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Representations of Māori in *colonial* health policy in Aotearoa from 2006-2016: a barrier to the pursuit of health equity

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ABSTRACT

An integral part of colonisation is the suppression and marginalisation of indigenous knowledges. The indigenous health system within Aotearoa (New Zealand) was supplanted with a colonial infrastructure and praxis which has proven ineffective in addressing systemic health inequities created by the processes of colonisation. This novel study interrogates discursive representations of Māori (Indigenous peoples of Aotearoa) within *colonial* public health policy between 2006 and 2016. Colonial policy refers to *generic* or *mainstream* policy that are designed for 'all' New Zealanders. We utilised thematic analysis to examine 106 policies and, after excluding 13 ethnic specific policies, identified 68 policies containing no mention of Māori. The analysis highlights five themes relating to discursive representations of Māori. These were: i) silence about Māori health; ii) Māori as especially at risk; iii) Crown (lack of) responsiveness to *te Tiriti o Waitangi* obligations; iv) recognition of Māori philosophical approaches to service provision; and v) utilising mātauranga Māori (Māori knowledge). These findings suggest colonial policy presents a barrier to the pursuit of health equity and is poorly aligned to global Indigenous human rights declarations. Within the context of Aotearoa it echoes the sentiments of the key Waitangi Tribunal [WAI 2575] finding that health policy is contributing to health inequities and failing Māori. Health policy must be decolonised to better engage with human rights declarations and *te Tiriti o Waitangi* obligations in order to achieve health equity.

Introduction

Colonial health systems and policies have been imposed on Indigenous peoples around the world as part of the wider colonial project (O'Sullivan, 2015). This has contributed to global patterns of health inequities between Indigenous and other peoples (Anderson et al., 2016). The *Declaration on the Rights of Indigenous Peoples*, amongst other human rights conventions, guarantees health equity for all Indigenous peoples as outlined within articles 21, 23, 24, and 31 (United Nations, 2007). Collectively, these articles guarantee Indigenous peoples the right to improve their health, their development, and to enjoy the highest attainable standard of health. The existence of entrenched ethnic health inequities is a breach of Declaration.

Studies across the globe show that entrenched biases and institutional racism within all levels of the health system, including its administration, have contributed to health inequities (Paradies et al., 2015; Starfield, 2011). There have been consistent calls from Indigenous scholars to strengthen Indigenous content and engagement in health policy (Gracey & King, 2009; Mowbray, 2007). These

calls have been echoed in Aotearoa (New Zealand) where Reid and Robson (2007) have articulated the right of Māori (Indigenous peoples of Aotearoa) to monitor Crown performance at all levels of the health system.

This article is a response to that call; and is informed by the 2019 release of the WAI 2575 Waitangi Tribunal[1] (2019) stage one report focussing on Māori health. In this report the Tribunal noted the widespread failure of the health system to deliver effectively to Māori and to address known inequities.

> We are faced with the prospect of whether an important – and hitherto insufficiently recognised – cause of the inequities suffered by Māori as a population group in the last two decades is the legislative and policy framework of the primary health care system itself (Waitangi Tribunal, 2019, p. 25).

This statement is reinforced by qualitative studies of health practitioner beliefs and practices in relation to Māori (McCreanor & Nairn, 2002) which show a firm reliance on discriminatory discursive themes. Likewise, quantitative work continues to identify patterns of disuse of services and unmet need, due to perceptions and/or experiences of discrimination (Harris et al., 2019). Came et al. (2019) have argued that Crown (government) inaction in the face of evidence of health service racism has further fuelled inequities.

Although omitting an ethnic analysis, MacKay and Quigley (2018) argue the enthusiastic orientation of public health policy to Western-influenced behavioural sciences leads to limited engagement with the social determinants of health. The evidence is now clear that the socio-economic circumstances in which Indigenous people live, work and play are key drivers of health status (Mowbray, 2007; Wilkinson & Marmot, 2003), as are the historical legacies of colonisation and institutional racism (Paradies, 2016). Indigenous writers maintain culture is critical to the successful delivery of health services and within the design of health policy in Canada (Fiedeldey-Van Dijk et al., 2017), Australia (Ciann et al., 2016), and elsewhere; yet culture is often invisible within colonial health policy.

