The Right to Health and Indigenous Peoples

Submission to the United Nations Human Rights Office of the High Commissioner

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Contact

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About Te Rūnanga o Aotearoa, New Zealand Nurses Organisation

Te Rūnanga o Aotearoa, New Zealand Nurses Organisation (Te Rūnanga) is the bicultural arm through which the Moemoeā, aspirations of Māori health professionals are achieved.

Our aim is to enhance the health and wellbeing of all people of Aotearoa. We are united in our professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all people.

Te Rūnanga represents the needs, concerns and interests of Māori members at regional, national and international forums. Te Rūnanga leads the development of Māori processes within NZNO.

EXECUTIVE SUMMARY

1. As indigenous health care professionals, Te Rūnanga o Aotearoa, New Zealand Nurses Organisation (Te Rūnanga) welcomes the opportunity to comment on United Nations Human Rights the Right to Health and Indigenous Peoples.

2. Te Rūnanga has consulted its members and staff in the preparation of this submission, in particular our Kaiwhakahaere (president), Te Poari (governance board) and policy advisers.

3. While it is widely acknowledged that there are long standing and significant disparities in health outcomes for Māori - shorter lives, less access to primary health care, less access to treatment, poorer treatment - we do not agree that such inequalities are acceptable, just, necessary or fair[i] in a developed country like Aotearoa New Zealand in 2016.

4. We strongly advocate that all tamariki in Aotearoa New Zealand should be entitled to the positive social determinants of health – the right to shelter, the right to love, the right to a safe environment, and the right to access free health and social services at any time 24/7.

5. The Māori term tamariki for children does not specifically linked to any particular age group, rather it overlaps with other terms, for example; tamariki (young, youthful, children), taitamariki (to be young, youthful), and rangatahi (younger generation)[ii].

6. It is our recommendation that underlying issues such as; poverty, family violence, systemic barriers to access culturally appropriate health care services and structural differences in funding and auditing processes between Māori and Iwi providers and Primary Health Organisations (PHOs) must be addressed as a priority as they severely impact the current and future health of our tamariki.

7. We are also distressed at the alarmingly high rates of Māori youth suicide and the need for culturally appropriate services to support our tamariki and their whānau.

8. As indigenous nursing professionals we are committed to reaffirming our rights under the United Nations Declaration of Indigenous people's article 3, to self-determine, and this will underpin any future Māori health strategies.

9. Te Rūnanga strongly recommends future investment in the Māori health workforce as a fundamental necessity to improve Māori health outcomes; and wish to raise our specific Māori health workforce concerns including:

    - structural differences in funding and auditing processes between Māori and Iwi providers and Primary Health Organisations;
    - Māori nurses as advocates;
    - Government strategies for Māori health workforce;
    - Māori health workforce;
    - Universal Periodic Review; and

- Cultural competency training.

DISCUSSION

Equity from the start

10. Article 1 of the United Nations Declaration on the rights of Indigenous people, acknowledges that Indigenous people have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedom as recognised in the charter of the United Nations, the Universal Declaration of Human Rights and international human rights law[iii].

Right to good health

11. Māori, as other indigenous people, have an equal right to the highest standards of health, and the State is responsible for ensuring this is achieved under article 24.2 of the United Nations Declaration on the Rights of Indigenous peoples[iv]. We also acknowledge the rights under te Tiriti o Waitangi of Māori to good health that encompasses wellness in its fullest sense and including the physical, spiritual and cultural wellbeing of Māori as individuals and collectively[v].

12. Māori make up 15 percent of the New Zealand's population. Māori have a much younger age structure than non-Māori population with an expected prediction that half of the Māori population will be younger than 28 years by 2038[vi].

