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Introducing critical Tiriti policy analysis through a retrospective review of the New Zealand Primary Health Care Strategy

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Abstract

Background: *Te Tiriti o Waitangi* was negotiated between the British Crown and Indigenous Māori leaders of Aotearoa New Zealand in 1840. Māori understood the agreement as an affirmation of political authority and a guarantee of British protection of their lands and resources. The Crown understood it as a cession of sovereignty. The tension remains, though legal and political developments in the last 35 years, have established that the agreement places a mandatory obligation on the Crown to protect and promote Māori health. It also requires that Māori may exercise rangatiratanga, or responsibility and authority, in relation to health policy development and implementation.

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Methods: *Te Tiriti* is, then, an instrument against which health policy is justly and efficaciously evaluated. This paper introduces critical Tiriti analysis as such an evaluative method. Critical Tiriti analysis involves reviewing policy documents against the Preamble and the Articles of *te Tiriti o Waitangi*. The review process has five defined phases: (i) orientation; (ii) close reading; (iii) determination; (iv) strengthening practice and (v) Māori final word.
Results: We present a working example of critical Tiriti analysis using the New Zealand Government's *Primary Health Care Strategy* published in 2001. This policy analysis found poor alignment with te Tiriti overall and the indicators of its implementation that we propose.
Conclusion: This paper provides direction to policy makers wanting to improve Māori health outcomes and ensure Māori engagement, leadership and substantive authority in the policy process. It offers an approach to analysing policy that is simple to use and, inherently, a tool for advancing social justice.

Keywords
Critical Tiriti analysis, primary health, policy analysis, health equity, health policy, Indigenous, New Zealand

Background

Te Tiriti o Waitangi (the Māori text of the *Treaty of Waitangi*) established the modern state of New Zealand but its original meanings and contemporary interpretations are contested (Walker, 1990). However, it does have profound influence on legal and political discourse and on public policy making (Tawhai and Gray-Sharp, 2011). Te Tiriti affirms, though does not define, Māori sovereignty and outlines the terms and conditions of non-Māori settlement. As such it has long been a focus for settler discontent over perceived impediments to economic development and control of Māori resources, with efforts to discredit it commencing almost immediately it was signed (Orange, 2011).

The widespread view in the late 19th century was that Māori extinction was the inevitable outcome of their encounter with a 'superior race' (Buck, 1924). However, by 1907, fears of extinction had passed, and to support the colonial project, parliament passed the *Tohunga Suppression Act* to quash traditional Māori healing methods. The Act complemented earlier policies such as the *Native Schools Act 1867* which was designed to marginalise Māori culture by privileging English language tuition in schools and undermining Māori educational advancement (Hill, 2004).

Many Māori saw these measures as breaches of *te Tiriti*. They held that *te Tiriti* was an agreement of enduring relevance that the Crown ought to honour (Orange, 2011). However, it was not until 1975 that the agreement began to acquire

sustained and meaningful policy relevance with the establishment of the Waitangi Tribunal, a permanent commission of inquiry into Māori grievances against the Crown for breaches of the Māori text and/or the English version of the treaty. In this paper, we deliberately use the terms *te Tiriti* (Māori text), the Treaty (English language version) and the Treaty principles. Historically these terms have been used interchangeably but we argue they are separate documents with unique meanings and implications.

During the 1980s, the New Zealand Government began a comprehensive policy of state asset sales. This raised questions about how the Crown actually acquired many of the assets it wished to sell. In some cases, Māori initiated legal proceedings to prevent these sales so questions of ownership could be resolved. The Crown was compelled by the Court of Appeal to consider Māori positions and not assume that it had unilateral authority over lands and resources (Hayward, 1997).

Policy discourse was fundamentally changed and while the specific place that *te Tiriti* ought to assume in public policy remains contested, the idea that at least the English version must always assume consideration is now entrenched in policy development. For example, it is explicitly acknowledged in both the *New Zealand Health Strategy* (Ministry of Health, 2016) and the *New Zealand Public Health and Disability Act 2000*. Its significance to Māori health is assumed by Māori scholars including Durie (1989, 1998), Ramsden (2002), Whitinui (2011) and Reid and Robson (2006).

The health claim presently before the Waitangi Tribunal (WAI 2575) (Isaac, 2016) has received evidence from 200 claimants. These evidence briefs methodically document instances of Crown Ministers and officials breaching *te Tiriti* in the administration of the health system. For example, Maipi et al. (2018) noted financial disincentives for primary health organisations to re-enrol complex Māori cases; while 'mainstream' clinics would reduce their own costs by referring their complicated patients to Māori providers.

This paper articulates a framework for conducting a critical Tiriti analysis (CTA) of health and social policy. We provide an overview of the socio-political and historical contexts of policy making in Aotearoa and existing critical approaches to policy analysis. We background and introduce our framework and demonstrate its application by using it to examine the Crown's *Primary Health Care Strategy,* the *PHCS* (King, 2001). This analysis is based on an evidence brief to the Waitangi Tribunal of two of the authors (Came and McCreanor, 2018). We conclude by advocating CTA as a useful method for policy evaluation and make recommendations for policy development practices, to support the efforts of Māori and non-Māori actors within Crown to develop policy to make a difference for Māori.

