

TANIA KINGI:  
(Speaks in te Reo Māori)

Thank you for the invitation to speak today. I feel like it means that I will say something profoundly important. (Laughter)

TANIA KINGI:  
It is an honour to be here. I was going to bring my camera and take a photo of you all. It will be interesting to gauge your response, and this is a different audience to one that I have ever presented to.

My organisation is a consumer-based organisation made up of six communities, the (unknown term) people with disabilities, the Turi deaf community, Kapo vision-impaired, blind community, Wakaturu, as they call themselves, people with physical disabilities, (unknown term - carers), the group I belong to, Hinengaro, intellectual disabilities, and (unknown term) have disabilities.

They are all part of this motley crew called Whanau. We are one of the few organisations that is whanau based and is mainly governed by the disability community.

We have this initiative that I have just come back from [presenting in] Hawaii. I have got to say, it was probably taken as a unique initiative, but in all aspects, we haven't seen it like that. There are a few initiatives [by Te Roopu], but it is just ways that our community create their own solutions.

This presentation is based on the health sector. Although it is in the health sector, it is applicable to any sector. I will ask you to broaden your thinking about what I am about to present. This covers about every field of industry and community.

This is a deprivation snapshot was published by the Ministry of Health, in a document called 'Living with Disability'. This bar graph, from your right to left, explained a continual deprivation from one to 10. One being least deprived, and then being most deprived.

It covers all population groups. The first is Māori people with disabilities. The second is Māori people without disabilities. The fourth is non-Māori without a disability. This shows you a deprivation status.

Māori people with a disability are the most deprived, followed by the Māori people without a disability. Then, Pakeha people with a disability. This graph gives you a snapshot of deprivation socially, culturally, economically.

Wellbeing is really determined by the way society responds to its most vulnerable. The key behind the first graph I showed you really underpins that statement.

We have a couple of photos here of board members. There are seven of them. These are members of what we call (unknown term). They are just chilling out in our carpark. Our board chair is a mouth and foot painter. He is known for the work that he does. He is hanging out here with Prince Harry. We do a lot of rubbing shoulders with famous people in our organisation. These people are influential in terms of the decisions that they make.

We have just come back from a conference, and Indigenous health conference. We took

some statistics to the conference. This graph is measuring performance, it has just been created by all district health boards, and it measures Māori health progress against 13 health indicators.

I will not go into too much detail about this graph, but what it does show is, the column there shows where health is out against those 13 health indicators. And the graph shows no red bars, in terms of what their performances are. The red bar indicates more than 20% away from the target.

In the other column that has seven red bars, but is Māori health. What this indicator shows is that we have an equity in terms of our health sector and the way in which Māori people experience the health system.

A lot of people will say that has got to do with individuals. And I'm here to challenge on a perspective because we have some structural issues on one this graph looks the way it does.

A piece of work that was done not so long ago by this group of physicians, he has taken the health sector little bit by storm because what they have managed to show through the research is that Māori people receive fewer referrals through the health sector.

They receive fewer diagnostic plans by physicians and specialists. They are offered treatments at substantially decreased rates and they are interviewed by GPs and specialists for fewer minutes. Less time with Māori patients. They are prescribed fewer secondary services, physiotherapy, chiropractors, that sort of thing.

And again, it shows that Māori experience a different health system and the quality of care that they receive. For married people with disabilities, it is more so.

Institutional racism is one of those topics that people avoid like the plague. But I think it is a really healthy environment when we can talk and address these issues. And clearly, the health sector is underpinned in its operations, some aspects of institutional racism that certainly needs to be addressed.

The work of Dr Heather Kane from Auckland University has shown that these are the sites of institutional racism. I'm not sure if you are aware of the background behind the (unknown term) which happened some time ago when we were arguing about the seats on Auckland Council.

Some of the issues that we found around there are some of the majoritarian decisions that are made on how people use their life and marry involvement in that was an issue. There has been a lot of misuse of evidence in the health sector in particular. And a misinterpretation of what that evidence means.

So there has been some challenges along those lines of how we get better, how we get more competent in understanding the issues that face our communities. There is certainly a deficiency in cultural competencies and I think the challenge for this forum is that there is a piece of work, that is to happen before universal design or inclusive design takes place.

