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A Critical Tiriti Analysis of the Health Workforce Plan 2023/24: The need to strengthen workforce planning

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Abstract

There has been a longstanding global shortage of clinically and culturally safe health practitioners, and a critical scarcity of Indigenous practitioners. Within Aotearoa New Zealand, the Health Workforce Plan 2023/24 (the Plan) is a major policy driver for addressing health workforce issues within Te Whatu Ora

(Health New Zealand), our major health employer. Using Critical Tiriti Analysis, this paper reviews to what extent the Plan aligns to the five elements of Te Tiriti o Waitangi. A Critical Tiriti Analysis involves a rigorous five-step process: i) orientation, ii) close reading, iii) determination, iv) strengthening practice and v) Māori final word. We found the Plan to be in partial alignment with Te Tiriti. This desktop

review showed Māori providers, practitioners, and academic voices were missing. Tino rangatiratanga (absolute authority) was not explicit, nor were plans to address the recommendations of the Hauora Kaupapa Waitangi Tribunal report, and tikanga (protocols) were missing. To address ethnic health inequities, we need to invest in the Māori workforce, build the cultural safety of the existing health workforce, eliminate racism and decolonise the health sector. Workforce planning needs to be equity focused and well aligned with Te Tiriti and Indigenous aspirations.

Keywords: Critical Tiriti Analysis, Te Tiriti o Waitangi, Māori public health, workforce planning, health inequities, Indigenous

Introduction

There has been a longstanding global scarcity of Indigenous health practitioners despite the Indigenous population growing to 476 million people (World Bank, 2025). Ethnic health inequities remain a longstanding and critical issue to which Indigenous leadership is often acknowledged as vital to reducing these systemic inequities (Bailey et al., 2021; Wilkie et al., 2023). Māori, the Indigenous people of Aotearoa (New Zealand), are no exception and continue to experience chronic and acute health inequities (Te Whatu Ora, 2024). The health sector has

been challenged to attract, retain and develop a Māori health workforce that reflects the demographics and health needs of the population (Health Workforce Advisory Board, 2022).

Generic universal health services have often failed Māori whānau (extended families) and helped maintain systemic preventable ethnic health inequities (Waitangi Tribunal, 2019). This failure has taken the form of significant, long-term underfunding of Māori health (Ministry of Health, 2024), legislation and policy that breaches Te Tiriti o Waitangi (Herbert, et al, 2019), a lack of commitment to equity (Came et al, 2019) or meaningful engagement with whānau, hapū (sub-tribes), iwi (tribes) and Māori providers. Hauora (wellbeing), innate to Te Ao Māori (the Māori world), recognises the intrinsic relationship to the collective health and wellbeing of the individual, earthly and celestial realms (Came et al, 2019). Hauora Māori-led systems are deeply rooted in Te Ao Māori, embedded in the whenua (land) and tikanga unique to each whānau (family) and hapū (nation) (Rénata, 2024). However, these systems have been replaced by monocultural colonial systems that align with Pākehā (White settler) cultural preferences.

The ongoing tolerance and acceptance of the seven-year life expectancy gap

between Māori and non-Māori (Te Whatu Ora, 2024) suggests an undervaluing of Māori lives. For three decades there has been consistent calls, by Māori, to increase the number of Māori working in the health sector (Barton & Wilson, 2021; Curtis et al., 2012; Savage et al., 2020; Te Rau Matatini, 2018). The assumption being, that Māori-led health services and Māori practitioners are likely to produce more equitable quality and quantity of care for Māori, thereby minimising inequities in health outcomes.

The health sector is the second most popular employment domain amongst Māori after the construction sector (Infometrics & Te Rau Ora, 2022a). Māori tend to make up a quarter of the total number of students completing undergraduate health qualifications. Trends indicate an increasing interest among Māori in qualifications embedded in mātauranga Māori (Māori knowledge) and they are making deliberate choices by enrolling in traditional hauora Māori based practice courses over regulated health professions (Infometrics & Te Rau Ora, 2022b).