Traditions of critical policy analysis

Critical policy analysis (CPA) assumes that policy development is not neutral, but rather it must navigate tensions over objectivity/subjectivity, and choices about

finite resources whose distribution may benefit some citizens in favour of others. Human betterment is subjectively defined and culturally, socially, politically and historically contextualised. CPA analyses public policy with explicit attention to these contextual factors (Durnová et al., 2015).

CPA emerged from dissatisfaction with rationalist approaches to the assessment of policy potential and impact. Diem et al. (2019) argued that CPA is concerned with gaps between policy rhetoric and the realities of implementation, among the roots of policy, how it emerged and its role in reinforcing dominant cultural norms. CPA scholarship is similarly interested in the distribution of power and how this creates policy winners and losers. It is concerned about social inequities, and the experiences of non-dominant groups in policy processes.

Harding (1986), from the forefront of feminist CPA, argued that public policy dominated by white men has left us with 'partial and perverse understandings from limited theoretical and political frameworks – greatly in need of dismantling'. Marshall et al. (2017) argued that feminist CPA examines how policies buttress patriarchal power structures to institutionalize male dominance. They seek to uncover hegemonic power sources and shed light on areas that have been blind to women's realities.

In Aotearoa, a number of Indigenous approaches to CPA have emerged (Lawson-Te Aho, 1995; Mullan, 2000; Wihongi, 2010). Fleras and Maaka's (2010) Indigeneity grounded analysis (IGA) is a decolonial approach to policy analysis and is aimed at 'indigenising' policy development by minimizing 'systemic policy bias while maximising Indigenous peoples inputs' (2010: 1). They provide examples of robust and significant Indigenous participation in the policy process as citizens, policy leaders and members of government. Tiriti analysis remains an important gap in CPA analyses of policy.

Cunningham and Taite (1997) were commissioned to develop a framework to assist Ministry of Health staff 'to incorporate a Māori perspective into their policy work' (1997: 4). We concur with its assumption that the Treaty is a fundamental part of the development of policy that impacts on Māori and indeed on all policy. They argued that public service policy makers need practical advice on how *Tiriti* analysis may be usefully incorporated. This paper contributes to that advice.

Moewaka Barnes (2009) argues that, in policy evaluation, rangatiratanga means that Māori have the right to 'exercise Māori world views, authority and control; meaning, in part, that we have a right to assert Māori worldviews as normal and legitimate' (2009: 3). For Moewaka Barnes, this means that essential characteristics of a Māori policy evaluation process include Māori control, meeting Māori needs, and grounding within a Māori worldview. A distinctive contribution of CTA is its detailed contextual attention to the colonial dynamics of Aotearoa that places *te Tiriti* and the well-being of Māori at the heart of policy analysis. Its limitation lies in the location of CTA in place, in Aotearoa, it is unclear how it will translate to other colonial contexts.

Policy analysis is, therefore in general, the critical study of what governments do, with a distinguishing feature of CTA being that it is a Māori-led approach especially focussed on the extent to which such actions and inactions are consistent with *te Tiriti o Waitangi*. CTA allows Māori to contribute 'a toolbox of diverse concepts and theories' (Ball, 1993: 10) to the analysis of policy as both text and discourse (Ball, 1993, 2015) – the text that is being examined and the policy discourse that *te Tiriti* raises in relation to Māori expectations of how the health system should work and what it should aim to achieve.

Te Tiriti o Waitangi

In this paper, *te Tiriti* refers to the Māori text of the agreement signed at Waitangi in 1840. It differs from the English text on which the Crown has relied for its claim that the agreement was a cession of Māori sovereignty (Healy et al., 2012). The Māori text is the instrument signed by the majority of rangatira (chiefs) and by William Hobson representing the British Crown. The Treaty (English version) was signed by 39 rangatira while the Māori text was signed by more than 500 (Fletcher, 2014). The international legal doctrine of contra proferentem indicates that in cases of ambiguity, a treaty is to be interpreted against the party drafting it (Te Puni Kōkiri, 2001).

Durie (1998) and others have argued that Māori remain committed to the Māori text. The Crown has sought to limit the mana (prestige and authority) of the Māori text by developing a collection of 'Treaty principles' (Hayward, 1997). The principles of partnership, participation and protection (Royal Commission on Social Policy, 1988) are most widely used in the health system and are included in the *New Zealand Public Health and Disability Act 2000*.

The Preamble of *te Tiriti* outlines its purpose and the intent to maintain and strengthen relationships between Māori and the Crown. In particular, the 'Queen of England' sought to extend her powers to Aotearoa in order 'to preserve [Māori] chieftainship and their lands to them and to maintain peace and good order'. These intentions were influential in persuading Māori of the Crown's honourable intent and that they would not be surrendering substantive political authority.

