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**The Royal Australasian College of
Physicians' submission to the Māori
Affairs Select Committee**

Inquiry into Māori health outcomes

Mahuru 2019

Introduction

“Being compromised is part of being colonial ... you have to compromise to survive”

Merata Mita

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to submit feedback on the Māori Affairs Select Committee Inquiry into Health Inequities for Māori (the Inquiry).

The RACP works across more than 40 medical specialties to educate, innovate and advocate for excellence in health and medical care. Working with our senior members, the RACP trains the next generation of specialists, while playing a lead role in developing world best practice models of care. We also draw on the skills of our members, to develop policies that promote a healthier society. By working together, our members advance the interest of our profession, our patients and the broader community.

In our written submission to the Inquiry, the RACP has sought the leadership, expertise and experience of our Māori Health Committee members – Fellows and Trainees of our College – to develop our response. Our Committee has positioned this submission as Māori medical specialists ‘writing back’ from within the system and highlighting its fallacies from the inside.

Key points

- The RACP sees Te Tiriti o Waitangi as the foundation for health equity in Aotearoa New Zealand, and the objectives stated in the Articles should be woven into each phase of development, implementation, evaluation and monitoring
- The Inquiry’s failure to effectively incorporate the social determinants of health and inequity risks the relevance of the Inquiry’s findings and subsequent recommendations
- Legislation has failed to effectively realise the Principles of Te Tiriti o Waitangi

Inquiry Terms of Reference

“The right to health cannot be realised if structural inequities in the presence of social, economic, environmental and political determinants of health exist”

Bridget Robson, Donna Cormack and Fiona Cram

The RACP strongly supports the Committee’s centring of whānau stories of their health care journeys as the RACP recognises that ill health happens to whānau; while individual patients will naturally have the primary relationship to their health condition, health conditions impact whānau and should be understood in this way.

We welcome the broad scope of the Inquiry’s Terms of Reference, which will enable many whānau to see their experience as a critical component and contribution to the Inquiry’s process. However, we do see the Terms of Reference as perpetuating a particular kind of Pākehā and non-Māori form of governance and directed inquiry, which discounts the value and strength of Te Ao Māori, mātauranga Māori and Indigenous worldviews. The Terms of Reference are shot through with a tacit acceptance

of the status quo: the ‘system’ is working as it was designed to; because the system was never intended to grow, support or protect Māori health and wellbeing.

In this section of our response, we contend that the absence of some key aspects of health inequity in the Inquiry Terms of Reference speaks as loudly as what has been included.

Absence of reference to the Social Determinants of Health

“Questions of imperialism and the effects of colonisation may seem to be merely academic; sheer physical survival is far more pressing ... constant efforts by governments, states, societies and institutions to deny the historical formations of such conditions have simultaneously denied our claims to humanity, to having a history, and to all sense of hope.”

Linda Tuhiwai-Smith

While the broad scope and incorporation of whānau experience is welcomed, the failure of the Terms of Reference to articulate any reference to the Social Determinants of Health risks the relevance of the Inquiry. Without acknowledgement of the impact of the Social Determinants and the distribution of inequity (often referred to as the ‘causes of the causes’ of ill health) as independent factors correlated to cancer incidence there is little potential for meaningful, systemic change to reduce the prevalence of cancer in Māori whānau^{1 2}.

The impacts of the social determinants of health – housing, education, employment, justice, disability, income, living status and experience of poverty – need to be understood within the context of the underlying fundamental causes of the differential distribution of social and economic determinants by ethnicity. In Aotearoa New Zealand, this context can be understood as colonisation, racism, and inter-generational trauma¹. The impacts of colonisation must be understood as a fluid, ongoing process; although the initial moment of contact has passed, colonisation has not ended because the colonising powers have never left.

The social determinants of health and economic inequity mean for many Māori, differences in exposure to risk and protective factors compared to non-Māori will impact on health outcomes. Māori are approximately 15 per cent of the total population, meaning the greater exposure to risk factors, the greater population affected.

Risk factor exposure, Māori and non-Māori 2017/18

Risk Factor	Māori (% of total pop)	Non-Māori (% of total pop)	Ratio
Current tobacco smoker	33.5	14.9	2.58
Hazardous use of alcohol	31.7	21.2	1.42
Body size – obesity (BMI over 30)	47.5	30.7	1.65
Physical activity	54.0	55.2	0.99
Nutrition – fruit and vegetable intake	35.5	42.2	0.94

All statistics taken from NZ Health Survey – Update of key results 2017/18. Ratios in bold are statistically significant.