And that is to make sure that you are competent to do it. It takes a bit of training, it takes a lot of understanding, it is not an issue you can just run into. You have to be competent. You have to be disability aware, you have to be culturally competent. These are some of the issues we are certainly facing in the health sector.

The other area that is a specific site of institutional racism is the impact of Crown and government filters. It took me a little while to understand what that might be. One example, for instance, the graph I showed you with the 13 indicators, somebody determines what those indicators might be and it wasn't the Māori community.

There are some decisions that are made before we enter into any kind of operation or strategic planning. I understand that for some of our groups that we visited in Hawaii, they were told by the university that hosted us not to use religion in the welcoming of the people.

Somebody made a decision that that should not be used. And yet, religion is part of spirituality, and it is actually a very important aspect of many communities. So this impact of Crown filters or government filters in our reality happens on quite a frequent basis.

It sounds a little bit dream and gloom but let me show you that there is some work being done by several communities, like organisations like ourselves, to challenge the way what we think is normal in the way we provide healthcare. Over the years, aspirations have moved from whanau to providers. Now there is some work to claim that back.

We believe that we are, or any community, is in the best position to determine what quality is. It's so much emphasis placed on providers to make that call. They have got to be better ways to ensure the community has a say and a voice in the decisions that affect their lives. They will know themselves far better than the health providers do.

We saw that case come to fruition not long ago where some physicians were trained in clinical care but not trained in clinical care for someone with a disability and had provided a whole range of options that were clinically based that were actually very detrimental.

This is a shot of our board, one of the members of our community who won the award back in 2008. We were really pleased to win that award because it was in a platform for all health providers in the country. What the saying is, is that what works for disabled works for everyone. It is just good business sense that we do this.

We have developed a workforce engagement, from a disability point of view. We call it an NZQA accredited course. To work with people to enhance the cultural competency and disability knowledge. It is made up of three modules. At the moment we're putting to staff from the Monaco District Health Board and the Auckland District Health Board to do the same.

What we have found is cultural competency is just as important as clinical competency. It doesn't make sense you would have one without the other. We also are looking at doing some stuff with Auckland Council. That is a very early stage. This is just a quick overview. We have worked very closely to make sure we have it right.

Kind of looks like this, our team goes in, just the training. Then it asks our communities to

see whether it has been a difference and the way in which organisations service them. They fill out an evaluation, an independent one, it goes back to the organisation to say you are doing a really good job or you need some more work, let's work on these issues.

We have spent the last 10 years bashing up organisations about how inappropriate or incompetent this side of their services are. And I guess we have come of age to make sure our knowledge is passed on to organisations to make it better. So, that is a little bit of a process to how we go through this. I haven't got the knack of pushing this thing.

Our response from the DHP, primarily Māori staff have enrolled in our program. That surprises me that Māori people would come on a program for cultural competency. But they have come on-board because of the disability competency that our team offers.

We have good support from Māori managers to get the staff involved. We've had no response from Pakeha staff or the staff of the DHB. They say there is no supportive environment for cultural competency and it is not provided. And we need to challenge some of the thinking.

So our recommendations is that we need to take deliberate steps as a health board to make cultural competence organisations, clinical training and to increase this work of all staff who are working with Māori. And as part of their procurement, they should not be buying health services unless the suppliers have a cultural competency baseline and their contractual agreement.

The calls for institutional racism have been long and hard, and you might have noticed that there have been a few calls lately for an investigation in the public sector by the minister. There has been a lot of public scrutiny following these reports. There has been really poor progress in terms of Māori help. There has been really good partnering done locally and we consider that needs to carry along.

Some take-home messages for you - what space do you create for partnering? Who do you design for? Or are you designing with? How competent is your engagement with our vulnerable members of society? And can you improve your relationships with the community and the most vulnerable?

Just a quick shot of sharing the vision we have. Working together takes a lot of time but saves time in the long run. So good luck on your journey. We're trying to change, I guess, what is unique to being normal.

(Speaks in te Reo Māori)  
no difference. So, thank you.