The agreement was presented to Māori in the Biblical language of covenant (kawenata), as solemn, binding and enduring, which explains why Māori have never resiled from arguments for the agreement to be honoured by the Crown. WAI 2575 is an important contemporary example, where claimants have systematically, and in great detail, set out their knowledge and experiences of discriminatory and otherwise ineffective health policy. For the claimants the Treaty is, as Tawhai and Gray-Sharp (2011) put it, '*always speaking*'.

Article 1 of *te Tiriti* provided the Crown with the right to government or kāwanatanga. Governments have interpreted this as a cession of sovereignty and continue to implement policy on this basis. The rangatira who signed the agreement saw it as conferring on Britain an authority to govern its own settlers, not an

agreement to surrender Māori rights and resources to colonial authority and this remains the focus of enduring Māori resistance. While policy processes and systems of government remain colonial in the sense that they restrict Māori political authority and capacities, they are moderated by the Preamble and Articles 2 and 3 of *te Tiriti* which make specific assumptions about how Māori may participate in processes of government and policy making with reference to both rangatiratanga and citizenship.

Article 2 of *te Tiriti* affirmed Māori absolute authority, or rangatiratanga, over lands, settlements, and taonga (all that was and is valuable). Rangatiratanga is first and foremost something that Māori do for themselves, by their own means and for their own purposes as free political agents. In the contemporary context, Matike Mai Aotearoa (2016) defines rangatiratanga as 'the right for Māori to make decisions for Māori' (2016: 8).

Article 3 of *te Tiriti* guaranteed Māori the rights and privileges of British subjects and has been characterised as ōritetanga (Berryman et al., 2018) which entails 'responsibilities to both groups to maintain the mana of the other, and understand the mana of both as ōrite [equal]' (2018: 4).

British subjecthood has been replaced by New Zealand citizenship, potentially a more robust, far-reaching and politically meaningful category. Citizenship moderates and contextualises the Article 1 right of the Crown to kāwanatanga. Liberal democracy means that government is the gift of the people, the expression of the people's collective authority. Article 3 imagines that authority as one in which Māori participate with the same capacity for influence as other citizens, protecting against racially exclusive government. It presumes that public authority should reflect *all* and not just *some* people's voice in the business of government.

Although not part of the written *Tiriti* text, discussions at Waitangi in 1840 also focused on wairuatanga (spiritual practices and well-being) as part of a broader commitment to religious freedom. It was raised by the Catholic Bishop Pompallier who feared Britain privileging the Church of England as the official religion of the state. Wairuatanga is an essential expression of rangatiratanga. It has received considerable Māori attention as a defining characteristic of good health (Kingi et al., 2017).

Method: Critical tiriti analysis

CTA is grounded in te *Tiriti o Waitangi*, the socio-cultural political context of Aotearoa and the dynamics of colonialism. We argue that, as a methodological approach, CTA may be useful for policy actors (Came and Griffith, 2017) seeking to disrupt the potential connection between policy-making and discriminatory or otherwise inequitable outcomes. Our objective is to provide an evaluative framework that helps to eliminate health inequities where they are avoidable, unjust and unnecessary (Black et al., 1992). Our evaluative approach presumes the exercise of rangatiratanga and distinctive Māori citizenship.

Phase 1 – Orientation

We propose a first reading of a public policy, using the broad objectives below, to establish if, how, and why, it makes reference to *te Tiriti o Waitangi*, the *Treaty of Waitangi* and/or the Treaty principles. The first reading asks whether the policy:

- Addresses Māori health as a Crown responsibility, in ways that Māori prefer. For example, with reference to language, cultural epistemologies and stated health priorities. (Preamble, A1, Wairuatanga).
- Reflects rangatiratanga, Māori citizenship and health equity (A2 and 3).

The absence of references to *te Tiriti*, the *Treaty of Waitangi* and/or the Treaty principles would be read as inattention to Māori perspectives and priorities and thereby a breach of Crown obligations.

Phase 2 – Close examination

A second reading seeks evidence of engagement with all of the elements of *te Tiriti*.

Preamble. In relation to the Preamble, discerning how *Tiriti* commitments are represented, is critical. Health policy should make it explicit that Māori are rangatira and citizens, not minority ethnic stakeholders. Māori are entitled to equal and distinctive political capabilities and one should ask how Māori values and expectations have informed the policy's development. Is the policy supported by a strong Māori evidence base?

Kāwanatanga. Māori engagement in policy development should be visible throughout. Māori and/or iwi providers and Māori practitioners and scholars have particular cultural expertise they can bring to policy making. The governance structures of Māori health providers often include local hapū and iwi representatives to ensure accountability to communities.

Rangatiratanga. Ideally rangatiratanga is embedded into policy development and reflected in structural mechanisms to incorporate diverse Māori realities (Durie, 2001). This could include meaningful and expert Māori involvement in policy drafting, advisory committees and the participation of kuia and koroua (respected Māori elders).

Māori scholarship should be evident in policy content, for example, in document reference lists. Assessing a document from this perspective is a simple and transparent way of identifying the depth of a policy's engagement with Māori thought and expectations. Policy writers and decision makers ought to be familiar with Māori health scholarship including material found in Māori oral traditions.