Why cancer

¹ Robson, B, Cormack D, Cram F. Social and economic indicators. In Robson B, Harris R. Hauora: Māori Standards of Health IV: A Study of the Years 2000-2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare; 2007.

² Commission on Social Determinants of Health. Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health. [Internet]. Geneva: World Health Organization; 2008. Available from https://www.who.int/social_determinants/thecommission/finalreport/en/. Accessed 2 September 2019.

The Inquiry has a specific focus on cancer, and the Terms of Reference have called for submissions that detail Māori “experience relating to prevention, screening, diagnosis, treatment, cures, and palliative care”. We posit that the Inquiry’s focus on cancer is due to the fact that, as a health condition, cancer is supported by the most robust, quality data on the persistent inequities in treatment and outcomes experienced by Māori whānau³.

Age-standardised rates for select cancers, 2015-17 per 100,000 population

Lung cancer		Breast cancer		Cervical cancer		Leukaemia		Colorectal	
Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori	Māori	Non-Māori
77.5	26.3	129.3	92.7	9.96	5.4	16.7	13.5	39.8	46.3

The RACP finds that evidence of inequity for Māori is well-documented, is comprised of robust data and subject to regular collection – the risk factors highlighted above are taken from the Ministry of Health’s annual update of key indicators as part of the New Zealand Health Survey, and registrations for cancer are made to the New Zealand Cancer Registry.

The emphasis on evidence and collating statistics as contained in the Terms of Reference should be articulated as having a supporting role in this Inquiry, not as its overarching goal. Statistics and evidence must be secondary to the primary emphasis placed on experience and hearing directly from whānau, and from health practitioners working in the areas of cancer diagnosis, treatment, management and support.

The RACP also notes the contemporaneous inquiry into health services and outcomes for Māori undertaken by the Waitangi Tribunal (WAI 2575), the recently-announced refresh of He Korowai Oranga The Māori Health Action Plan, and the launch of the New Zealand Cancer Action Plan 2019-2029^{4 5 6}. Beyond these major initiatives, the Health Research Council of New Zealand has funded research into cancer outcomes for Māori whānau, including projects lead by Dr Lis Ellison-Loschmann in 2016 and Dr Jason Gurney in 2018⁷. As such, there is an imperative for the Inquiry to complement these other initiatives and contribute in discourse more broadly.

Reference to bias

The reference to unconscious or deliberate bias is welcomed; though we note the process and impact of unconscious or deliberate bias is racism and should be stated in these terms.

The language of cultural safety as a framework for working with whānau has been incorporated into nursing practice for some time; the seminal work of Irihapeti Ramsden articulates that “nurses cannot provide quality, patient-focused care if they have unconscious negative attitudes towards patients who

³ Ministry of Health. Tatau Kahukura: Māori Health Statistics. [Internet] Wellington: Ministry of Health; 2018. Available from <https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/cancer>. Accessed 2 September 2019.

⁴ Waitangi Tribunal. Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. Wellington: Waitangi Tribunal; 2019. Available from <https://www.waitangitribunal.govt.nz/inquiries/kaupapa-inquiries/health-services-and-outcomes-inquiry/>. Accessed 4 September 2019.

⁵ Ministry of Health. Māori Health Action Plan. Wellington: Ministry of Health; 2019. Available from <https://www.health.govt.nz/our-work/populations/maori-health/maori-health-action-plan>. Accessed 19 September 2019.

⁶ Ministry of Health. New Zealand Cancer Action Plan 2019-2029. Wellington: Ministry of Health; 2019. Available from <https://www.health.govt.nz/publication/new-zealand-cancer-action-plan-2019-2029>. Accessed 19 September 2019.

⁷ Dr Lis Ellison-Loschmann’s 36-month project explores Cancer support programmes for Māori whānau, while Dr Jason Gurney’s 48-month project will investigate improving the quantity and quality of life for Māori with cancer. Health Research Council of New Zealand. Funding recipients. Auckland: Health Research Council of New Zealand; 2019. Available from <http://www.hrc.govt.nz/funding-opportunities/recipients>. Accessed 3 September 2019.

are different from them”⁸. Ramsden’s theoretical framework of cultural safety highlights the work of the clinician or practitioner in engaging in self-reflection, working through biases to address them, leading to improved, meaningful connections with patients and whānau.