Health policy in Aotearoa

Addressing health inequities between Māori and non-Māori, has been claimed as a strategic priority of governments in Aotearoa for decades (King & Turia, 2002; Ministry of Health, 2016). Despite this, inequities have persisted since monitoring began in the 1950s (Statistics New Zealand, 2014). Marriott and Sim (2014) monitored twenty-one indicators of Māori health over a ten year period and found only eight domains where Māori health was improving relative to non-Māori.

Addressing health inequities evolved out of recognition of the governments' obligations under *te Tiriti o Waitangi* (te Tiriti), a founding document of the modern state of Aotearoa. Te Tiriti, negotiated between the British and Māori rangatira (chiefs) in 1840, reaffirmed tino rangatiratanga (Māori sovereignty), the protection of Māori taonga (that which is treasured, including health), and outlined the terms for equitable citizenship (Berghan et al., 2017). Contested, appealed, and even attacked by some, te Tiriti is one of the defining features of political life within Aotearoa. It deeply influences relationships between Indigenous and settler peoples, identities, social organisation, aspirations, health and wellbeing (Durie, 1999; Wyeth et al., 2010).

The *New Zealand Public Health and Disability Act 2000*; key health legislation in Aotearoa, responds to te Tiriti obligations as articulated by the New Zealand parliament under section 4 of the Act. This places a legislative requirement on the Ministry of Health who administer the NZPHDA 2000 to address inequities in health between Māori and non-Māori. However in 2019, the Waitangi Tribunal (2019, p. 162) recommended the Act be revised as they determined it was not compliant with te Tiriti. The Tribunal also asserted that the core Māori health policy, *He Korowai Oranga* (King & Turia, 2002), and other health policy documents do not meet te Tiriti obligations. Consideration also needs to be given to the Waitangi Tribunal (2014) ruling in WAI 1040 which found Māori never ceded sovereignty.

This high-level assessment of health legislation and policy by the Waitangi Tribunal, fits within the wider socio-economic and political context prevalent since the mid-1980s, whereby social policy in Aotearoa has been overwhelmingly influenced by neoliberalism (Kelsey, 2002; Rashbrooke, 2013). In Aotearoa, neoliberalism is characterised by its colonialist continuity, economic rationalism, market provision, social atomism and rolling back the state. Health policy, despite the weak fit with market models, has not been spared as the Crown systematically divested responsibility onto individuals and commercial providers (Came et al., 2016). The downgrading of commitments under te Tiriti, along with incipient individualism, has thrived in this environment. This has generated a dysfunctional, decontextualised universalism in Aotearoa, that denies or ignores the needs of whole sectors of society including Māori and other groups such as Pacific peoples, workers, older people and impoverished families.

While the causation of health inequities is complex, we argue that health policy is an important determinant. In this paper we report a novel study of ten years of Crown public health policy frameworks, attending to the ways in which they represent Māori. Using thematic analysis, we critically interrogate how Māori are discursively constructed within colonial health policy and the implications of these framings for Māori health and health equity.

We deliberately use the term *colonial* health policy in this article to refer to policy that is drafted with the intent to address the needs of the entire population, to emphasise policy links with an overtly racist past, and to avoid terms such as 'mainstream' that marginalise Indigenous experience. 'Colonial' health policy thus captures the power dynamics at play within contemporary health policy.

Method

This analysis of health policy forms part of a larger project examining racism and te Tiriti in health policy and policy making (Came et al., 2018; Came et al., 2019). As Māori and Pākehā (settler) activist scholars our focus is on how Māori are positioned within colonial public health policy and consequent implications for health equity. Collectively the authors have had seventy years of involvement in anti-racism and Tiriti work.

We review policy documents from the Ministry of Health's website between 2006 and 2016; a period which covered both Labour-led and National-led governments. The review identified 119 public health policy documents. That is, those without a clinical orientation; and that prioritise keeping the population healthy. We excluded thirteen ethnic specific strategies. The final database (N = 106) comprises policies and strategies around a broad range of subjects included, but not limited to: oral health, mental health (including suicide prevention), addictions (drug, alcohol, tobacco and gambling), breastfeeding, emergency planning, cervical screening, workforce development, diabetes, immunisation, health of older people, cancer control, and disabilities.

For the analysis we drew on the discursive analytical approach offered through Braun and Clarke's (2006) phase method of thematic analysis. First, a search within the policies for the term 'Māori' was made and one author (HC) familiarised herself with this corpus to get a sense of key ideas, actions and intentions. This was followed by a second reading to generate initial codes such as Māori as high priority, Māori comparisons to non-Māori, recognition of Māori rights, acknowledgement of Māori approaches to service provision, references to *te Tiriti o Waitangi*. We then identified and allocated relevant data excerpts to codes. Next, these working divisions were named and shaped into draft themes. These were then reviewed by the second author (SH) to ensure themes reflected the coded extracts.