Public investment in Māori providers and kaupapa Māori health programmes can be an indicator of Crown acceptance of tino rangatiratanga in public policy,

since it facilitates local decision making that is by and for Māori. Ratima et al. (2015) argue Māori control and autonomy are determinants of successful health outcomes. In this respect, it is also significant that clinical evaluations consistently show that culturally tailored interventions are more effective for Māori than generic approaches (see Chino and De Bruyn, 2006; Ramsden and Erihe, 1988).

A barrier to tino rangatiratanga is the normalisation of institutional racism within the health system (Came and Tudor, 2017). Institutional racism is a pattern of differential access to material resources, social legitimation and political power that disadvantages Māori, while advantaging others (Came, 2014). For example, the disproportionate auditing of Māori Health providers (Came et al., 2017). Naming institutional racism is a key step towards eliminating its influence. The original *He Korowai Oranga* (King and Turia, 2002) identifies institutional racism as a crucial determinant of Māori health but the updated version has removed references to racism.

Ōritetanga. CTA leads policy makers and policy systems to a position that where disparities exist, and pathways towards equity can be developed particularly through Māori defining policy intent. CTA considers both historic and contemporary determinants of health (Kiro, 2000; Robson, 2007) and explicit statements about how equitable outcomes will be achieved.

Chin et al. (2018), in their recent review of health equity, argued that good intentions and ad hoc approaches will not result in the structural reorientation required to eliminate health inequities. They came to the conclusion that clear targets, commitment to key deliverables, sustained efforts towards Māori health workforce recruitment and retention were required. He confirmed that institutional and interpersonal racism in health service delivery also needs to be eliminated, as there is an explicit relationship between the values that policy makers and health professionals bring to their work and its efficacy for some groups of people relative to others (O'Sullivan, 2015).

Wairuatanga. Demonstrated policy recognition of Māori custom and wairuatanga may reflect whether Māori have distinctively influenced its development. It may also indicate the exercise of rangatiratanga in the policy development process. Wairua is a manifestation of custom; an expression of spirituality and a descriptor of psychological well-being. It is an example of what it means to receive health services as Māori.

Wairuatanga articulates Māori expectations of the health system because 'without a spiritual awareness and a mauri (spirit of vitality) an individual or collective cannot be healthy and is more prone to illness or misfortune' (Durie, 1998). Durie's (1998) *te Whare Tapa Whā* (four walls of the wharenui) health model represents interrelated dimensions of Māori health – hinengaro (mental health), wairua (spiritual health), whānau (family health) and tinana (physical health). These themes are widely repeated in Māori health scholarship and contribute to

the values that Māori argue should be present in health policy (Mark and Lyons, 2010; Marsden, 2003a; Ramsden and Erihe, 1988).

Wairua is a complex set of physical and metaphysical relationships. It is a spiritual communion between human beings and the environment (Durie, 1985). It is one's mauri, one's life force or the very essence of one's being. It may include karakia – prayer or incantation reflected in everyday cultural practice. It may entail connections to people, place and spirit (Moewaka Barnes et al., 2017) and may be seen as an example of the World Health Organization's (WHO, 1948) broad conception of health as 'not merely' the 'absence of disease'.

Phase 3 – Determination

Here we propose a series of indicators of policy development, performance and evaluation that could be ranked on a Likert-type scale for each of the five CTA domains outlined above.

Indicator 1 (Preamble) – Elements showing that *te Tiriti* is central and Māori are equal or lead parties in the policy processes.

Indicator 2 (A1) – Mechanisms to ensure equitable Māori participation and/or leadership in setting priorities, resourcing, implementing and evaluating the policy.

Indicator 3 (A2) – Evidence of Māori values influencing and holding authority in the policy processes.

Indicator 4 (A3) – Evidence of Māori exercising their citizenship *as* Māori in the policy.

Indicator 5 (Wairuatanga) – Acknowledgement of the importance of wairua, rongoa and wellness in the policy.

Phase 4 – Strengthening practice

The next phase of CTA is to consider how policy processes could be strengthened. CTA ought to critique robustly in respect of a policy's positive and negative potential. It is important to identify examples of content and processes that give effect to *te Tiriti* so that successful approaches may be transferred across policy domains. Ideally, evaluation requires a longitudinal dimension that produces research-based knowledge on what works and where improvements could be targeted. This is important wherever a policy objective includes enhancing sustainable performance in social, cultural, environmental and economic domains.

Ways of making public policy that are consistent with Māori expectations may thus be replicated and further contributions made to the indigenisation of the policy process. Indigenising the policy process recognises that policy is not an abstract phenomenon pursuing a neutral and always agreeable conception of the common good. That it is a reflection of people's relative political standing, trade-offs among different interests and perceptions of the role of the state vis-à-vis the individual in pursuing a good life. It balances different perspectives on the role of culture in public policy, the significance that should be attached to prior occupancy

and to group rights vis-à-vis the rights of the individual. Policy is an inherently political process where influence can come only with the meaningful presence that CTA assumes as a just reflection of *te Tiriti*, and also because:

> ... the only ground for a claim that a policy or decision is just is that it has been arrived at by a public which has truly promoted the free expression of all. (Young, 1989: 263)

Phase 5 – Māori final word

Undertaking a CTA requires long-standing, robust, critically and culturally informed engagement with the diversity of Māori policy thought and aspirations. Māori leadership, engagement, critique or peer review are inherent to holistic CTA which encourages Māori to assert authority and validate the CTA.