This speaks to a chronic and acute failure of the tertiary education sector to attract, manaaki (care for) and graduate Māori students and the failure of the health sector to retain Māori graduates. The literature on the barriers to Māori student success within

euro-centric universities and pathways forward is extensive (Caldwell, 2024; Chittick et al., 2019; Davis et al, 2022). Māori-led whare wānanga (universities) report no such difficulties in recruiting and caring for their students.

Significant work by Crampton et al. (2023) has shown the socio-demographic characteristics of health workforce preregistration. They recommended a nationally coordinated system of collecting data across the tertiary sector, mechanisms to allow agencies to fund tertiary education to address the projected health workforce needs, and funding decisions based on Te Tiriti with a strong pro-equity focus. Thomson et al. (2021) concur that more health workers are needed in Aotearoa and that a more diverse health workforce should exist. The University of Otago developed a Socioeconomic Equity support programme to address the lack of health practitioners from lower socio-economic backgrounds and minority groups. Early evaluations showed significant improvements in diversity after the implementation. (Thomson et al., 2021).

Māori employment in the health sector almost doubled between 2000 and 2020, with a much younger workforce than non-Māori (Infometrics & Te Rau Ora, 2022a). A high proportion (71%) of the Māori health workforce work within unregulated

roles, and 15% of Māori work in the regulated workforce (Sewell, 2017). While improvements in health and education have occurred for Māori over the last forty years, inequities persist, with Euro-centric ideology acting as a powerful social and cultural force that reproduces inequities. Nineteen percent of the Aotearoa population have Māori whakapapa (genealogy), yet only 9% of the Te Whatu Ora workforce are Māori (Te Whatu Ora & Te Aka Whai Ora, 2023). The majority of the Māori health workforce remains employed outside of Te Whatu Ora.

From a desktop review of the regulatory health practitioner competency documents using the KAI (knowledge-action-integration) framework for culturally responsive practice, (Heke et al, 2018) identified gaps and areas of concern. These concerns included variable engagement with cultural competency for some professions and none for others. A Critical Tiriti Analysis by Came, et al. (2021) provided a comprehensive analysis of those same documents about Te Tiriti. Benchmarking different professional disciplines demonstrated a substantive lack of compliance. It supported the argument for standardised Te Tiriti, cultural safety, and antiracism competencies across all regulated health disciplines.

Māori health workforce development is most effective when it is centred on the knowledge and skills that already exist within te ao Māori (Russell et al., 2022, 2023; Wiapo et al., 2023). Kaupapa Māori is a unique approach incorporating te ao Māori, ways of being, doing and knowing. Russell et al. (2023) found relationships, collective vision, care, and doing what is right (tika) were at the heart of kaupapa Māori. Kaupapa Māori initiatives that are framed within te ao Māori (see Table 1) include Kia Ora Hauora, Ngā Manukura o Āpōpō, Te Rau Matatini – now Te Rau Ora.

Barrett et al., (2023) have argued that the growth of the Māori health research workforce is critical to achieving health equity for Māori. Their mixed method study identified the need for a dedicated Māori research engagement strategy, providing opportunities for Māori health staff to train, undertake research, and support Māori staff in research leadership roles. Chalmers (2020), in her response to the State of the World's Nursing 2020 Report, identified that Aotearoa was heavily reliant on internationally qualified nurses (27%). She noted the urgent need to address the persistent inequity of Māori nurses and Māori nursing leadership capacity and capability.

Table 1: Kaupapa Māori workforce initiatives

Kia Ora Hauora	Ngā Manukura o Āpōpō	Te Rau Matatini now Te Rau Ora
<p>Māori Health as a Career Programme is a national Māori health workforce development programme to increase the number of Māori working in the health and disability sector.</p> <p>https://www.kiaorahauora.co.nz</p>	<p>Clinical Leadership Training Program is tailored to Māori Registered Nurses and Māori Midwives.</p> <p>https://www.digitalindigeno.us.co.nz/general-5</p>	<p>National Māori Health Workforce Development Centre is focused on leadership, education, research, evaluation, health workforce development and system transformation.</p> <p>https://terauora.com/</p>

Method

Critical Tiriti Analysis (CTA) (Came et al 2020; 2023) is a retrospective and prospective methodology to determine to what extent a strategy/ policy/ curriculum/ piece of legislation is aligned to the five elements of Te Tiriti of te kupu whakatahi (Preamble), kāwanatanga (governorship), tino rangatiratanga (autonomy), ōritetanga (equity), and (spirituality). A CTA assessment involves a five-step process of: i) high-level orientation to the document, ii) a close read of the document against Te Tiriti, iii) a determination against a set of indicators, iv) suggestions for strengthening practice and v) an overall Māori final word.

