitment to organizational cultural change, and genuine Māori leadership.

Marshall Chin et al., referring to equity rather than racism, have argued that policy should be specifically designed for equity.[60] They also emphasize the importance of adequate resources in Māori health, accountability, and frank and fearless conversations about the drivers of inequity: institutional racism and colonial assumptions in the policy process. Fiona Cram has developed an evidence-based framework that outlines particular actions for the health sector, but it does not yet appear to have been implemented.[61]

The evidence is overwhelming with regard to the fact that achieving equity also requires consideration of the other political and historical determinants of health.[62] It is well accepted that there is a considerable population-level health gain to be achieved by raising the level of health of those with the most compromised health.[63] Lifting people out of poverty into meaningful work with a living wage will raise the level of household incomes and subsequently improve health.[64] Investment in Māori public health, with a focus on keeping *whānau* well and living in conditions that do not compromise *hauora* (health), is cost-effective, ethical, and equity enhancing.[65]

Conclusion

As critical scholars, we are interested in the right to health. For Māori, *hauora* and *oranga* (health) are inclusive terms for the physical, spiritual, and cultural well-being of Māori as individuals and collectively. It is widely accepted that there are long-standing significant disparities in health outcomes for Māori, fueled by the intergenerational

legacy of colonization. Along with many health professionals, we do not accept that such inequalities are acceptable, just, necessary, or fair in a developed country such as Aotearoa. Breaches of *te Tiriti* are unacceptable breaches of the social contract between Māori and non-Māori—and often also breaches of human rights agreements.

Human rights are interdependent, indivisible, and interrelated. Māori have an equal and inclusive right to the highest standards of health. The right to health is articulated in the constitution of the World Health Organization, the Alma-Ata Declaration, and the Universal Declaration of Human Rights.[66] The government of New Zealand is responsible for ensuring that this right is achieved under article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, article 12 of the International Covenant on Economic, Social and Cultural Rights, articles 11(1)(f), 12, and 14 (2)(b) of the Convention on the Elimination of All Forms of Discrimination against Women, article 24 of the Convention on the Rights of the Child, article 25 of the Convention on the Rights of Persons with Disabilities, and article 24(2) of the Declaration on the Rights of Indigenous Peoples, all of which it has ratified.[67]

The WAI 2575 report raises urgent imperatives for the New Zealand health sector—a sector that has failed to uphold the right to health for Māori. The strategy of one or two Māori seats at the decision-making table has proven ineffective. We argue that what constitutes equitable needs to be defined by Māori and will require substantive Māori participation in policymaking and implementation. Indeed ultimately, the transformations called for by WAI 2575 will require Māori leadership of the changes in order to give effect to *tino rangatiratanga* as well as substantive and distinctive citizenship.

This Māori leadership might take the form of Te Rūnanga Whakapiki Mauri, as Durie proposes, which is a reasonable response to the tribunal's recommendation for an independent Māori Health Authority. Certainly, it needs decision-making authority in relation to policy development, implementation, and evaluation, as well as fiscal decisions and clinical governance. A decolonized and *te Tiriti*-compliant health system would necessitate a reallocation of power and health investment. Policy needs to be realigned to engage with the Māori text, rather than the English version or the treaty principles. We support the tribunal's recommendation that a more than proportionate allocation of Vote Health to Māori health may be necessary over several generations to acknowledge the current inequitable burden of disease and the legacies of colonization that are reflected in the conditions in which many Māori *whānau* currently live.

Existing structural mechanisms need to be utilized and new ones developed to ensure sector-wide transformation toward accountability for Māori health. This needs to occur at ministerial, bureaucratic, and clinical levels of the sector. We need a planned approach to achieve health equity and to eliminate institutional racism

Clearly, there needs to be early and substantive inclusion of Māori evidence in health planning. The significant contributions of Māori scholars should be recognized and trusted, and Māori scholarly work should inform health policy and decision-making. Māori leadership and the application of critical *Tiriti* analysis could become structured into the development of health policies and services that respect both *rangatiratanga* and distinctive Māori citizenship.

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