Results

We report our application of the CTA under the headings outlined under each phase above.

CTA orientation

The *PHCS* (King, 2001) was published as part of a package of health sector reforms to strengthen the population health focus, enable stronger community control and collaboration, introduce capitation funding (based on enrolled populations) and shift from the medicalised emphasis of doctors to a more socio-culturally oriented paradigm. While these intentions make reference to the *Treaty of Waitangi*, there is no mention of *te Tiriti* and King (2001a) argued that these reforms were underscored by the aspiration to reduce health inequalities and address the causes of poor health status.

CTA close examination

In this section of the article, we use CTA to assess the *PHCS*.

Tiriti *Preamble*. The *PHSC* refers to the English version of the *Treaty of Waitangi* without addressing the Māori text. It describes a 'special relationship between Māori and the Crown' (McCreanor, 2012), the un-elaborated term 'special' evoking a deep vein of Pākehā resistance because of its association with the notion of Māori special privileges/rights (2012: 2) where 'special' can be a touchstone to conservative activists supporting claims that redress of historic injustices are unwarranted and anti-democratic.

The health and needs of Pasifika populations and Māori are bundled together, mixing very different issues and undermining the primacy of Crown–Māori relations.

There is an assumption that because the Strategy has particular target groups that Māori disproportionately constitute – the poor, the unemployed, the under-educated and those in inadequate housing (10) – that the *PHCS* addresses Māori health needs. Our analysis is that this 'one size fits all' thinking minimises *te Tiriti*. In minimising the right to culture and the right to participate in decision making as rights of *all* Māori, not just the poor, unemployed, under-educated and inadequately housed, the *PHCS* is concerned with egalitarian rather than relational justice.

Māori are also positioned within the *PHCS* as a 'hard to reach group' (King, 2001), a construction that presents Māori as ignorant, negligent or recalcitrant in keeping with discourses about Indigenous people globally (Nairn et al., 2017). The *PCHS* does not reflect substantive measures to reach that group. Such discourses reflect a colonial approach where Māori are seen as problematic and implicitly blameworthy for not responding to generic, monocultural public provision of primary care services.

These deficiencies are compounded by the monocultural schematic representation of the relationships entailed within the policy (Figure 1). In the model, power rests with the Minister supported by, and in conjunction with, public institutions – the Ministry of Health, the District Health Boards (DHBs) and Primary Health Organisations (PHOs). Māori are reduced to providers and end users of health services in a manner quite divergent from the expansive, inclusive language of the Preamble.

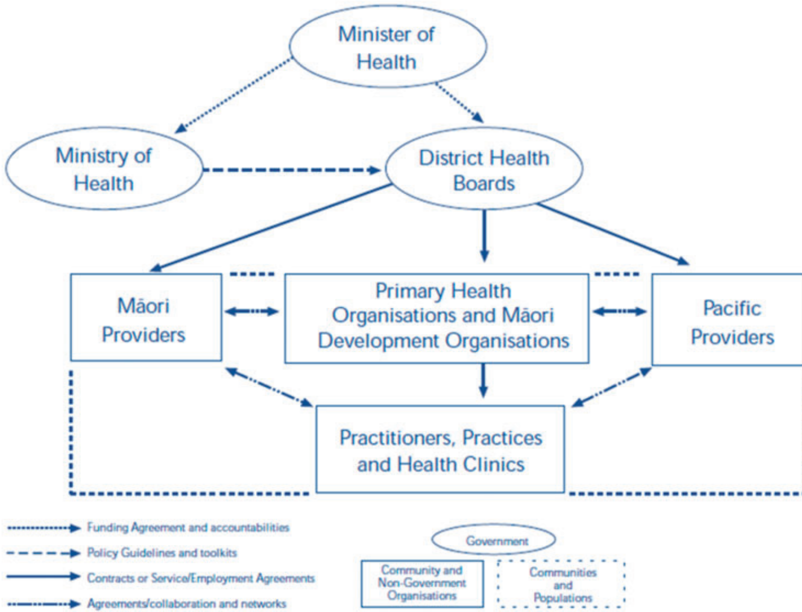

Figure 1. The primary health care sector in New Zealand (King, 2001).

Article 1 – Kāwanatanga. The *PHCS* makes no provision for Māori to have an equitable and sovereign voice in the development, application and evaluation of policy underling the everyday dishonouring of the kāwanatanga arrangements proffered in *te Tiriti*.

The New Zealand Health and Disability Act (2000) allows that DHBs will be governed by boards of up to 11 members and there must be at least two Māori members dependent on the proportion of Māori in the Board's population. In practical terms, this means that Māori are consistently a small minority on Boards ensuring that they are usually out-voted and compromised in efforts to effect change (Came, 2014).