Researcher Positionality Statement

This CTA was carried out by Haidee Rēnata, of Ngāpuhi, Ngāti Kahu whakapapa, a registered nurse, clinical educator and aspiring academic. She is passionate about advancing a hauora Māori workforce, and the reclamation of mana motuhake (autonomy) of whānau, hapū and the community. Carlton Irving of Te Whakatōhea, Te Ūpokorehe is a Māori Health Leader, with a background in allied health and medicine, who has a strong interest in health equity. Maria Baker, of Ngāpuhi, Te Rarawa whakapapa, CEO Hauora Māori Organisation, advocate for Māori-led capacity and capability building strategies to build Māori workforces and whānau. Heather Came is a Pākehā activist scholar at large with a background in critical public health who is

passionate about Te Tiriti o Waitangi and racial justice.

This desktop review does not speak to the character of the authors or the organisations who published the document. CTA analysis is simply about strengthening public policy, so it more strongly aligns with Te Tiriti. It embraces traditions of radical candor (Vich & Kim, 2016) which brings a proactive and compassionate engagement to forthright and honest feedback. We recognise that the words that ultimately end up on paper may not reflect the richness of the development process or the ideological battles that were fought and won, and critically the battles that are invisible to the reader that were lost. We recognise that responsibility for any plans lies with the senior managers and politicians who do the final editing and sign-off. We acknowledge the tensions and complexity of the context for those who held the pen of the Plan.

Findings

The Plan was co-developed by Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority). We acknowledge the expertise and leadership Te Aka Whai Ora provided in advocating for Māori health equity and the implementation of Te Tiriti. It was the first major workforce plan since the

implementation of the Pae Ora (Healthy Futures) the 'once-in-a-lifetime health reforms'. It is important to note that in June 2024 the National-led Coalition government disestablished Te Aka Whai Ora in the face of widespread public opposition.

Phase one: Orientation

The naming of the Health Workforce Plan suggests that it is a plan for the entire health sector. However, a closer read confirms it is a plan for Te Whatu Ora – the largest public employer in the health system. The Plan focuses on six action areas: i) growing pathways for Māori in health, ii) growing pathways for Pacific peoples in health, iii) driving local-led innovation in training, iv) bolstering priority workforce groups, v) supporting and retaining workforce, and vi) growing future leaders. The Plan states;

These action areas are all underpinned by our commitments to health equity and to Te Tiriti o Waitangi and reflect our commitments through Te Pae Tata – Growing the Māori workforce is identified as a priority (2023, p. 6).

The Plan consistently refers to Te Tiriti but twice refers to Tiriti principles, specifically the principles identified in the WAI 2575

Waitangi Tribunal (2019) report. We note the occasional use of te Reo Māori throughout the Plan and the representation of Māori people and design in the imagery. The reference list consists exclusively of Crown and regulatory authority data sets and appears not to have engaged with qualitative workforce research or Māori literature.

Phase two – Close reading

The Plan was informed by a series of hui with whānau Māori facilitated by the Ministry of Health, Te Aka Whai Ora and Te Whatu Ora. The Plan recognised the underrepresentation of Māori in the health workforce (p. 6) and the need to increase Māori recruitment into the health sector and within specific key professions, such as nursing, midwifery and medical workforce. Given the current staffing shortages the short-term solution presented was further international recruitment, the medium and long-term strategy remains domestic training. A key focus was on working with the tertiary education sector to improve completion rates for taura Māori (students), expanding postgraduate opportunities and scaling up programmes that work for Māori.

The Plan proposed the introduction of streamlined pathways for Māori students into health careers, including earn-while-

you-learn pathways and expanding cultural and clinical support for kaimahi (workers). The Plan commits to investing in Māori for Māori leadership programmes and a proposed leadership institute will incorporate mātauranga Māori. Working with Iwi-Māori Partnership Boards, Te Whatu Ora aims to be an employer of choice for Māori.