Underlying issues of poverty

13. There are well documented ethnic disparities in life expectancy, the enjoyment of good health and differential health outcomes between Māori and non Māori.[vii]

14. While Māori are to be found within all socioeconomic sectors of Aotearoa New Zealand society, Māori children are over represented in child

poverty statistics with recent study (2012-2014) indicating that on average, around 33% of Māori children and 28% Pacific children lived in poor households, compared to an average of 16% European children[viii]. For many Māori children child poverty translates into poor educational performance, high offending rates, severe and on-going health problems, low income and high state dependency rates[ix]. Research also indicates that Māori tamariki are also proportionally more exposed to the impacts of poverty as evidence by rates of admissions to hospital for infectious and non-infectious diseases often associated with poverty[x].

Family violence

15. As indigenous health professionals, Te Rūnanga draw attention to Article 22.2 of the United Nations Declaration on the Rights of Indigenous Peoples which states that 'States *shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination'.*

16. As Māori are disproportionately represented as both victims and perpetrators, with Māori women twice as likely as other women to experience family violence, we strongly recommend that training in cultural competency should be mandatory for all frontline staff across all health and social sectors.

17. Te Rūnanga agree that services for Māori should recognise cultural needs and continue to shift to a whānau (family group) based delivery model grounded in tikanga (correct procedure or custom[xi]) and be culturally responsive services.

18. As frontline health service staff, our members play a vital role in providing better services for victims, perpetrator and whānau, and sharing information, providing training to support the wider workforce to practice in a responsive, safe and competent way.

Barriers to accessing health care

19. Access to health care is a major issue for indigenous people worldwide despite compromising only 5% of the world's population, they account for 15% of the world's poor[xii]. As with other indigenous people, colonialism has left a legacy of health inequalities for Māori[xiii] and where Māori experience more barriers towards accessing health services and as a result achieve poorer health outcomes[xiv]. The devastating ongoing effects of racism and discrimination towards Māori on health has been well documented[xv], along with the impacts these disparities have had on Māori and on the differential distribution of social, political, environmental and economic resources and wellbeing within this country[xvi].

20. Te Rūnanga members have provided specific examples of structural or systems barriers that have impeded the care that they have delivered to tamariki children and their whānau families. These include:

    - *greater importance placed on smoking health targets, than focussing on the health needs of clients or whānau;*
    - *inability to access key agency services for at risk clients afterhours, people-related services need to be available 24/7 not just Monday to Friday 9-5pm;*
    - *cost cutting of key services meant having to deal with an overseas call centre when what was really needed were local people available to offer real solutions to crisis;*
    - *no accessibility to children's specialist hearing appointments outside hours for parents who work Monday to Friday 9-5pm;*
    - *inappropriate resourcing of services for pregnant mothers, with mental health issues, no proactive services to support mother and baby, having to wait for a 'crisis' to intervene in welfare of mother and baby; and role confusion, losing trusting relationships with patient when they see you not as the nurse*

but as 'the policeman', when mandatory reporting becomes a priority over practical solutions.

Structural differences in funding and auditing processes between Māori and Iwi providers and PHOs

21. Research has shown that there are a lot of structural difference in funding and auditing processes between Māori and Iwi Providers and PHOs. We refer you to Dr Came's research (2013)[xvii] which found in relation to fund practices confirmed the pattern of Māori providers were being disadvantaged by how the Crown administers public health funding. Came (2012)[xviii] provided the following suggestions on how funders could reduce, minimise and/or eliminate racism within contracting:

    - develop transparent criteria for the allocation of discretionary and/or one-off public health funding and publish it on-line and consistently follow it;
    - make the application of the prioritisation guidelines mandatory in funding decisions and ensure Crown Officials have access to the relevant training to apply these guidelines; and
    - ensure a consistent approach is taken to the allocation of costs of living and/or Forecast Funding Track (FFT)[xix].

22. Our members have reported that there appears to be no national standard or consistent transparent process for assessing or monitoring health service providers. It would appear that the decision making process is subjective, based on who you are, who you know, and who you are connected to.