Through capitation funding, the *PHCS* sets up a strong financial incentive to enrol the healthiest and least costly patients and creates a barrier to enrolling complex, long-term cases, categories into which Māori disproportionately fall (Millar et al., 2018; Stokes et al., 2018). Governance decisions that erect financial disincentives to treating Māori patients, and economic imperatives to deliver contract outputs over programme effectiveness, seem likely to have compromised Māori health and dishonoured the requirements of kāwanatanga. This is why the New Zealand Māori Council (2019) has argued for the abolition of district health boards.

Article 2 – Tino rangatiratanga. The institutional racism of the *PHCS* is its denial or discounting of Māori knowledge, capability and culturally framed aspirations for good health. A review of the reference list of the *PHCS* shows that Māori health literature has not informed its development. Yet there is a strong body of Māori scholarship and policy advocacy on which the strategy might have drawn. For example, during the 1980s and 1990s, a series of important Māori meetings, especially Hui Whakaoranga (Department of Health, 1984), articulated, from a Māori perspective, how to protect and promote Māori health. Crengle (1999) recalls these hui, emphasising the importance of culture, engaging with Māori health philosophy, knowledge and models, taking a positive development approach, and striving for self-determination. Table 1 provides examples of what these could mean, noting core recommendations of Hui Whakaoranga alongside an assessment of their application in the *PHCS*, showing only nominal engagement with Māori aspirations.

Article 3 – Ōritetanga. It is well-established that Māori carry a differentially high burden of disease and injury compared with other New Zealanders (Marriott and Sim, 2014; Robson and Harris, 2007). The Crown Māori health objective has long been that Māori should enjoy the same levels of health as non-Māori. However, the Māori scholarship cited in this article shows that health outcomes for Māori cannot be evaluated only by reference to an equitable distribution of the burden of disease. There are culturally framed conceptions of health and well-being that need to be brought into account.

Table 1. Hui Whakaoranga themes integrated into *Primary Health Care Strategy (PHCS)*.

Hui Whakaoranga	Primary health care strategy
Engage with Māori health philosophy and models	Not addressed.
Recognise Māori culture as a positive resource	Not addressed.
Establish Māori-led health initiatives to meet the needs of Māori as defined by Māori	Section about Māori services p. 11.
Encourage Māori to become health practitioners	Shortage noted. p. 22.
Recruit and promote Māori health practitioners	Shortage noted. p. 22.
Strengthen cultural competencies of the health workforce	Statements p. 6 and p. 10
Invest in marae-based initiatives	Marae mentioned as site for delivery of services pp. 10–11.
Involve Māori in a consultative and advisory capacity	Not addressed.
Promote the use of Te Reo (Māori language)	Statement about producing materials in different languages. Te Reo not mentioned. p. 16.
Produce bi-lingual health education programmes and resources	See above.
Enable tino rangatiratanga (self-determination)	Not addressed.
Recognise the importance of wairua and spirituality	Not addressed.
Involve Māori in governance boards and senior management teams	Not mentioned.
Encourage a return to rongoa and traditional healing	Traditional healing mentioned once. p. 1
Strengthen the collection of ethnicity, iwi and marae affiliation data	Not addressed.
Develop Māori wellness measures	Not mentioned.
Promote community ownership of health facilities	Statements about involving community p. 1, community focussed p. 6, accountability to communities' p. 24. Nothing about ownership.
Transparency around investment in Māori health	Not addressed.

The *PHCS* is based on the premise of universally accessible services. In reality there are innumerable barriers to equitable access as Wilkinson and Marmot's (2003) notion of the social gradient of health shows where variations in health outcomes occur at a population level because of the conditions in which people are born, grow, learn, develop, work and age.

The strategy pays limited attention to the historic and contemporary determinants of health and yet these are critical to the pursuit of health equity. To understand the social gradient of health it is necessary to examine the political determinants of health (O'Sullivan, 2015), including the impact of colonialism. These political determinants of health may be understood as *causes* of the

causes of health inequities. Practically this means acknowledging the impacts of colonialism as an historic, intergenerational and contemporary political determinant of health, which the *PHCS* does not acknowledge.

Marmot (Marmot Review Team, 2010) argued that to reduce health inequities, interventions must be universal, but at a scale and intensity that is proportional to the level of disadvantage. The absence of proportionate provision means only a small part of the problem of inequalities is addressed. The existence of a social gradient in which outcomes for Māori are significantly worse than for other groups reflects this problem and may, in conflict with Article 3, reflect inequities in the distribution of the capacities of citizenship including the capacity to influence the policy process and the goals that it should pursue.

Wairuatanga. The notion of wairuatanga is central to Māori health (Marsden, 2003b). Durie (1985) describes it as 'the most basic and essential requirement for health'. The *PHCS* is silent in relation to wairua, ignoring this important aspect of rangatiratanga and distinctiveness in the ways that Māori may wish to claim their rights of citizenship.