Results

Our analysis shows diverse policy approaches which draw on five dominant discursive representations of Māori. These were: i) silence about Māori health; ii) Māori as especially at risk; iii) Crown (lack of) responsiveness to *te Tiriti o Waitangi* obligations; iv) recognition of kaupapa Māori (Māori philosophical)

approaches to service provision; and v) utilising mātauranga Māori. Each discursive representation was equally important and forms a theme that will be described and illustrated below using excerpts from the policies.

Silence about Māori health

More than two thirds of policy documents (sixty-eight) made no mention of the term 'Māori'. These policies covered a range of key health topics including cancer control, workforce development, smoking cessation, and diabetes. Within the remaining thirty-eight policies which mentioned Māori; only half referenced *He Korowai Oranga* (King & Turia, 2002); the key Māori health policy document. Those policies which referenced either Māori and/or *He Korowai Oranga* did so minimally. For example, Ministry of Health (2008), identified *He Korowai Oranga* and mentioned health inequities while within Ministry of Health (2010a), Māori are described as vulnerable populations and Māori providers were recognised as serving a key function in reducing inequities.

Crown (lack of) responsiveness to te Tiriti o Waitangi obligations

In addition to the silencing of Māori health, there was also minimal consideration given to Treaty obligations. Of the policies analysed there was one reference to *te Tiriti o Waitangi* (Māori text) and fourteen references to *Treaty of Waitangi* (English version) across the data. Treaty principles; partnership, protection, and participation (Royal Commission on Social Policy, 1988), were referred to 25, 7 and 45 times respectively. Specifically, several policies (e.g. Associate Minister of Health, 2006; Thornley et al., 2007) called for improved mechanisms for Māori participation at all levels; including decision-making, development, and, delivery of services. Other documents (Minister of Health, 2006; Ministry of Health, 2007a) reinforced effective partnerships being critical to improving Māori health.

Minimal references were also made to te Tiriti obligations for health providers, particularly district health boards (DHBs), to consult and engage with Māori leaders and iwi (nations). Of the policies reviewed, six had visible Māori mechanisms or representation into the policy document. A further nine noted advisory committee input and the remainder provided no information about Māori (or other wider sector/community) input into policy development. Only one policy (Ministry of Health, 2006b) noted collaboration with a Māori Monitoring and Review Group in the development of their strategy.

There were some statements (e.g. Associate Minister of Health, 2006; Inter-Agency Committee on Drugs, 2015) about the importance of being 'responsive to Māori', and a requirement that interventions are accessible, effective and appropriate. Others emphasised the need to be 'relevant to Māori' (Ministry of Health, 2006a; National Breastfeeding Committee, 2009), and noted generic services need to accept increased responsibility for Māori health and deliver quality and appropriate services. Several policies emphasised the importance of systematic evaluation to ensure interventions worked for Māori (Minister of Health, 2006; Ministry of Health, 2006a). It was rare for documents to cite evaluation frameworks that had been commissioned by the Ministry of Health specifically to help review service delivery to Māori (Cunningham, 1995; Ministry of Health, 2007e).

There was some recognition of Māori as a priority group, with a few policies (Ministry of Health, 2009, 2010b) mandating the elimination of disparities, barriers to access for Māori, and the establishment of dedicated Māori-led services. For instance, one policy notes: 'Services that target inequalities are the first priority for funding … DHBs will also be required to demonstrate the steps their own services are taking to ensure services meet the needs of the Māori population' (Ministry of Health, 2006a, p. 13).

One policy (Associate Minister of Health, 2006) was explicit in trying to reduce differences in injury rates, emphasising the importance of a multi-faceted and intersectoral approach to achieving this. They noted the importance of removing physical, financial and cultural barriers to services. Of note, Māori and Pacific people are often discussed together in policy (Ministry of Health, 2007b, 2007c) without culturally nuanced analyses. Politically, this is problematic as it reduces Māori to an ethnic minority rather than as a sovereign treaty partner.