The Medical Council of New Zealand has recently consulted on updates to its statements *Cultural competence and the provision of culturally-safe care* and *Achieving the best health outcomes for Māori*, and the language of cultural safety is explicitly articulated in each. The RACP defines the differences in cultural competence and cultural safety as

- Cultural competence describes the skills, attitudes and knowledge of a practitioner to engage with a patient and the patients’ whānau – the practice.
- Cultural safety describes the experience of the patient and their whānau in their interactions with health practitioners and health organisations. Although influenced by cultural competence, cultural safety is an independent requirement which is not bound to expectations for clinicians to be culturally competent – because it is determined by the patient.⁹

The RACP believes embedding tikanga Māori, mātauranga Māori and the principles of Te Tiriti o Waitangi is critical to articulating a health and disability system which nurtures, supports and protects hauora Māori as a taonga.

Eliminating the gap

Health inequities are unjust and unfair. For Māori, inequities in health outcomes compared to non-Māori are not only unjust and unfair; they are perpetuated by a system borne out of colonial government assumption that its role in part was to “smooth the pillow of a dying race”¹⁰.

Evidence presented during the WAI 2575 hearings from Statistics New Zealand, the Ministry of Health and others found Māori had on average the poorest health status of any ethnic group in Aotearoa New Zealand. One measure of poor health status is life expectancy, and the gap for Māori remains persistent.

The 2019 Cancer at the Crossroads symposium stated that achieving equity must be a central goal of any cancer strategy for Aotearoa New Zealand. Further, for this element to be realised, actively supporting the Māori right to self-determination and to freely pursue cancer control development in accordance with Māori aspirations. Achieving survival equity between Māori and non-Māori by 2030 was identified as a goal for an equity-informed cancer action plan, and the thematic summary concludes that “we must be prepared to invest disproportionately in our least privileged populations, so they can expect the same cancer outcomes as our most privileged.”¹¹

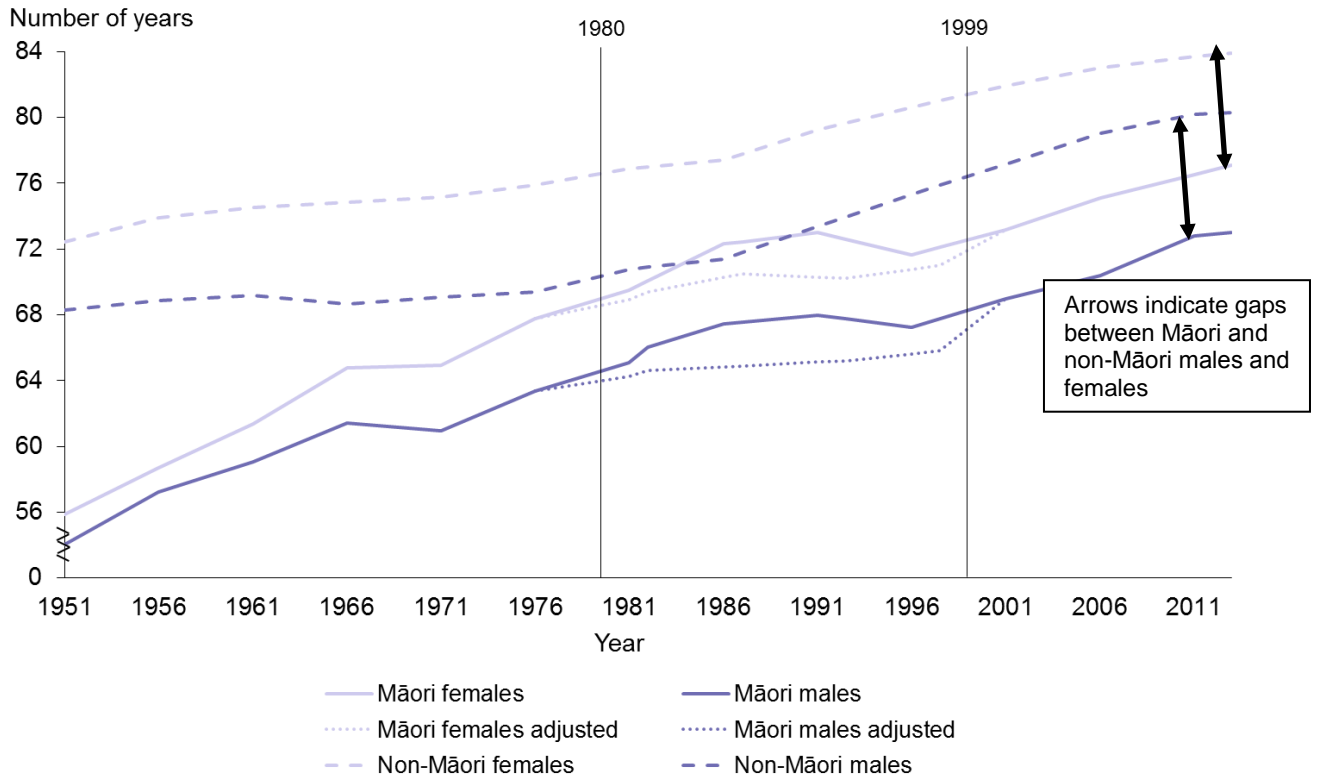
⁸ Papps E, Ramsden I. Cultural safety in nursing: the New Zealand experience. [Internet] Int J Qual Health Care 1996; 8(5):491-7. Available from <https://www.ncbi.nlm.nih.gov/pubmed/9117203>. Accessed 3 September 2019.

