

# Envisioning a Tiriti-responsive New Zealand Health Plan: lessons from district health boards' annual plans

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## ABSTRACT

**AIMS:** Over recent decades, a body of research has established the presence of pervasive health inequities experienced by Māori. Work to identify the root causes of inequities has focussed on the unequal distribution of the determinants of good health, access to healthcare, and racism. This study contributes to a small but growing field of work which engages with Te Tiriti o Waitangi to critique key health documents, focusing on district health boards' (DHBs) annual plans.

**METHODS:** A qualitative, directed content analytical approach was used to investigate whether DHBs' 2019/2020 annual plans were consistent with the principles of Te Tiriti o Waitangi, as identified by the Wai 2575 Waitangi Tribunal inquiry.

**RESULTS:** While annual plans contained actions that aligned with the principles of active protection and equity, comparatively few related to the principles of options, partnership, and tino rangatiratanga. Overall, DHB actions operated to constrain options available to Māori and efforts to exercise the Tiriti-guaranteed right of tino rangatiratanga in the provision of health services.

**CONCLUSION:** While DHBs' annual plans expressed commitment to Te Tiriti o Waitangi, their content did not give effect to these commitments. Significant shifts are necessary if future New Zealand Health Plans are Tiriti-responsive documents that deliver Tiriti-responsive health services.

Over decades, a large body of research has documented pervasive health inequities experienced by Māori. Inequities are differences in outcomes that are avoidable, unnecessary, unfair, and unjust.<sup>1</sup> This includes higher incidence of infectious and non-communicable diseases among Māori,<sup>2</sup> worse outcomes than non-Māori for the same diseases,<sup>3</sup> poorer access to healthcare,<sup>4,5</sup> and receiving poorer quality care.<sup>6</sup> On average, Māori live 7 years fewer than other New Zealanders.<sup>7</sup> These inequities reflect a health system that systematically disadvantages Māori.

Health inequities illustrate a failure by the Crown to uphold Māori rights to health as guaranteed in Te Tiriti O Waitangi, an agreement signed between Māori and the British Crown in 1840. Broadly, Te Tiriti o Waitangi granted the Crown the right to govern non-Māori residents, while guaranteeing Māori te tino rangatiratanga (absolute sovereignty) over their lands and taonga (that which is treasured), and promised Māori the same rights and privileges of all British subjects.<sup>8,9</sup> Using Te Tiriti o Waitangi as a framework to undertake critical analyses of the Crown's delivery of health services is appropriate as it affirms Māori rights to health

and to monitor Crown performance.<sup>10</sup> Critical Tiriti Policy Analysis is another approach which places Tiriti rights at the centre of policy analyses; however, this deliberately centres the Articles of the Māori text.<sup>11</sup>

The subject of this research was district health boards' (DHBs) 2019/2020 annual plans. Although Māori health plans were developed by DHBs, these were not statutorily required at the time of the study. Under previous health system arrangements, annual plans were statutorily required documents in which DHBs communicated how they would deliver health services to meet their legislative and Treaty [sic] obligations and make measurable progress towards health equity for Māori.<sup>12</sup> They represented the most detailed publicly available documents relating to health service delivery at a population level. Plans play an important role within organisations, communicating how strategic goals will be achieved, and highlighting key priorities. DHB annual plans are worthy targets for critical scrutiny as potential enablers or barriers to achieving equity. Despite improving Māori health outcomes being a primary objective of DHBs, this had not occurred over their 20 years of existence.<sup>13</sup>

In April 2021, Aotearoa New Zealand's Minister of Health announced the government's intention to undertake major health system reforms. A key influence on this decision was cited as the pervasive health inequities experienced by Māori.<sup>14</sup> Our research involved a critical review of DHBs' annual plans to examine the extent to which they meaningfully operationalised the principles of Te Tiriti o Waitangi, offering insights for the New Zealand Health Plan. Te Pae Tata, the interim New Zealand Health Plan, was released in 2022 as a replacement for DHB annual plans.

## Methods

The study methodology aligned with principles of Kaupapa Māori Research, including seeking to centre Māori health priorities while reviewing each annual plan, adopting an overarching aim of eliminating health inequities for Māori, upholding Māori rights to health and wellbeing, and striving for social justice.<sup>15</sup> The study design and ownership of the research sits with Māori and the analysis was informed by a Māori world view. In this study, the first and third authors are Māori, and the second author is NZ European.