23. A recommendation on consistent process, Came (2012) PhD thesis, page 281[xx]:

> *"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".*

24. An example of inconsistent monitoring processes, Came (2012) PhD thesis, page 239[xxi]:

> *"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".*

Tamariki Māori

25. Te Rūnanga believes that this whakatauakī (proverb) *"Kia korowaitia āku mokopuna ki te korowaitanga hauora, let our future generations be embraced with good health",* reflects the need for every Aotearoa New Zealand person to be committed and involved in making changes to the ways our society views tamariki, and to ensure our future generations are protected, respected and treated as taonga (treasured possessions).

26. We strongly agree, that a proactive approach to improving the health and wellbeing of every tamariki is essential for the future wellbeing of Aotearoa.

27. The Māori term tamariki for children does not specifically linked to any particular age group, rather it overlaps with other terms, for example; tamariki (young, youthful, children), taitamariki (to be young, youthful), and rangatahi (younger generation)[xxii].

28. As health professionals, we understand why it is necessary to be proactive in addressing health inequity and know from the evidence-base[xxiii] that ensuring free access to culturally appropriate primary health care services for all tamariki is an essential first step in promoting better health outcomes for our tamariki.

29. Te Rūnanga agrees that disparities in child health status signal the need for universal health services responsive to the needs of Māori children - and this needs to start with good antenatal and maternity care and societal change to focus on the health and wellbeing of our future generations.

Māori Youth suicide

30. We are distressed at the alarmingly high rates of youth suicide in Aotearoa New Zealand. In 2011, New Zealand had the second highest youth suicide rate for both males and females in the Organisation for Economic Cooperation and Development (OECD) countries[xxiv], with Māori youth suicide rates 2.4 times higher than the equivalent rate for non Māori youth[xxv].

31. This is unacceptable rate of death for our tamariki, we recommend that culturally appropriate youth mental health services aimed at building cultural identity, supportive caring community and better recognition of symptoms at primary health care level, are available to identify and help our young people and their whānau who are in distress[xxvi].

Māori Nurses Advocacy role

32. Te Rūnanga have advocated for changes to health care service delivery for Māori tamariki and their whānau in submissions to the New Zealand governments green paper on vulnerable children[xxvii](2012) subsequent white paper (2012[xxviii]), and the Māori Affairs Select Committee (2012) inquiry[xxix] into the determinants of wellbeing for tamariki Māori. Little change, however has been seen to the care of the most vulnerable

children. The recommendations from the Māori Affairs Select committee included further extensive research, evaluation of the impact of whānau focused services and long term funding for relevant service providers and how this impacts on the work is being measured.

33. Te Rūnanga strongly assert that suitably funded indigenous health initiatives are required to address the contemporary effects of colonial history by supporting self-determination, reinforcing cultural integrity and rebuilding trans-generational relations and the wellbeing of indigenous women[xxx].

Government strategies for Māori Health Workforce

34. There are numerous government strategies (Primary health care strategy (2001)[xxxi]; He Korowai Oranga: Māori Health Strategy (2002) [xxxii]; Raranga Tupuake Māori health workforce development plan (2006)[xxxiii] ; Whānau ora: Report of the Taskforce on Whānau centred initiatives (2010)[xxxiv]; that all focus on improving Māori health inequalities.

35. We acknowledge the concept of Whānau ora that aims to place whānau at the centre of service design and delivery to empower and realise their own solutions; but also demands greater accessibility, integration and coordination amongst services[xxxv].

36. These strategies are all reliant however on a Māori workforce to deliver a 'Māori for Māori by Māori health service delivery to addresses disparities. We strongly believe that the Māori health workforce is a key factor in any long-term strategy[xxxvi] to improve Māori health outcomes and requires dedicated development and resourcing.

37. It is of serious concern that at a time when the gap between Māori health and the health of the average New Zealander is *increasing, that* reducing disparities[xxxvii] and acknowledgement of the rights of Māori to equal health under Te Tiriti have disappeared from Ministry policy objectives.