⁹ The Royal Australasian College of Physicians. Submission to the Medical Council of New Zealand, July 2019. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/racp-submission-mcnz-statements-on-provision-of-cultural-competence-and-culturally-safe-care-and-achieving-the-best-health-outcomes-for-maori.pdf?sfvrsn=5b921c1a_8. Accessed 3 September 2019.

¹⁰ This phrase is even attributed to a doctor: physician and politician Dr Isaac Featherston, who stated this in 1856. Poole I, Kukutai T. Taupori Māori – Māori population change: decades of despair 1840-1900. Te Ara – the Encyclopaedia of New Zealand. Available from <https://teara.govt.nz/en/taupori-maori-maori-population-change/page-2>. Accessed 9 September 2019.

¹¹ Sarfati D, Jackson C, Macfarlane S, Bissett I, Robson B, Gurney J et al. Cancer care at a crossroads: time to make a choice. Editorial. N Z Med J [Internet] 2019; 132(1493): 6-11. Available from <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1493-12-april-2019/7851>. Accessed 17 September 2019.

Life expectancy at birth, by gender, Māori and non-Māori 1951-2013



Ministry of Health, Tatau Kahukura: Māori Health chartbook, 2015.

Eliminating the discrepancy in life expectancy between Māori and non-Māori is one of the overarching drivers for action. While there is a clear, central leadership role for the Ministry of Health, improvements in health and wellbeing (and the causes of poor health, disability, morbidity and mortality) are in the social and economic determinants of health – not explicitly within the remit of the health system, though not without it either. Understanding health inequities and translating this into comprehensive, tangible and measurable actions can be achieved in Aotearoa New Zealand when all agencies collaborate towards achieving the same goal.

Mana Motuhake

“These principles require the Crown not only to recognise and provide for Māori to act in partnership with the Crown in designing and providing health services for Māori, but to design and provide services that actively pursue equitable Māori health outcomes.”

Waitangi Tribunal

At this point in time, the health and disability system in Aotearoa New Zealand is poised to either capitalise on the findings of major system level reviews, inaugurating significant change and reorienting a system, or to maintain a variant of the status quo. There is increasing demand from society, from patients and whānau, and from health practitioners for the system to acknowledge it is not designed to support everyone’s right to health⁹.

Divergence: the Tohunga Suppression Act 1907

“The Tohunga Suppression Act had dual but contradictory purposes: on the one hand it sought to promote Māori health while on the other it actively discouraged Māori autonomy.”

Tā Mason Durie

While the foundations of the current New Zealand public health system were established by the Social Security Act 1938, the decimation of hauora Māori kaupapa can be traced to 1907, and the passing of the Tohunga Suppression Act. The Act ostensibly sought to impose Western medical standards and treatments on Māori by prohibiting the practice and teachings of traditional Māori medicine and healing (rongoā), but in effect dismantled the intrinsic order of Māori health and wellbeing: opposing Māori methodologies and the legitimacy of mātauranga Māori in medicine as well as the links between health and the environment, human behaviour, arts and spirituality¹². The passing of the Act also attempted to assuage misguided Pākehā fears of a growing Māori autonomy and undermine the efforts of tohunga and prophet Rua Kenana, rendering the Act the product of “an anxious time”¹³. Moreover, the Act’s very title sent an aggressive and provocative message about the government’s view of Māori beliefs¹⁴.