A qualitative directed content analysis design was used, which involves selecting a pre-existing theory or framework to focus the research question, guide the definition of categories and codes, and test alignment of the study data.<sup>16,17</sup> A coding framework was developed using Te Tiriti o Waitangi principles identified as particularly relevant by the Waitangi Tribunal in the first stage of the Wai 2575 Hauora Kaupapa inquiry, namely active protection, equity, options, partnership, and tino rangatiratanga.<sup>18</sup> The Tribunal's report provided examples of how these principles might be operationalised in the context of the health system, and these were used to form codes. Māori scholars have critiqued the reduction of the text of Te Tiriti o Waitangi to principles.<sup>9</sup> While this study does not presume to dispute the views of these experts, Crown entities such as DHBs and Manatū Hauora – Ministry of Health have predominantly operationalised Te Tiriti o Waitangi obligations using the principles identified as relevant for health and health services by the Waitangi Tribunal and which are subsequently reflected in, for example, Whakamaua: Māori Health Action Plan.<sup>19</sup> Given the widespread use of principles in the health sector, this study took a pragmatic

approach to measure DHBs' performance against such principles.

Copies of the 2019/2020 annual plans for each DHB were obtained in March 2020, and uploaded into NVivo (Version 12 for Windows, QSR International) for analysis. Each plan was read, and codes were applied to the text, with some having multiple codes applied. Coding was tested on a single annual plan by the lead author to assess feasibility of the proposed coding scheme. It was then independently coded by the other authors to check reliability and refine interpretations of coded data. The remaining data were coded by the lead author. Analysis was restricted to the annual plan proper, and did not include performance measures, statements of intent, or statements of performance expectation. Portions of text determined to be contravening the codes were allocated to a separate category, labelled inductive, for further analysis. Annotations were made during the coding process to flag pertinent details or latent meaning.

For coding purposes, taha Māori services were defined as those delivering Māori health services within the DHB system. These services often employ Māori staff and aim to align Westernised health service delivery mechanisms with Māori values and tikanga. In contrast, Kaupapa Māori services are developed, led, and governed by iwi (tribal groups) or Māori organisations for whānau Māori.<sup>20</sup>

Coded data were examined in detail in the context of the corresponding Te Tiriti o Waitangi principle, including reading the text fragments to identify commonalities and divergent responses, and quantifying coded units for each principle. The incidence of each category was calculated to provide a snapshot of the total DHB response to each principle.<sup>16</sup> Overall, the analysis sought to determine the extent to which annual plans upheld these principles.

This study was exempt from requiring ethical approval as the source material consisted solely of publicly available documents.

## Results

As shown in Table 1, 84% of data were coded under active protection and equity, with only 16% under options, partnership, and tino rangatiratanga.

**Table 1:** Quantification of codes for each principle of Te Tiriti o Waitangi.

Principle	n (%)	Code	n (%)
Active protection	1273 (48)	Culturally appropriate health services	563 (21)
		Data disaggregated by ethnicity, and for Māori, access, unmet need, and outcomes are measured	528 (20)
		Māori health workforce development	182 (7)
Equity	943 (36)	Prioritisation of Māori to achieve health equity	359 (14)
		Intervention to address barriers to accessing healthcare for Māori	515 (19)
		Targets for Māori access and outcomes that are at least equal to that of the population as a whole	69 (3)
Options	164 (6)	Development of new kaupapa Māori services	15 (0)
		Support of existing kaupapa Māori services	107 (4)
		Funding for kaupapa Māori and Māori-led services	42 (2)
Partnership	262 (10)	Designing health services with Māori	124 (5)
		Genuine co-governance	138 (5)
Tino rangatiratanga	7 (0)	Māori autonomy	7 (0)

### Active protection

Active protection was detailed in annual plans primarily as improving cultural appropriateness of DHB-provided services, and by providing data disaggregated by ethnicity. There were no mechanisms to measure unmet need for Māori. Examples of improving cultural appropriateness of DHB-provided services included incorporating tikanga Māori into health services, publishing education resources in te reo Māori, and modifying the site of healthcare delivery, for example, to marae. Some DHBs aimed to implement culturally appropriate initiatives for specific services, such as “Manaaki Mana: Excellence in Emergency Care for Māori,” aimed at achieving equity for Māori using the emergency department.<sup>21</sup>

DHBs planned to improve cultural responsiveness among staff, mainly by improving cultural competence. While training in Te Tiriti o Waitangi

and equity was offered by many DHBs, only three suggested more critical approaches such as understanding colonisation, institutional racism, and bias.<sup>22-24</sup>

All DHBs used disaggregated ethnicity data, allowing for Māori/non-Māori comparisons. Dashboards to help staff identify areas of inequity were an example of how this data was used.<sup>25-27</sup> Many DHBs identified problems with data quality, for example, incomplete workforce ethnicity data, and had plans for improvement.<sup>21,28,29</sup>