Māori as especially at risk

Within most policy documents epidemiological data was used to negatively compare Māori with the entire population; often arguing that Māori are most at risk for ill health. Specifically, many policies grouped Māori, Pacific, and low socioeconomic groups together as experiencing poor outcomes, or as having the highest health needs. For example, the *Preventing and minimising gambling harm* policy (Ministry of Health, 2007b, p. 4) states: 'The 2006 needs assessment … highlights several groups that disproportionately experience harm from gambling: Māori and Pacific peoples, and populations in areas of high deprivation'.

The *Good oral health for all, for life: The strategic vision for oral health in New Zealand* (Ministry of Health, 2006a, p. 5) policy, states: 'Inequalities in oral health and in access to oral health services have become increasingly evident, with Māori, Pacific, rural and low socioeconomic populations all showing progressively poorer oral health relative to other groups.'

In other policies, Māori were compared against other groups in the population as being 'dis-advantaged', 'over represented', 'at-risk', 'vulnerable', and/or 'marginalised' to highlight the particu-lar needs among Māori. For example, *Te Raukura: Mental health and alcohol and other drugs* (Ministry of Health, 2007c, p. 9), policy states: 'Māori experience greater health disparities generally and have a greater prevalence for mental illness than other ethnic groups'.

Recognition of kaupapa Māori approaches to health service provision

Within the policies that did mention Māori health (N = 38), many acknowledged the need and value of kaupapa Māori approaches to health service provision. Kaupapa Māori entails Māori-led initiatives, that incorporate tikanga Māori and aim to advance the political, social, economic and cultural well-being of Māori. For example, Ministry of Health (2007a, p. 13) acknowledged that: 'While all approaches will address the needs of Māori, specific Māori approaches are also needed'. Likewise, the National Breastfeeding Committee (2009, p. 13) states: 'It is widely accepted that in order to be successful, public health initiatives for Māori must be grounded within a framework that makes sense for Māori and incorporates Māori values'.

One policy (Ministry of Health, 2006a, p. 9) noted Māori providers were 'breaking the traditional mould', positioning Māori approaches as different from generic providers rather than accepting a kaupapa Māori approach as being ordinarily acceptable. The Ministry of Health (2006a, p. 12) notes the commitment to 'support Māori and Pacific providers to develop … solutions that meet the needs of these populations'. Another frames it as strengthening the capacity and scope of Māori providers, thus recognising pre-existing agency (Associate Minister of Health, 2006).

Integral to strengthening the capacity and scope of Māori providers lies in having a culturally competent workforce. Within some policies, Māori providers and professionals are described as 'critical to ensuring programmes are delivered appropriately' (Ministry of Health, 2006a, p. 16). We noted that there are often statements emphasising that Māori health professionals are in short supply (Ministry of Health, 2007d) and that there is a need to grow the Māori workforce, so that the workforce overall is ' … more representative of the ethnic diversity of New Zealand' (Ministry of Health, 2006a, p. 7).

Utilising mātauranga Māori

Drawing on mātauranga Māori is fundamental to designing effective services for Māori. Several policies (e.g. Associate Minister of Health, 2006; Ministry of Health, 2006b) noted gaps in the evidence about what interventions worked for Māori and emphasised the need to develop Māori health research agendas and strategies. For example, the National Breastfeeding Committee (2009, p. 9) acknowledged that: 'While there is good evidence for the effectiveness of ethno-specific programmes overseas, there

is limited research specifically looking at what constitutes effective breastfeeding support for Māori women and whānau'.

One policy (Ministry of Health, 2006a, p. 17) noted 'Māori providers will be encouraged to develop and deliver evidence-based programmes that promote good oral health and behaviours'. Another policy (Ministry of Health, 2010a, p. 7) stated:

> Māori can access parenting programmes which have been adapted to reflect Māori cultural concepts and values to reduce their children's behavioural, emotional and mental health problems. A training provider is contracted to work with Māori to adapt evidence-based parenting programmes.

The implications seem to be that customary Māori approaches are not evidence-based; so evidence-based interventions need to be imported or adapted from elsewhere.

Several policies (e.g. Associate Minister of Health, 2006; National Breastfeeding Committee, 2009) emphasised the importance of capturing historical and cultural knowledge to strengthen interventions. They highlighted the importance of pūrākau (stories), whaikōrero (formal oratory), waiata mōteatea (traditional songs), karakia (blessings), and whakapapa (genealogy).