Māori health workforce

38. The Human Rights Commission document 'A Fair go for all' indicated that in health another form of structural discrimination is the under representation of Māori in the health workforce[xxxviii].

39. Without 'measuring the problem in a manner consistent with the epidemiological base of modern health and medicine' as suggested by the World Health Organisation Commission on Social Determinants of Health, 2008[xxxix], no confidence can be placed in a "Māori health workforce strategy", or in achieving health equity for Māori.

40. Current New Zealand nursing workforce does not reflect the communities it services. There are 50,356 practising nurses (March 2015) in New Zealand, with only 7% (3,510) identified as New Zealand Māori[xl].

41. Workforce planning for nurses to date has been limited with an estimated 15,000 nurse's shortage by 2035[xli], with little work undertaken or planned to address this alarming shortage.

42. As Māori nurses we need to have access to become decision makers and advocate for quality health care systems that look after everybody to continue to ensure universal access to health care right from the start. We need our Maori nursing identity and skills to be recognised and valued and to be empowered to nurse in a culturally appropriate way.

Universal Periodic review

43. In 2013, NZNO submitted to the 18th session of the Human Rights Council universal periodic review New Zealand that the New Zealand government was not collecting essential Māori health workforce data (i.e. comprehensive, accurate and meaningful) as they relate to regulated nurses (Registered Nurses and Enrolled Nurses) and unregulated health care assistants (HCAs)[xlii].

44. We believe that such data are essential for the development of evidence-based strategies to address the inadequate numbers of the Māori health workforce which contribute to endemic and increasing systemic health disparities.

45. While development of the Māori health workforce is key to improved Māori health outcomes[xliii] there is little investment in evidence based research to demonstrate the outcomes of any investment or workforce strategy planning. Work is underway to strengthen the capacity and capability of the Māori health and disability workforce in order to maximise its contribution to improve health outcomes for Māori[xliv] and it is essential that investment in this work is grown and robust evaluation of outcomes is undertaken.

46. Te Runanga requests that the government to address the pay parity campaign Te Rau Kōkiri that continues for Māori and Iwi providers working in Primary Health Care (NZNO, 2009). This workforce is vital for the health and wellbeing of the Māori community and health sector, and will be essential for the implementation of a whānau centred approach to Māori wellbeing and fundamental to improving health outcomes for Māori. We note that the Māori health workforce is a key factor in any long-term strategy (Ministry of Health, 2006) to improve Māori health outcomes and requires dedicated development and resourcing – note in particular support is needed for the development of Māori midwives and midwifery services.

<u>Cultural competency training</u>

47. While we agree that training in cultural safety should be mandatory for all frontline staff across all government agencies, we also believe that this should be mandatory for all Ministry policy makers, funders, planners and contract managers.

48. Regulatory bodies such as the Nursing Council of New Zealand have included cultural safety into nurse's scopes of practice which require the

nurse to practise nursing in a manner that the health consumer determines as being culturally safe, and to demonstrate the ability to apply the principles of te Tiriti o Waitangi to nursing practice.

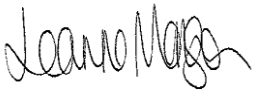
49. While most nursing students are educated on inclusive models of health and wellbeing like Mason Durie's Te Whare Tapa Whā (Ministry of Health, 2009) that places holistic approaches to one's health and wellbeing based on four corner stones of a whare, it is essential that overseas registered health professionals are required to complete any bicultural training before working with Māori.

CONCLUSION

In conclusion NZNO recommends that you:

- **note** our comprehensive submission; and
- **agree**, that a proactive approach to improving the health and wellbeing of every tamariki is essential for the future wellbeing of Aotearoa;
- **note** our recommendations for future investment in the Māori health workforce as a fundamental necessity to improve Māori health outcomes;
- **note,** the current **s**tructural differences in funding and auditing processes between Māori and Iwi providers and Primary Health Organisations; and
- **agree** that training in cultural safety should be mandatory for all frontline staff across all government agencies, including policy makers, funders, planners and contract managers.