The Waitangi Tribunal found the Act unjustified, as not only did it do nothing to respond to the very real Māori health crisis (Māori had very little access to health services – the 1907 Vote Health for Māori was around £3,000, the majority of which was paid as medical subsidies to doctors); but it was also racist¹³. The Tohunga Suppression Act “defined a core component of Māori culture as wrong and in need of ‘suppression’. Moreover, it continued to fail Māori by not replacing rongoā with anything, meaning the impacts of the social determinants of health became entrenched¹⁴.”

The Tohunga Suppression Act is a key example of the assumptions held by Western science: it refuses to acknowledge that the biomedical model and the spiritual dimension could coexist. The RACP finds that, although the Tohunga Suppression Act was repealed in 1962, its effects are still discernible today, for example in the marginalisation and under-resourcing of rongoā health services. The Waitangi Tribunal goes further, positing that rongoā Māori is caught between the central governing functions of the Ministry of Health and the population-based priorities of the District Health Boards. “There is theoretically nothing to stop DHBs greatly expanding the number of contracted rongoā services ...DHBs have limited funds and, we suspect, limited appetite for services that may be regarded as politically or clinically problematic.”¹⁴

When Apirana Ngata spoke out in Parliament against the Tohunga Suppression Act he stated “you are getting down to bedrock when you get to tohungaism”. Although Ngata was speaking of the fundamental place of the tohunga in Te Ao Māori, and that Pākehā attempts to quell its position would be ineffectual, he could equally be describing the inextricable links between whenua, hauora, and tangata Māori. The relationship between people, place, health and wellbeing is central to identity and culture. Considering this relationship, Tā Mason Durie noted

¹² Durie MH. Identity, nationhood and implications for practice in New Zealand. N Z J Psychol. [Internet] 1997 26(2):32-8. Available from <https://www.psychology.org.nz/wp-content/uploads/NZJP-Vol262-1997-5-Durie1.pdf>. Accessed 6 September 2019.

¹³ Stephens M. A return to the Tohunga Suppression Act 1907. [Article submitted in fulfillment of the LLB(Hons) requirements at Victoria University]. Wellington (NZ): Victoria University; 2000. Available from https://www.victoria.ac.nz/_data/assets/pdf_file/0004/825439/Stephens.pdf. Accessed 19 September 2019.

¹⁴ Waitangi Tribunal. Ko Aotearoa Tēnei: A report into claims concerning New Zealand law and policy affecting Māori culture and identity. Wellington: Waitangi Tribunal; 2011. Available from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_68356054/KoAotearoaTeneiTT1W.pdf. Accessed 19 September 2019.

“...the depopulation was greatest where land alienation had been most extensive. Loss of land had more than economic implications. Personal and tribal identity were inextricably linked to Papatūānuku – the mother earth – and alienation from land carried with it a severe psychological toll, quite apart from loss of income or livelihood”¹².

Alienation of Māori from traditional lands and fisheries is an immutable reality of colonial trauma, and its intergenerational links to health loss are stark. As lands were transferred through legislation, confiscation and Pākehā models of ownership through the nineteenth century, the Māori population declined to 43,000 in 1896. At this time, Māori had lost more than 99 per cent of their lands, with only eleven thousand acres remaining in Māori ownership¹².

The cyclic, holistic and symbiotic relationship between Māori and whenua can be seen in many facets of Te Ao Māori, from ethical dimensions of kaitiakitanga and mana whenua to the kupu *whenua* itself being land, territory or ground as well as placenta or afterbirth. Access to the institutions and taonga of Te Ao Māori, including language, arts, flora and fauna species and rongoā are critical to the development of a secure identity, which in turn support and reinforce health and wellbeing.

The RACP calls for a system which articulates a strengths-based framework to bring together mātauranga Māori and Western medicine – drawing on both foundational systems of knowledge which have contributed to Aotearoa New Zealand – for the improvement of Māori health outcomes. Mana Motuhake (self-determination) should be a foundational principle, and we call for a system which supports whānau needs and aspirations for healthy lives as Māori, not as something other (and therefore different and difficult to accommodate).