Other policies (e.g. Associate Minister of Health, 2006; Ministry of Health, 2007a, 2007d) utilised holistic Māori concepts and models of hauora (health and wellbeing). They also acknowledged the needs of whānau (extended families) as well as individuals. Such policies encouraged engagement with cultural concepts such as tātau tātau (togetherness), manaakitanga (care and hospitality), wairuatanga (spirituality), whanaungatanga (relationships), kawa (processes), whānau ora (collective wellbeing), and tikanga (protocols). Within mental health (Ministry of Health, 2006b), Māori health outcome measures have been developed to strengthen accountability and alignment to Māori aspirations. Others (e.g. Thornley et al., 2007; Wilson, 2007) named Māori settings such as kōhanga reo (Māori language preschool), as important sites for health interventions.

Discussion

The five dominant discursive representations of Māori in public health policy pose concerning and important considerations when striving to achieve health equity in Aotearoa. For instance, as our first theme highlights, most policy documents simply don't mention Māori health suggesting an assumption that, in this context, 'one size fits all'. This may reflect broader assumptions of a generic norm that subsumes all cultures including that of indigenous Māori, to the colonial centre (Moewaka Barnes et al., 2012).

This substantive silence in much health policy can be interpreted as a denial of the evidence that culture has relevance to health. It is also an affirmation of the value and worth of Pākehā norms, knowledges and values. As a result of this silencing, Māori aspirations, knowledge and approaches to health interventions are not afforded due consideration in efforts for the elimination of health disparities in Aotearoa, which we argue, contributes to ongoing health inequities between Māori and non-Māori. Moreover, as articulated by the Waitangi Tribunal (2019), while the government claims strong engagement with equity as a strategic priority, the wording within policies is inadequate in fully considering how the goal of health equity may be fulfilled.

Given the Waitangi Tribunal (2019) recommendations about realigning health policy and legislative frameworks, the key Māori health policy document; *He Korowai Oranga* (King & Turia, 2002), and its re-iterations, must urgently become Titiri-compliant. Once this realignment has occurred we argue that, as a minimum, all public health policy should be aligned to, and reference, the core Māori health policy document. Then, considerable work must be invested into the integration and implementation of this Māori health strategy across the health sector focussing on mechanisms for accountability and monitoring for Māori health outcomes.

We argue from a *te Tiriti o Waitangi* perspective that all health policy needs to strengthen Māori health, reduce inequities and pursue health equity. Upholding te *Tiriti o Waitangi* and working with

the articles of te Tiriti (Berghan et al., 2017) is a potentially fruitful approach to health equity that is not currently being pursued within health policy. These ideas are not new, having been identified previously by Cunningham and Taite (1997, p. 5) as being central to effective development of Māori health policy.

As outlined by the second theme, there is minimal reference to *te Tiriti o Waitangi, the Treaty of Waitangi* and Crown obligations. Given that *te Tiriti o Waitangi* is a foundational document of the modern state it should be consistently referenced in contemporary health policy. Reid and Robson (2007) argue Māori have the right to monitor the Crown's performance in relation to Māori health. Such monitoring is compromised through the absence of clear policy statements about Māori health. Cooper (1998) has also argued, a Tiriti relationship should reflect accountability, responsibility and transparency. We argue that failure to adequately engage with these domains within colonial health policy may contribute to ongoing health inequities between Māori and non-Māori. Cunningham and Taite (1997) maintain that effective health policy for Māori needs to be based on a policy framework which is consistent to *te Tiriti O Waitangi*. Likewise, we argue that all ethnic groups in Aotearoa have a right to experience good health and wellbeing (under Article 25 of the Universal Declaration of Human Rights (United Nations, 1948), under Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination (United Nations, 1966)). These human rights conventions and declarations assume even access to the right to health across all ethnic groups.

As our third theme highlights, epidemiological data are being used within colonial health policy to construct Māori as especially at risk [to ill health]. Epidemiological data is often the cornerstone of public health policy development. Such information can provide insight into health status and needs of particular groups. Data can be used neutrally to track negative and/or positive progress in reducing injury or disease, and it can also be used to equitably compare ethnic groups. In colonial health policy our analyses highlight Māori being represented as those 'most in need' or 'most at risk'. Such representations encourage blame to be attributed to Māori for their poor health whilst failing to interrogate the 'advantaged?', 'under-represented', 'low-risk' representations of non-Māori, who are almost never mentioned and thus have no sense of fault attached to these representations (Moewaka Barnes et al., 2014).