Nāku noa, nā



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REFERENCES

[i] Human Rights Commission. (2012) *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services.* Human Rights Commission: Wellington.
[ii] Māori dictionary website. (2016). Website accessed 3/3/16. http://maoridictionary.co.nz
[iii] United Nations. (2008). *United Nations Declaration on the rights of Indigenous Peoples. United Nations:* Geneva.
[iv] United Nations General Assembly. United Nations Declaration on the Rights of Indigenous People: Retrieved on 1/3/16 from http://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf
[v] Aparangi Tautoko Auahi Kore (ATAK). 2003. *National Māori Tobacco Control Strategy*. Wellington: Aparangi Tautoko Auahi Kore.
[vi] Statistics New Zealand. (2016) Māori population. Website accessed 2/3/16. http://www.stats.govt.nz/browse_for_stats/people_and_communities/maori/maori-population-article-2015
[vii] Human Rights Commission. (2011). *Tūi Tūi Tuituiā Race Relations in Aotearoa (2011)*. Human Rights Commission: Wellington.
[viii] Perry, B. (2015). *Household incomes in New Zealand: Trends in indicators of inequality and hardship 1982 to 2014.* Ministry of Social Development: Wellington.
[ix] Salmond, A. (2003). To the Social Policy Research and Evaluation Conference. *Social Policy Journal of New Zealand*. 20:1-5, June 2003.
[x] Craig et al. (2012, unpublished). Te Ohonga Ake: the Health Status of Māori Children and Young People in New Zealand. Otago: New Zealand Child and Youth Epidemiology Service.
[xi] Māori dictionary website. (2016). Website accessed 3/3/16. http://maoridictionary.co.nz
[xii] Canadian Coalition for Global Health Research. (2008) *Structural issues affecting the Worlds Indigenous People.* Accessed 26/2/2016. ://www.ccghr.ca/wp-content/uploads/2013/04/StructuralIssues_GIHR_2008_en.pdf
[xiii] Crampton, P., Robson, B. Ongoing leadership and effort needed to keep the focus on improving Māori health. NZMJ. 2 May 2014, Vol 127 (1393).
[xiv] Theunissen, K. (2011). The nurses' role in improving health disparities experienced by the indigenous Māori of New Zealand. *Contemporary Nurse,* 39(2): 281-286.
[xv] Expert Advisory Group on Solutions to Child Poverty. (2012). *Working paper no.14 Reducing Child Poverty in Māori Whānau.* Expert Advisory Group on Solutions to Child Poverty: Wellington.