The continued inadequacy of health legislation in Aotearoa New Zealand

“Policy remains a contested site of colonial power, and that decolonisation as represented by te Tiriti promises, and the guarantee of Māori sovereignty, remain distant goals”

Heather Came

The RACP finds it necessary to reiterate the findings of the Waitangi Tribunal’s *Hauora* report as part of our response to the Select Committee’s Inquiry⁴:

1. The New Zealand Health and Disability Act 2000 does not give proper and full effect to the Treaty and its principles, and is not Treaty-compliant
2. He Korowai Oranga and its articulation of “partnership, participation and protection” does not adequately reflect the Treaty and its principles
3. The removal of specific Treaty references from lower-level documents amounted to a concerning omission of the health sector’s Treaty obligations.

Within this context, it is increasingly clear to patients, whānau, and medical practitioners that failures and inadequacies at multiple structural points have compounded to perpetuate a system which disadvantages, marginalises Māori health, and subsumes active aspirations for health equity. New Zealand’s neo-colonial health system reinforces a predominantly deficit mentality in relation to Māori health: this framing persists through all levels of health care design and delivery; derived from the euro-centric model imposed in the early twentieth century¹⁵.

¹⁵ Belgrave M. Primary health care – establishing medical control, late 19th and early 20th centuries. Te Ara – Encyclopaedia of New Zealand. Available from <http://www.TeAra.govt.nz/en/primary-health-care/page-2>. Accessed 17 September 2019.

- **At the level of Te Tiriti** – the founding document of Aotearoa New Zealand – historic and contemporary breaches by the Crown perpetuate Māori health inequity
- **At the legislative level**, Acts of parliament, regulations and other legislative instruments fail to give “full and proper effect”⁴ to addressing Māori health inequities
- **At the systems level**, the institutions, design and delivery of health services fails to address Māori health inequities as the legislation which establishes these structures does not embed te Tiriti
- **At the policy and service commissioning levels**, while references to Te Tiriti, health equity and hauora Māori are becoming more visible, deficit framing is still evident – Māori services are funded for shorter periods and required to undertake more audits^{16 17}. Services are not designed to mitigate for health inequity; rather deliver “equal access” to services across the population¹⁸.

Institutional racism, colonial structures and systemic bias permeate through the system at every level and are in turn compounded by the impact of the social determinants of health and wellbeing. Māori must be present as partners, not as a point of consultation in the path to implementation.

Health policy and practice is shot through with language that is ultimately about power-sharing: “co-design”, “patient-centred” and “shared decision-making” being salient examples. While the roles are interchangeable to an extent – the dynamic can be set up between clinicians and patients, between practitioners of different disciplines or experience, or between an individual and the system – an inherent inequality is at play. Power imbalances and in many cases, no opportunity for Māori to engage, participate or collaborate in decision-making which affect their people are detailed extensively in *Hauora* and signal failure to include tangata whenua in decision-making and co-design at almost every level of the primary health system⁴.

The RACP supports the findings of the Waitangi Tribunal and the Health and Disability System Review, that state unequivocally that the existing health care system has not worked for Māori and it has contributed to the inequities in health and wellbeing outcomes experienced by tangata whenua^{4 17}.

Te Ara Whakamua: Te Tiriti o Waitangi

The strategy and framework to support an equity-oriented system is already in existence: Te Tiriti o Waitangi and the United Nations Declaration of the Rights of Indigenous Peoples. Te Tiriti was distilled in 1987 to three principles of “partnership, participation and protection”, but remains poorly articulated

¹⁶ Came H, McCreanor T, Manson L, Nuku K. Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity. [Internet] N Z Med J. 2019; 132(1492):61-66. Available from www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2019/vol-132-no-1492-29-march-2019/8746. Accessed 4 September 2019

¹⁷ Health and Disability System Review. Interim report Pūrongo mō tēnei wā. Wellington: Health and Disability System Review; 2019. Available from <https://systemreview.health.govt.nz/interim-report/>. Accessed 3 September 2019.

¹⁸ The Royal Australasian College of Physicians, New Zealand Society of Gastroenterology. Submission to the Ministry of Health, January 2019. Available from https://www.racp.edu.au/docs/default-source/advocacy-library/racp-feedback-ministry-of-healths-guidance-national-bowel-screening-programme.pdf?sfvrsn=be26141a_4. Accessed 19 September 2019

or even present at all in many of the currently-used frameworks¹⁹. The RACP strongly supports future directions for all health care (and in this instance, cancer) implementing a Te Tiriti-driven framework which would address all points in a cancer journey for whānau.