While every DHB stated their intention to increase the number of Māori employees, the particular focus was on Māori midwives, nursing, and allied health. Five DHBs aimed to achieve proportionality of Māori employees with the Māori population in their regions, though nearly half of DHBs failed to state a measurable target.<sup>21,23,25,28,29</sup> Increasing Māori senior management and clinical leadership roles were only mentioned by three DHBs.<sup>21,30,31</sup>

## Equity

Barriers to access were addressed by DHBs by moving services closer to the communities who need them, providing outreach and tele-health services, providing services outside of normal work hours, reducing financial barriers, and improving integration of related services. To address problems with navigating complex health services, support was offered to Māori by many DHBs in the form of Equity Clinical Nurse Specialists or navigators.

Prioritisation of Māori to achieve equal utilisation or health outcomes was an expected finding, as DHBs were explicitly instructed to do so by the Manatū Hauora – Ministry of Health annual plan guidance across pre-selected action areas.<sup>12</sup> While overt prioritisation of Māori to achieve equitable outcomes was observed, this occurred infrequently. A positive example was Hawke's Bay and Lakes DHBs noting in their annual plans that in order for the National Bowel Screening Programme to deliver equal health gains for Māori compared with non-Māori, they would need to ensure 73% of eligible Māori participated compared with 62% of non-Māori.<sup>24,32</sup>

Targets were used as an outcome measure in all DHB annual plans, and while many were equity-consistent, examples of lower targets for Māori were also evident, for example with respect to immunisation: “coverage for total population at eight months is 91% by 31 March 2020 ... coverage for Māori at eight months is 86%”.<sup>26</sup>

## Options

Two large urban DHBs planned to offer taha Māori mental health and addiction services.<sup>27,30</sup> Discrete packages of healthcare, such as smoking cessation interventions and screening, represented the majority of services contracted to Kaupapa Māori providers. While many DHBs expressed their intent to partner with Kaupapa Māori providers in various ways, only Waikato, Capital and Coast and Tairāwhiti committed to financial support, with the latter committing a defined percentage of its community funding to Māori health providers.<sup>25</sup> Options informed by mātauranga Māori were limited to five examples in Northland, Bay of Plenty and Tairāwhiti DHBs, including Te Kuwatawata, a service for whānau experiencing mental health distress.<sup>25</sup>

## Partnership

With respect to co-governance, nearly all DHBs discussed their engagement with an iwi relationship

board; however, considerable variation was evident in the nature and functionality of these relationships. Descriptors of the iwi board's role included influencing planning, strategy, and analysing performance.<sup>25,33,34</sup> At an operational level, DHBs planned to involve Māori in governance across a range of health services, but often implied this would be undertaken by a single Māori representative within a larger leadership group.

## Tino rangatiratanga

Across annual plans, articulation of Māori autonomy was scarce. A positive example was the commitment of Bay of Plenty DHB to implement an independent iwi-developed health strategy.<sup>26</sup> In contrast, a second example of the exercise of tino rangatiratanga involved a dispute between Tairāwhiti DHB and an iwi health provider, leading to the iwi invoking their Te Tiriti o Waitangi right to deal directly with the Crown regarding the inequitable health status of their people.<sup>25</sup>

## Discussion

This study used a qualitative, directed content analysis approach to investigate whether DHBs' annual plans were consistent with the principles of Te Tiriti o Waitangi.

With respect to active protection, evidence demonstrated that DHBs focussed on making their own services more culturally appropriate, when an alternative and more successful approach could have been to increase contracts for service provision to Kaupapa Māori providers. This bias towards DHB provided services is reflected in a Manatū Hauora – Ministry of Health report on DHB spending, which showed that funding to Māori health providers as a percentage of DHBs' Crown funding remained small and static at around 1.5% over a five year period.<sup>35</sup> There was a lack of focus on measuring and responding to unmet need for Māori, and references in annual plans largely related to secondary care, despite evidence demonstrating that Māori experience high levels of unmet need in accessing primary care services.<sup>2</sup> While efforts to increase Māori representation among DHB employees was positive, it tended to focus on patient-facing clinical roles rather than enabling Māori leadership within the system. This is problematic, given recent evidence to suggest that Māori were gravely under-represented in DHB senior leadership roles,<sup>36</sup> and acts to perpetuate the

marginalisation of Māori voice across the health system.