Additionally, deficit framing of Māori as 'vulnerable', 'at-risk' and 'in-need' is accurate in so much as Māori carry a disproportionate burden of disease. However, this narrative also feeds into entrenched racism directed at Māori within Aotearoa (McCreanor & Nairn, 2002; Moewaka Barnes et al., 2012). For example, the construction of Māori as vulnerable is part of a repertoire that researchers have characterised as 'good Māori/bad Māori'; a discursive resource which serves to split Māori society into those who acquiesce to, and those who resist, the colonial impetus (Nairn & McCreanor, 1991). The bad Māori dimension of this resource constructs Māori as not fitting into contemporary society through inability, under-education, ill-health, improvidence, dependence and other characteristics, centred in both cultural orientation and personal attributes. Essentialising Māori inadequacies (rather than acknowledging contextual causality in the intergenerational impacts of colonisation) constructs Māori as a burden on society which is obliged to support Māori in diverse ways that are an anathema to neoliberal ideologies about the 'responsibilisation' of individuals (Kelsey, 2002).

The reality is many Māori continue to live in circumstances that put their health at risk. For instance, the average Māori household income in 2013 was $22,500 (Statistics New Zealand, 2013). This is well below a living wage; that is, the real costs of essential family needs as well as energy, health, communication and education costs. Further, the contributions that colonisation and institutional racism make to these inequities is rarely articulated (National Breastfeeding Committee, 2009). Policy rarely addresses the historical and contemporary underlying causes of inequities and ill health outcomes among Māori.

Comparisons between Māori and non-Māori health outcomes can be a useful mechanism to monitor inequities. Māori health also needs to be evaluated on its own terms; against progress over time, and using cultural measures that are meaningful for Māori (Cunningham & Taite, 1997;

Warbrick et al., 2018). Further, rather than reinforcing negative discourses, the authors call on policy writers to embrace complexity, and to consistently consider the wider economic, social and cultural factors which impact on Māori health.

Our fourth theme highlights kaupapa Māori approaches as being an integral component of the solution to improving Māori health outcomes. However, as previously mentioned, policy does not adequately address the upstream determinants such as educational outcomes, which influence the numbers of regulated and unregulated Māori health practitioners in the workforce. Further, this theme highlights a strong resonance with another key strand of the conventional discourses of Māori/Pākehā relations (Nairn et al., 2006) that arises from the construction of Māori as requiring culturally unique approaches to health care and in the pursuit of health equity. This articulates an untenable notion that such measures – along with proactive approaches to diverse dimensions of social life including: electoral representation, education, resource allocation, redress of historical grievances, access to finance, cultural support and sporting activities – are evidence that Māori are excessively privileged in Aotearoa society. This rendition of privilege would characterise such initiatives in Māori health within the same ideological frame which holds that such provisions are unfair, impinging on majority rights and a threat to democracy in this context. A much wider inclusion of kaupapa Māori approaches is needed in order to redress the decades of marginalisation of Māori knowledges, which are vital to the restoration and maintenance of hauora and thus necessary to approach the broad goal of health equity.

The final theme seeks the acknowledgement and incorporation of customary Māori knowledge within the policy frameworks emerging for Māori health and the elimination of health inequalities. Increasing these intellectual and cultural resources into programmatic and institutional change has made dramatic differences in diverse fields such as educational outcomes (Bishop et al., 2009) and cot death (Tipene-Leach et al., 2000). There is every reason to believe that with appropriate support and investment, similar gains may result in other domains of health disparity.

Conclusion

International research and human rights conventions highlight health equity for indigenous people as a goal of just health policy and practice. There intent is to facilitate universal access to health care not the maintenance of ethnic health inequities. If we are to address health inequities, it is imperative that policy affirms diverse Māori realities and embraces Māori expertise and vision. The Waitangi Tribunal and this study reinforce that colonial health policy fails to achieve this. Policy transformation is needed to better engage with, and more effectively respond to, the health needs of Māori.

Such advances require all health policy development to be primarily informed by the grounded, contextualised work of Māori communities, leaders and academics who have a unique insider vantage point to understanding Māori health. If the health sector is to eliminate health inequities in Aotearoa, it is critical that policy consistently provides a clear direction as to what works best for Māori. Where Māori evidence doesn't exist, a plan needs to be put in place to fund the development of such evidence. In short, generic Pākehā-led solutions have proven unsuccessful. We need to support and trust Māori knowledge and insights (and indigenous equivalents in other contexts) into the complex challenges of the particular forms of health inequities, characteristic to this place and society.

Note

1. The Waitangi Tribunal is an independent permanent Commission of Enquiry into breaches of te Tiriti o Waitangi.

Disclosure statement

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