We note the balance has shifted further towards “international best practice and quality” as being the principal definitions of systemic efficacy. There is little to suggest that the patient and their whānau have any agency in a system which is increasingly shaped by globalised, industrialised and corporate conditioning. The RACP’s Māori Health Committee references Dr Don Berwick, founder of the Institute for Healthcare Improvement when it states, “We are guests in our patient’s lives, but it is for whānau to decide to accept the invitation”. This sentiment of Māori autonomy and self-determination is noted by filmmaker Merata Mita, who stated “we have a history of people putting Māori under the microscope... the ones that are doing the looking are giving themselves the power to define”²⁰.

A new system based on Te Tiriti o Waitangi and kaupapa Māori values would not seek to reverse Mita’s metaphoric (and literal) microscope. A new system – which is in the remit of the Select Committee to recommend – would acknowledge that

- the solution for Aotearoa New Zealand must begin with Te Tiriti o Waitangi
- a person is never separate from their whānau, and further is never alone from the significance of place, of land, of landscape
- Māori doctors and health practitioners must be part of the solution
- The environment of training and practice will define performance – safe systems not only mediate unsafe practitioners but make it challenging for these practitioners to continue to function in biased, discriminatory ways.

For the RACP, kaupapa Māori cancer services would

- Again, utilise Te Tiriti o Waitangi as a foundational framework establishing principles for equitable care which achieves the best possible outcomes.
- Place whānau and the person with cancer at the centre: decision-making, needs and priorities are determined by whānau.
- Take Whānau Ora approaches as the norm for navigating and supporting whānau through their cancer journey.
- Be based on Māori models of health, including Te Whare Tapa Wha to recognise the importance of the spiritual domain (taha wairua) of health and wellbeing for the person with cancer and their whānau²¹.
- Ensure whānau have access to support services through their cancer journey, and have equitable, barrier-free access to any entitlements
- Build on the successes of kaupapa Māori health services and screening programmes – for example, Mana Tū, a whānau ora approach to type 2 diabetes, and the strategies utilised to improve wahine Māori participation in breast screening programmes^{22 23}

¹⁹ Came H, Cornes R, McCreanor T. Treaty of Waitangi in New Zealand public health strategy and plans 2006-2016. [Internet] N Z Med J. 2018; 131(1469):32-38. Available from <https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1469-2-february-2018/7478>. Accessed 19 September 2019.

²⁰ Mita M. “Merata Mita on ...” in The New Zealand Listener. 14 October 1989. In Tuhiwai-Smith L. Colonising knowledges. In Decolonising Methodologies: Research and Indigenous Peoples. London; Zed Books; 1999.

²¹ Laking G. Ratonga Hauora Matepukupuku He aratohu tautuhi. Guideline for Service Specification: Kaupapa Māori Community Oncology. Unpublished, 2018

²² Harwood M, Tane T, Broome L, Carswell P, Selak V et al. Mana Tū: a whānau ora approach to type-2 diabetes. [Internet] N Z Med J. 2018; 131(1485):76-83. Available from <http://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2018/vol-131-no-1485-9-november-2018/7742>. Accessed 4 September 2019.

²³ Thomson R, Crengle S, Lawrenson R. Improving participation in breast screening in a rural general practice with a predominantly Māori population. [Internet] N Z Med J. 2009; 122(1291):39-47. Available from <http://www.nzma.org.nz/journal/122-1291/3510/>. Accessed 13 August 2019.

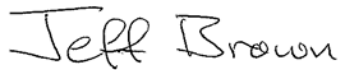
- Provide services – from consultation, diagnosis, treatment, counselling and rehabilitation – which are responsive to the needs of whānau and actively address any barriers to achieving the best possible outcomes
- Be delivered in accessible, safe and community-based settings by multidisciplinary teams encompassing medical, nursing and health navigator roles in a culturally safe way.

The RACP sees Te Tiriti o Waitangi as the foundational framework to guide the development of an equity-based public health system in Aotearoa New Zealand, to achieve equity of outcome for tangata whenua.

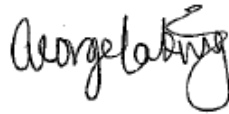
Conclusion

The RACP thanks the Māori Affairs Select Committee for the opportunity to participate in this important Inquiry, and we would like to attend a hearing to present in person. To discuss our submission further, please contact the NZ Policy and Advocacy Unit at policy@racp.org.nz.

Nāku noa, nā



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