DHBs' interpretations of equity within annual plans was concerning. While DHBs prioritised Māori across a range of health issues, some predetermined by Manatū Hauora – Ministry of Health guidance,<sup>12</sup> it was unclear how priority areas were chosen and how Māori voice was reflected in this process. For example, very few actions related to coronary disease and lung cancer, which could be reasonably expected to be prioritised, given they are the primary contributors to the life expectancy disparity between Māori and non-Māori.<sup>37,38</sup> Additionally, aligning with Wai 2575 findings, DHB statements about reducing inequities rather than the Te Tiriti o Waitangi-consistent goal of eliminating them altogether illustrated a superficial understanding of the meaning of equity. A further example was the use of proportional utilisation of health services by Māori as a target, regardless of greater Māori health need for that service.

Annual plans failed to demonstrate genuine options for Māori, particularly those grounded in mātauranga Māori (Māori knowledge). They often conflated Kaupapa Māori services with culturally adapted generic services, suggesting a lack of understanding around the distinction between the two, and Te Tiriti o Waitangi obligations to provide options. Similar to previous findings, annual plans contained some evidence that DHBs subjected Kaupapa Māori providers to more onerous accountability than DHB-delivered services.<sup>39</sup> As noted by the Waitangi Tribunal, Kaupapa Māori health providers are an expression of tino rangatiratanga,<sup>2</sup> therefore by limiting service provision by Kaupapa Māori providers, DHBs not only failed to uphold the principle of options, but also the guarantee of tino rangatiratanga.

Actions within annual plans relating to the principle of partnership were scarce. Engaging with Māori to co-design health services was planned by many DHBs; however, it was difficult to ascertain how Māori voice was incorporated in resulting outputs, or the degree of agency afforded to Māori. Actions to compensate for participants' time and costs were few. Similar to Came, McCreanor et al. who investigated Māori DHB board member experiences,<sup>40</sup> the present study found that governance arrangements constrained tino rangatiratanga, with annual plan descriptions of the relationship between Māori boards and their DHB counterparts reflecting

a passive or advisory role without the ability to exercise authority or vote on board decisions. Furthermore, there were instances where Māori were framed as one of many stakeholders in DHB services, rather than as equal Tiriti partners.

## Conclusion

In summary, while DHBs' annual plans universally contained expressions of commitment to Te Tiriti o Waitangi, their content did not sufficiently realise these commitments, amounting to a response grounded in rhetoric and non-performativity. The *Pae Ora (Healthy Futures) Act 2022* sets out the requirement for a New Zealand Health Plan. These plans will be jointly developed by Te Whatu Ora – Health New Zealand and Te Aka Whai Ora – Māori Health Authority and consist of a population health needs assessment and a 3-year costed plan for the delivery of publicly funded health services. The plans are acknowledged in the *Act* as a mechanism by which the Crown will “give effect to the principles of Te Tiriti o Waitangi”.<sup>41</sup> Applying the findings of this study, some critical enablers are evident if future plans are to achieve this aim.

With regards to active protection, the availability of high-quality data, disaggregated by ethnicity will be essential to conduct health needs assessments, and to measure performance and outcomes as required by the *Act*. To “empower Māori to improve their health,”<sup>41</sup> Māori must be present in leadership roles, not only in Te Aka Whai Ora – Māori Health Authority, but across all health system entities. To uphold the principle of equity, plans must explicitly prioritise Māori to achieve health equity, maximise Māori health gain, and allocate resources proportional to Māori health need. A fresh approach to commissioning of services from Kaupapa Māori providers will be essential to provide legitimate options for Māori, removing undue bias towards Te Whatu Ora – Health New Zealand provided services.

Whether New Zealand health plans will allow for genuine partnership between iwi Māori and the Crown is complex. As both Te Aka Whai Ora – Māori Health Authority and Te Whatu Ora – Health New Zealand are Crown entities, Iwi-Māori partnership boards are Tiriti partners within the new structure. They will have indirect influence over the New Zealand Health Plan through their relationships with its co-authors, Te Aka Whai Ora – Māori Health Authority and Te Whatu Ora – Health New Zealand, and their approval

of locality plans. The extent to which the boards are treated as equal partners, enabled to exercise tino rangatiratanga and empowered to make key decisions remains to be seen.

Limitations of the study include the restriction of our sample to the 2019/2020 annual plans, meaning findings may not be generalisable to other years, or to assess adherence to Te Tiriti o Waitangi over time. Critics of directed content

analysis state that its use of pre-existing frameworks can lead to bias when interpreting data.<sup>16</sup> However, placing Te Tiriti o Waitangi at the centre of our analysis is consistent with Māori rights to monitor the Crown,<sup>10</sup> and enables a critical Kaupapa Māori lens to be cast on the health system, thereby exposing the role of colonisation, and resulting privileging and normalising of Pākehā views and values.



**COMPETING INTERESTS**

Nil.

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