The contribution of kaiāwhina roles (support roles) during COVID-19 was acknowledged as a flexible, tremendous contribution to the sector. Current health inequities were acknowledged within the plan, the historic unmet complex needs of Māori whānau (both quality and quantity of care) and tangata whaikaha (Māori with a disability). There was no discussion around the recognised differences between the notions of health and that of hauora Māori; wairuatanga was not mentioned; however, rongoā (traditional healing practices) was incorporated within the plan.

Discussion

Phase three and four – Determination and strengthening practice

Given this Plan was jointly developed with Te Aka Whai Ora, before its disestablishment, the authors have chosen not to produce a standard CTA determination table. In the current political

environment, we are wary of the potential of our words to be used to undermine the legacy of Te Aka Whai Ora. We maintain this authority was the best hope we have had to advance hauora Māori, and Māori public health in a generation, and we acknowledge what they achieved during their limited lifespan. That said, we respectfully offer the following critical reflection on the Plan.

Preamble

While the Plan rightfully acknowledges a commitment to Māori health, the limited inclusion of the broader hauora Māori and Māori health sector, particularly Māori providers, is especially concerning, given the success and development of the Māori health workforce at large has been within these workforces, embedded in values that align. Full integration of these voices and leadership, as exemplified by other work of Te Aka Whai Ora, would have added significant rigor and Māori authority and strengthened the Plan's alignment with Te Tiriti.

The Plan contains explicit references to the importance of Te Tiriti. Hui were held with Māori communities and there are stated commitments to engage with Iwi-Māori partnership boards established under the Pae Ora legislation. Leadership of the Plan,

however, clearly resides with Crown agencies.

Kāwanatanga (Governorship)

The Plan's focus is on the needs and aspirations of Te Whatu Ora as a major employer of the health sector. In the absence of an overall New Zealand health workforce plan, this Plan is in effect the plan for the entire sector. Either way Māori authority and leadership from inside and outside the Crown needed to be central throughout its development. Given the disparities in size, resources and status of the Crown agencies - Ministry of Health, Te Whatu Ora to Te Aka Whai Ora - it is unclear how joint decisions around setting priorities, resourcing, implementation and evaluation were achieved. It is however reasonable to expect Te Aka Whai Ora made critical contributions in shaping these discussions.

The Plan lacks mechanisms to position Māori as equal partners in all stages of policy development. This could have been achieved through utilising co-design practices. Establishing a governance body with equitable Māori representation would have helped uphold Te Tiriti throughout the policy lifecycle. This approach is supported by research that emphasised the importance of partnership in decision-

making to meet Māori health needs (Crampton, 2003).

Tino rangatiratanga (authority and autonomy)

Māori health values, authority and worldviews have limited presence in the Plan. This Plan does not clearly engage with notions of tino rangatiratanga, mana motuhake, or the collective whakapapa of hauora Māori. The aspirations of hauora Māori and Māori health providers appear missing. Evidence from Māori health practitioner networks and Māori academics about what works in Māori development is absent or subsumed by other generic priorities.

Māori leadership within the health workforce is essential to addressing longstanding inequities. Strengthening Māori public health leadership requires embedding mechanisms that ensure Māori are at the table and heard, and insights equitably enacted. This could include increasing the number of Māori in key governance roles and expanding well established, hauora Māori and Māori health workforce development organisations and programmes that have demonstrated increased Māori health workforce capacity (Maxwell-Crawford, 2011).

The Plan needs to be a living document that can be continuously adapted and reviewed. This necessitates a structured feedback mechanism, where Māori leaders, practitioners, and iwi representatives have the power to review and influence ongoing policy changes. Ensuring this level of dynamic engagement will ensure that the Plan aligns with Te Tiriti and can evolve to address emerging challenges in the health workforce.

Ōritetanga (Equity)

Māori are recognised in the Plan as a priority population in terms of health equity. There is limited engagement with the evidence-based recommendations of the Waitangi Tribunal (2019) hauora kaupapa (WAI 2575) report within the Plan. The Tribunal's recommendations were developed to remedy historic and prevent future Te Tiriti breaches. Equitable health outcomes will not be achieved without substantive engagement with WAI 2575.