[xvi] Expert Advisory Group on Solutions to Child Poverty. (2012). *Working paper no.14 Reducing Child Poverty in Māori Whānau.* Expert Advisory Group on Solutions to Child Poverty: Wellington.
[xvii] Came, H. (2013). Beginning to address institutional racism within the public health sector: insights from a provider survey [invited paper]. Keeping up to date: Health Promotion Forum. No.38,pp1-4.
[xviii] Came, H. (2012). *Institutional Racism and the dynamics of Privilege in Public Health*. PhD thesis. Waikato: Waikato University.
[xix] Came, H. (2013). Beginning to address institutional racism within the public health sector: insights from a provider survey [invited paper]. Keeping up to date: Health Promotion Forum. No.38,pp1-4.
[xx] Came, H. (2012). *Institutional Racism and the dynamics of Privilege in Public Health*. PhD thesis. Waikato: Waikato University.
[xxi] Came, H. (2012). *Institutional Racism and the dynamics of Privilege in Public Health*. PhD thesis. Waikato: Waikato University.
[xxii] Māori dictionary website. (2016). Website accessed 3/3/16. http://maoridictionary.co.nz
[xxiii] Russell, L., Smiler, K., Stace, H. (2013). *Improving Māori Health and Reducing inequalities between Māori and non Māori: has the primary health care strategy worked for Māori? An evaluation of the period 2003-2010.* Wellington: Health Research Council of New Zealand and Ministry of Health.
[xxiv] Ministry of Health. (2016). Understanding suicide New Zealand. Website accessed 8/3/16. http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/understanding-suicide-new-zealand
[xxv] Wakahourua. (2016). Māori youth suicide factsheet. Website accessed 2/3/2016. http://wakahourua.co.nz/suicide-facts
[xxvi] BPAC. (2010) Suicide prevention in Māori youth. Website Accessed 8/3/16. http://www.bpac.org.nz/BPJ/2010/June/suicide.aspx
[xxvii] New Zealand Nurses Organisation. (2012). *Green Paper for Vulnerable Children*. Wellington: New Zealand Nurses Organisation.
[xxviii] New Zealand Nurses Organisation. (2012). *White Paper for Vulnerable Children*. Wellington: New Zealand Nurses Organisation.
[xxix] Te Rūnanga o Aotearoa New Zealand Nurses Organisation. (2012) *Māori Affairs Select Committee inquiry into the determinants of wellbeing for Māori tamariki*. Wellington: Te Rūnanga o Aotearoa New Zealand Nurses Organisation.
[xxx] Canadian Coalition for Global Health Research. (2008) *Structural issues affecting the Worlds Indigenous People.* Accessed 26/2/2016. ://www.ccghr.ca/wp-content/uploads/2013/04/StructuralIssues_GIHR_2008_en.pdf
[xxxi] Ministry of Health. (2001) *Primary Health Care Strategy*. Wellington: Ministry of Health.
[xxxii] Ministry of Health. (2002). *He Korowai Oranga: Māori health strategy.* Wellington: Ministry of Health.
[xxxiii] Ministry of Health. (2006). *Raranga Tupuake: Māori Health Workforce Development Plan.* Wellington: Ministry of Health.
[xxxiv] Whānau ora Taskforce. (2010). *Whānau ora: report of the taskforce on whānau centred initiatives.* Wellington: Whānau ora Taskforce.
[xxxv] Te Puni Kōkiri website. 2015. Whānau ora. Retrieved on 8/3/2016.
[xxxvi] Ministry of Health. 2006. *Raranga Tupuake – Māori Health Workforce Development Plan.* Wellington: Ministry of Health.

[xxxvii] Russell, L., Smiler, K., Stace, H. (2013). *Improving Māori Health and Reducing inequalities between Māori and non Māori: has the primary health care strategy worked for Māori? An evaluation of the period 2003-2010.* Wellington: Health Research Council of New Zealand and Ministry of Health.

[xxxviii] Human Rights Commission. (2012) *A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services.* Wellington: Human Rights Commission.

[xxxix] World Health Organisation Commission on Social Determinants of Health. (2008). *Primary Health care: now more than ever.* Geneva: World Health Organisation.

[xl] Nursing Council of New Zealand. (2015). The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2014¬2015. Author: Wellington.

[xli] Nursing Council of New Zealand. (2015). The New Zealand Nursing Workforce: A profile of Nurse Practitioners, Registered Nurses and Enrolled Nurses 2014¬2015. Author: Wellington.

[xlii] New Zealand Nurses Organisation. (2012). *18th Session of the Human Rights Council Universal Periodic review –New Zealand.* Wellington: New Zealand Nurses Organisation.

[xliii] Maxwell-Crawford. (2011) Indigenous workforce development in Aotearoa. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health. 9 (1), 53-64).

[xliv] Ratima, M., Brown, R., Garrett, N., Wikaire, E., Ngawati, R., Aspin, C., Potaka, U. (2007). *Rauringa Raupa Recruitment and Retention of Māori in the Health and Disability Workforce. Auckland: Taupua Waiora: Division of Public Health and Psychosocial Studies.* Faculty of Health and Environmental Sciences: AUT University.