CTA indicator determination

Our ranking of the CTA indicators follows as Table 2. We ranked Indicator 1 as poor because, while the relationship with Māori is described as special, there was no evidence of a *Tiriti* orientation or that Māori were equal or lead parties to policy development. Indicator 2 was ranked as poor due to the low number of Māori involved in senior management and health governance. There was no evidence that an equitable relationship with Māori was active in the development of the *PHCS*. Indicator 3 was ranked poor to reflect the failure of the *PHCS* to engage with Māori epistemology, knowledge and health aspirations. The *PHCS* mentions the importance of providing health services to Māori as a high needs group but not investment in Kaupapa Māori approaches and providers.

Under Indicator 4 we have ranked the *PHCS* fair; since the rhetoric of addressing inequalities occurs throughout the policy, but the Strategy is not explicit in dealing with historical and contemporary determinants of health. Nor is it explicit as to how it pursues proportional universalism; that is using both a universal and

Table 2. Critical Tiriti analysis (CTA) determination against indicators.

Indicators	Poor	Uncertain	Fair	Good	Excellent
1. Māori lead policy development	X				
2. Equitable Māori participation/leadership	X				
3. Evidence of inclusion of Māori epistemologies, approaches and authority	X				
4. Māori exercising their citizenship			X		
5. Acknowledgement of wairuatanga	X				

targeted approach to address health inequities based on social need. In addition, the quantity and quality of care for Māori are compromised by financial, geographic, epistemological, cultural and systemic barriers to Māori accessing care as measures of inequality (Anderson et al., 2017; Crengle, 2000; Lee and North, 2013; Loh et al., 2015). Indicator 5 ranking as poor reflects the failure to engage with wairuatanga.

Strengthening practice

The enduring life expectancy gap between Māori and non-Māori suggests the *PHCS* has failed to deliver its promise of health equity (Statistics New Zealand, 2017). Quality and quantity of life should always be key measures of the performance of the health system and health policy.

The *PHCS* would have been strengthened if the Ministry of Health (as a Crown agency) had engaged with *te Tiriti* as suggested by the explanation of CTA above. Māori are self-determining cultural beings whose rights to participate in public life with reference to rangatiratanga and distinctive citizenship are affirmed in *te Tiriti* and in international instruments such as the *Declaration on the Rights of Indigenous Peoples* (United Nations, 2007). These foundational and distinguishing features of Māori political authority ought to be reflected structurally at all levels of the health system, particularly at decision-making points where Māori should have an equitable sovereign voice in policy decisions.

The *PHCS* is correct in that Māori disproportionately carry the burden of disease and often live in circumstances that put their health at risk. However, this does not make Māori 'hard to reach', but requires the health system to be responsive to diverse Māori realities. Māori as citizens have a right to health (United Nations, 1966). Health policy needs to engage with the causes of the causes of ill health. Colonisation and racism are critical determinants of Indigenous health (Paradies, 2016).

If *te Tiriti* were being honoured, one would see Māori-centred health policy that seeks to engage authentically with the aspirations of Māori citizens and the evidence of Māori academics. Policy would be more obviously focussed on the complexities of improving and protecting Māori health. Wairuatanga as an essential component of holistic Māori health along with ōritetanga and rangatiratanga need to be acknowledged in policy.

Policy makers ought to consider the possible outcomes of policy. For instance, the introduction of capitation funding created a financial disincentive to enrol Māori patients in health practices which has compromised the primary care sector's ability to improve Māori health outcomes. Equity and cultural tools (Ministry of Health, 2004, 2007) have been developed to minimise the risk of policy causing harm, yet it remains unclear whether they are consistently and competently utilised.

The sequencing of policy release is important. Ideally the *PHCS* ought to have been released after or with *He Korowai Oranga* (King and Turia, 2002) ensuring

these two key policy documents could be aligned. Alternatively, a second edition of the *PHCS* could have been released to realign it with *He Korowai Oranga*.

The *PHCS* does contain significant aspirational statements about the commitment of the Ministry of Health and wider public health sector to addressing health inequalities. A considerable consultation process was involved in the development of the Strategy, giving people the opportunity to contribute to policy development. Care was taken to identify some of the barriers to Māori and other New Zealanders accessing primary health care and attempts were made to mitigate them. Māori providers and practitioners are recognised within the strategy as a key part of the health system.

Māori final word

There was some Māori contribution to the *PHCS*, although the relative seniority and influence of Māori in drafting the Strategy is not clear. As a matter of transparency, and to support policy critique from outside the bureaucracy, the level and nature of Māori participation should be evident. If there were good reasons for not engaging with Māori thought, through the Hui Whakaoranga, published Māori scholarship or other material on the public record, these should be publicly defended. CTA provides a process for evaluating how public policy is made, by whom and for which purposes. And in its final phase, for ensuring Māori concurrence with the policy.

Discussion

The primary health care strategy

This retrospective CTA of the *PHCS* found that the relationship between Māori and the Crown was described as 'special' and Māori were seen as 'hard to reach'. Both descriptions reduce the mana (prestige and authority) of Māori as signatories of *te Tiriti o Waitangi*. In terms of kāwanatanga, the *PHCS* provided no evidence that Māori had an equitable and sovereign voice in the development of the Strategy.