The Plan acknowledges health workforce data is difficult to collect, and they do not have good quality data of health workforces internal and external to Te Whatu Ora. Accurate and timely data is extremely important to support informed workforce development decisions. However, the workforce infrastructure operates through a set of practices that

disadvantage Māori. Māori need to be actively leading their own health workforce data systems. While the Plan aims to improve Māori representation in the health workforce, systemic barriers prevent the full exercise of Māori citizenship.

With the new National-led Government (Cabinet Office, 2024) outlining their expectations that any targeting service provision or commissioning will need a strong analytical case based on empirical evidence it is challenging times to pursue equity. To maintain and expand investment in Māori workforce development will require compelling arguments about the value of Māori whānau and clarity of Tiriti responsibilities and human rights obligations.

Wairuatanga (Spirituality)

The Plan includes some recognition of rongoā Māori (traditional Māori healing), although it lacks a comprehensive understanding of hauora Māori, to be embedded appropriately into the health system. Formal pathways are needed for hauora and rongoā Māori within generic universal healthcare to understand and ensure the needs and values of te ao Māori are embedded. Additionally, the collective notions of hauora, including whenua and wairuatanga should be expanded in both

policy and practice to ensure hauora is understood and addressed holistically.

Research highlights the need for incorporating te ao Māori into health policy to improve Māori health outcomes and nurturing culturally safe environments (Russell et al., 2023). A more comprehensive understanding and acknowledgment of mātauranga Māori is necessary to ensure that Māori values, such as manaakitanga (care), whanaungatanga (relationships), and rangatiratanga, are embedded in health policies and practices. Came et al., (2019) argued the need to position whenua as a determinant of hauora, recognising the innate connections to health, well-being, the environment and whenua. Ensuring that these values are honoured and understood in practice, not just acknowledged in documents, will lead to a more culturally safe health system for Māori, which is critical for improved health outcomes (Came et al., 2021; Curtis et al., 2012). Kaupapa Māori evaluation has an important role to play in this context (Cram et al., 2018).

Conclusion: Te whakaaro Māori

The Plan reflects a commitment to increasing Māori representation in the health workforce, particularly through leadership pathways and recruitment

initiatives. However, there remains a pressing need to ensure that Māori leadership and governance, drawn from all regions of whānau and hapū in Aotearoa, are consistently embedded across the health system, including within the health workforce data system. While the Plan outlines pathways for Māori workforce development, it falls short in ensuring that Māori have equal decision-making authority, especially in policy development, resource allocation, and the implementation of workforce initiatives. Māori call for co-governance structures that provide sustained roles for Māori in shaping and directing the health workforce and its priorities.

The inclusion of rongoā Māori in the Plan is a positive step; however, a more robust recognition of hauora and its collective orientation to the collective people, whenua, wairua, broader Māori worldviews and relevant tikanga is essential. The connection between the collective, whenua, wairuatanga and health and wellbeing must be fully acknowledged and normalised within universal generic healthcare practices. Cultural safety is not a supplementary consideration but a core requirement for a system that truly responds to Māori needs (Ramsden, 2002). It must be woven into healthcare policy and practice, ensuring that hauora Māori values

are respected and operationalised across the entire system (Wepa, 2015).

Looking ahead, future iterations of the Plan must prioritise hauora grounded in Te Ao Māori and elevate Māori decision-making. While expanding the Māori workforce is essential, true equity will only be realised when Māori leadership and the mana motuhake are central to the health system's governance. This means not only fostering Māori involvement in workforce development but also recognising Māori as key decision-makers in shaping the strategic direction and evaluation of our health system. Achieving this will cultivate a workforce that reflects Māori aspirations and works towards delivering health services that are more equitable and culturally aligned.

Despite its professed commitment to Te Tiriti, the Plan lacks the depth of understanding, and aspiration needed to cultivate a health workforce capable of meeting the needs of whānau Māori. Workforce development efforts within Te Whatu Ora remain constrained by monocultural traditions which contributes to nurturing rather than addressing health inequities. By largely focusing on improving Māori health through a Western lens, the Plan shifts attention away from the root causes of these inequities.

