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Treaty Partnership

Te Pouhere Sunday

6 June 2021

Today is Te Pouhere Sunday, the day on which we celebrate the 1992 constitution of Te Hahi Mihinare ki Aotearoa ki Niu Tireni, ki Nga Moutere o Te Moana Nui a Kiwa, our three tikanga church. A model of church unique to Aotearoa which reflects our unique heritage as a nation founded on Te Tiriti o Waitangi between our land's indigenous people, Maori, and the British colonisers and our close relationships with our Pacifica brothers and sisters.

1992 is a long time ago now - nearly 30 years - and the finessing of this ground-breaking model of relationship continues. As at 2003 when Commissioners including our own Pip Colgan reported back to General Synod on their Review of Achievements in the Principles of Partnership, they pointed to gains for Maori in terms of equity, representation, independent resourcing and greater theological and religious freedom but serious underfunding of ministry with only a handful of stipended clergy positions across the motu. There were gains for Pasefika in becoming an equal integral and full member of the whole church and for Pakeha a better understanding of Treaty issues and what it means to be Pakeha but a concerning lack of awareness of change for many.

However the report also reflected concern at a loss of engagement between Pakeha and Maori and called for more interaction between tikanga.

That picture is probably very much the same today. A good start but room for growth, for ongoing mahi on the partnership to achieve an equitable distribution of resources and to ensure the mana of all three tikanga is promoted and respected.

And that's where the connection to today's Gospel reading comes in. In the Gospel John lays out the model for that ongoing mahi. Jesus tells us to abide in his love. He tells us how to do that - by keeping his commandments. And he tells us what his commandment is - to love one another as Jesus has loved us.

What Jesus is saying is bound to cause trouble, upset the established order and call it into question. He's saying salvation doesn't depend on slavishly following the law given to Moses. That it's love that salvation is founded on.

Suggesting that love is the key might seem fanciful and unrealistic. It's a radical departure from a winner takes all approach or a legalistic, rules bound approach founded in the laws and understandings of just one of the parties. Like Jesus, the church stands outside the mainstream. It too could be accused of being out of its mind with its high-minded ideas about love and inclusion. It could be accused of being unrealistic, possessed by fantasies of a world where justice and equity prevail.

Following Jesus, the church can (and I would say should) be an unsettling voice, speaking truth to power, calling out injustice. Sometimes it does this simply by modelling ways of being in the world which suggest the possibility of greater respect, greater equity and respect – more love. The three tikanga model is just such a model, an expression of our church's active commitment to greater respect for the Treaty partnership between Maori and Pakeha and for our Pasefika brothers and sisters. It calls all of us into active expression in the everyday lives of our congregations of the commitment to honour and love our partners. It doesn't say we've got it all sorted but that we are committed to hanging in together in love, in aroha.

The model is one of love for each other. Love is the foundation of everything and the pinnacle of everything. Love is what will carry us through the difficult conversations about how we work together as a three tikanga church or, taking a wider perspective, how we right the hurt caused by 80 years of failing to honour Te Tiriti and achieve justice and equity for Maori in Aotearoa-New Zealand.

It's a loving attitude which will allow reforms like those we have just seen outlined for the health sector move towards addressing some of the inequities caused by our failure to honour Te Tiriti. My work in the health sector means I am acutely aware of the way our health system has failed Maori.

Māori suffer from more avoidable deaths than most New Zealanders, have lower life expectancy, and do not always receive the same quality of care. The government has recognised that these inequities cannot continue.

To ensure they do not persist, and in recognition of the government's obligations to Māori under Te Tiriti o Waitangi, our health system needs to support hauora Māori in a different way. Rangatiratanga Māori over hauora Māori needs to be strengthened, Māori need to be empowered to shape care provision to give real effect to Te Tiriti o Waitangi in the way health services are delivered.

To champion the voice of Māori in the health system, the future health system will have a Māori Health Authority with significant authority to craft care which better meets the needs of both Māori and other New Zealanders – as well as directly funding and commissioning more kaupapa Māori and te ao Māori-grounded services.

Iwi-Māori Partnership Boards will be strengthened to act as an influencing and decision making voice for iwi and Māori in each locality, so that Te Tiriti partnership operates at every level of our health system.

This means that there will be more deliberate investment in equity of access and outcomes for Māori, increased accountability, and a much greater role for iwi and Māori in shaping service design and provision for Māori communities. In addition, targeted support for Māori care providers will grow the range of kaupapa Māori and Māori-centred services offered in our health system – which will improve reach into Māori communities, the diversity of service options available, and improve health outcomes for Māori and non-Māori alike.

Is this enough? Obviously the answer is no. It's a start but it's not enough. Critics are already pointing to deficits and disappointments.

For a start, the budget allocated to the Maori Health Authority is only somewhere between 3-6% of the total health spend.

Then there's concern about what difference the changes will make for people using health services. Simon Royal, the chief executive of the National Hauora Collective says "The crucial question is, 'what is the changed experience for whānau in this new infrastructure coming into place? If it doesn't change that experience it will all just be a bureaucratic exercise." [1]

Add to that that control will sit with the new and huge super ministry and Health New Zealand. The Maori Health Authority will have to influence New Zealand's generic health policy and services from the side.

Teresa Wall on the night of the budget, argued that the new authority must not take its gaze off generic mainstream health services, our GP surgeries and our hospitals which is where most of the problems for Māori are located. Most of the time, most Māori won't be accessing kaupapa Māori services, they'll be lining up at their local GP and hospital. How will the Maori Health Authority make a difference to the way those services are delivered?

And if you're wondering whether we really need a Maori Health Authority, let me give you some illustrations from my own district health board where we have identified areas where Maori are significantly over-represented in morbidity and mortality terms.

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[1] https://www.stuff.co.nz/pou-tiaki/300282517/selfdetermination-at-the-heart-of-new-mori-health-authority

In 2016 we ran a pilot screening programme for abdominal aortic aneurysm or Triple A targeting Maori men.

The case for the pilot was that:

- Maori men are at a significantly higher risk of dying of Triple A. Maori men are also at a substantially higher risk of dying of Triple A than women.
- Only 40% of aneurysms detected in Māori are repaired by elective surgery, compared with 61% in Europeans.
- Reducing the 7-9 year gap in life expectancy between Māori and non-Māori men is a national, regional and local health sector priority.
- Ethnic inequalities in Triple A mortality contribute to that life expectancy gap and screening will make a small but significant contribution to reducing it and die from AAA at an age 8 years less than New Zealand European men.
- The purpose of the pilot was to improve health equity for Maori men to levels comparable with other groups of men through early identification of AAA.

Just last month we announced the pilot of another screening programme focused on Maori - this time a lung cancer screening programme.

Lung cancer is the single biggest contributor to the difference in life expectancy between Māori and non-Māori, with lung cancer the leading cause of death for Māori women and the second leading cause of death for Māori men after cardiovascular disease. Māori women's rates are more than four times higher and Māori men's rates nearly three times higher than those of non-Māori.

This makes lung cancer a major public health and equity issue in Aotearoa New Zealand. The future national lung cancer screening programme will be designed by Maori so that it works for Māori from the get-go - is hospitable in ways Maori recognise and appreciate and invites Maori in in culturally appropriate and engaging ways.

Is this enough? Obviously the answer is no. It's a start but it's not enough. It's going to take a lot more love, an abiding in love, love at every step, because in the end love is more important than all the money and fancy government structures we can throw at a problem.

Love, aroha, that's it.