The release of the *PHCS* was prior to *He Korowai Oranga* (King and Turia, 2002) and reduced the vital contributions of the latter to an add-on. In reviewing the *PHCS* against the recommendations from the Hui Whakaoranga (Department of Health, 1984) poor alignment is evident in the failure to incorporate Māori aspirations or reflect tino rangatiratanga.

The *PHCS* does clearly attempt to address health equity. It recognises Māori carry a disproportionate burden of disease but is orientated to the universal, rather than needs-based provision of services. Operationally, we know the Strategy has failed to address the financial, geographic and cultural barriers to Māori accessing primary care. Despite wairuatanga being central to Māori health (Marsden, 2003b) the *PHCS* is silent in this respect.

Overall after applying the CTA, we maintain that the *PHCS* is poorly aligned with the Articles and provisions of *te Tiriti*. Any revisions of the *PHCS* would be strengthened by evaluation against the CTA framework that we propose. The purpose would be to achieve a policy revision orientated to a Māori world view, transparently addressing Māori aspirations and informed by evidence about what works and does not work for Māori. A revised Strategy needs to robustly address racism and other historical and contemporary determinants of health and well-being (Came et al., 2019). With respect to primary care, a new strategy would need to engage with the body of work of the numerous Māori academics.

Structurally and operationally, all providers and funders of health services need to be monitored and held accountable for their performance in relation to Māori health outcomes. The health workforce, at all levels of the policy process, requires the political and cultural competencies to work effectively with Māori. These competencies need to complement demonstrably efficacious clinical skills. These broad competencies are important because, as Walsh and Grey (2019) show, 53% of Māori deaths are attributable to avoidable causes, many of which could be addressed through a stronger public health system (Skegg, 2019).

Critical tiriti analysis

Moving into the present, the evidence from the WAI 2575 hearings has initiated further engagement with the Crown's Tiriti responsibilities. For instance, the Ministry of Health's (2018: 1) workplan now explicitly states, 'In our work we will address the Government's *Treaty of Waitangi* obligation to improve Māori health outcomes'. This marks a significant shift from the Ministry's position in 2006, in response to Don Brash's (2004) nationhood speech, when all references to *te Tiriti* were systematically removed from health policy documents (Wall, 2006).

CTA is an evaluative and analytical tool that focuses beneath rhetorical policy statements to examine the detailed intent and policy-making processes that are used in relation to policy. It evaluates the strength of Māori participation in policy making and the extent to which Māori aspirations and expectations are positioned to influence policy decisions. It rejects the assumption of a non-partisan, ethically constituted Pākehā Crown, making just and equitable policy for Maori and the nation.

Stronger and more focussed policy on health equity and social justice requires that policy makers are explicit about their policy making processes. In the first instance, explaining the extent of Māori participation in a policy's authorship and being explicit about whether a Māori advisory group has been involved in its development would be valuable. Where appropriate, naming the advisory members or describing their expertise would be helpful. Being transparent about what evidence has informed the policy by citing references and describing the bibliographic search terms and rationale is crucial. If there is not constructive

engagement with Māori health literature, an explanation of why this is so is needed. Explicitly engaging in peer review processes allows proper scrutiny and may raise Māori confidence in the policy process.

This paper addresses a gap in *Tiriti* scholarship's attention to health policy. An important exception is Came et al.'s (2018) study showing that public health policy documents under the Clark and Key governments between 2006 and 2016, rarely addressed *te Tiriti* or the Treaty. Given the compelling argument by Māori academics of the relevance of *te Tiriti* to hauora (health) and the Ardern Government's commitment to health equity, it is timely that its place in health (and all public policy) is reconsidered.

Conclusion

CTA provides a transparent process for policy makers, decision-makers, advisory groups and interested citizens to strengthen and review policy work in relation to *te Tiriti*. A strength of the CTA approach is that it requires Māori involvement. It assumes Māori rangatiratanga as substantive political authority and that requires Māori may exercise rangatiratanga, or responsibility and authority, in relation to health policy development and implementation. CTA also requires health policy to engage with wairuatanga, which it has rarely done well, but is essential for holistic Māori oranga (well-being).

We also argue that CTA may have useful application in other contexts where Indigenous and settler values must come into a just relationship. Our analysis responds to the *Declaration on the Rights of Indigenous Peoples* (United Nations, 2007) specifically by affirming self-determination, autonomy, protection of collective rights and the right to practise cultural and spiritual traditions.

Although designed for the health sector, we argue the five-phase process outlined might be usefully applied across policy domains. For instance, policy responses to the Royal Commission of Inquiry into Historic Abuse in State Care, and the review of the criminal justice system, both of which have disproportionally affected Māori, might benefit from a CTA analysis. We hope that the CTA framework outlined here will be challenged, debated, adapted and adopted widely as a tool for evaluating policy and programmes designed to enhance and advance goals of social equity, sustainability and justice for Aotearoa.

Authors' Note

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Authors' contributions

This paper is based on initial analysis undertaken by HC and TM. In the major redevelopment and reconfiguration of the paper HC, DO and TM all contributed equally. All authors read and approved the final manuscript.

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