In a short time, the legacy of Te Aka Whai Ora will continue to guide and inspire future health strategies. Their lasting contributions ensure that tino rangatiratanga, co-governance, and equity remain central. Far from being confined to history, their work is deeply embedded in the ongoing pursuit of a health system that truly honours and uplifts Māori ways of being, doing, and knowing. Authentic alignment with Te Tiriti requires Māori authority, mātauranga and tikanga to be embedded across governance, planning, data and delivery, not appended. Realising tino rangatiratanga and mana motuhake entails co-governance with equal Māori decision making, kaupapa Māori workforce pathways, and Māori leadership of workforce data systems, so that commitments translate into measurable and sustained gains for Māori health outcomes. In this way the Plan can move beyond symbolic reference to Te Tiriti toward a living framework that enables culturally safe practice, disrupts racism, and supports a thriving Māori health workforce. Through this transformative lens, grounded in Māori leadership and vision, Māori aspirations in the future of health in Aotearoa will be realised.

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About the authors:

Haidee Rēnata (Ngāpuhi, Ngāti Rēhia) is a registered nurse with a Master of Health Science. With 14 years of clinical experience in mental health nursing and five years in nursing education. Proud of her whakapapa Māori, she is an advocate for the realisation of Māori and Indigenous rights and autonomy. Her Master's thesis (2024) argues the activation of hauora kaupapa as a way to assert Māori aspirations and disrupt racism within the health and education sectors. Currently prioritising whānau responsibilities, while

working in two casual positions with Health New Zealand and Auckland University of Technology. This paper was informed by Haidee's masters research.

Dr Carlton Irving (Te Whakatōhea, Te Ūpokorehe) is Director of Māori Health and Consumer at Te Tāhū Hauora | The Health Quality & Safety Commission and is a medical doctor and registered paramedic with more than 20 years experience across clinical care, leadership, and health systems work in Aotearoa. He began his career in emergency services, working across rural and remote communities, and now combines clinical work with research and policy roles. He holds a Master of Health Practice and an MBChB. His areas of focus include rural health, Māori health equity, workforce development, and system reform. He is particularly interested in models of care that are team-based, culturally grounded, and practical in resource-constrained settings. Carlton has held senior national roles, including Clinical Chief Officer – Allied Health at Te Aka Whai Ora (The Māori Health Authority). His work has supported integration of kaupapa Māori principles into national quality frameworks and workforce planning. He continues to practice clinically and contributes to research on hauora Māori, equity, and rural service delivery. His approach is grounded in service, focused on solutions, and shaped by kaupapa Māori

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Dr Maria Baker (Ngāpuhi, Te Rarawa)

initially trained as a Registered Nurse and has over two decades of expertise in the development and delivery of healthcare, mental health, organisational, and workforce development. Her passion lies in building the capacity and capability of talent amongst Māori. She earned her PhD in Māori Health by developing the theory "Seeking Solutions to Being Restricted," which reveals how Māori manage mental distress and mental health services in Te Tai Tokerau (Northland). Maria has contributed to a range of Māori health initiatives. In the early 2000s, Maria worked at Te Hiku Hauora as a Māori Mental Health Nurse. She returned to the organisation in 2023 as the CEO. This paper drew on Maria's extensive background in Māori workforce development.

Dr Heather Came (MNZM) is a seventh generation Pākehā New Zealander. She has a background in public health and social justice activism. Her research focuses on critical policy analysis, Te Tiriti o Waitangi, antiracism and institutional racism in the health sector. As an activist scholar Heather is a founding member and co-chair of STIR: Stop Institutional Racism, has prepared expert evidence for the Waitangi

Tribunal hearings, and has presented to United Nations human rights committees. In 2020 she co-founded the Decol 2020 series of virtual anti-racism gatherings. In 2023 she was made a member of the New Zealand Order of Merit for her contributions to Māori, health and education. She is an Adjunct Professor with Te Herenga Waka – Victoria University of Wellington and has a consultancy – Heather Came & Associates – pursuing racial justice. This paper drew on Heather’s expertise in Critical Tiriti Analysis.