



NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

**Submission of the
New Zealand Council of Trade Unions
Te Kauae Kaimahi**

to the

**Committee on the Elimination of Racial Discrimination, 93rd
Session**

on the

21st and 22nd Periodic Report of New Zealand

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Wellington
7 July 2017**

Table of Contents

1. Introduction.....	2
2. Health and Safety disparities for Māori and ethnic minority workers.....	3
3. Case Study: Māori workers exposure to Pentachlorophenol (PCP).....	6
4. Overview: Structural discrimination against Māori education and health workers	8
5. Structural discrimination against Māori health workers.....	9
6. Structural discrimination against Māori education workers	12
7. Summary of recommendations.....	15

1. Introduction

- 1.1. This submission is made on behalf of the 30 unions affiliated to the New Zealand Council of Trade Unions Te Kauae Kaimahi (CTU). With 320,000 members, the CTU is one of the largest democratic organisations in New Zealand.
- 1.2. The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.
- 1.3. The Komiti Pasifika of the CTU represents approximately 30,000 Pasifika workers in the union movement.
- 1.4. Māori workers face urgent issues of racial discrimination, including disparities in health and safety at work and pay equity. Māori education and health workers employed by Māori and iwi (tribal) organisations receive unequal pay for work of equal value as a result of discriminatory government funding arrangements.
- 1.5. Other ethnic minorities, including Pasifika peoples and migrant workers, also face racial discrimination at work, including disparities in health and safety.
- 1.6. The issues raised in this report are not exhaustive, but represent examples of structural racial discrimination that require urgent action to remedy.

2. Health and Safety disparities for Māori and ethnic minority workers

- 2.1. Māori and Pasifika workers are consistently over-represented in workplace injury rates. This reflects systematic racial inequalities in New Zealand workplaces, where Māori and Pasifika workers are more likely to be allocated hazardous work and lack the power to challenge unsafe practices. In addition, there is a lack of culturally appropriate approaches to workplace communication and training, as part of a more general lack of a tripartite strategy to involve workers and their unions in health and safety systems.
- 2.2. Between 2002 and 2015, Māori workers were on average 39% more likely to suffer a serious non-fatal injury at work than the general population. For the years 2013-2015, Māori workers were 31% more likely to suffer a non-fatal serious work injury.¹
- 2.3. Research by the Department of Labour (now part of the Ministry of Business, Innovation, and Employment – MBIE) in 2012 found that Pasifika workers in Manufacturing had consistently higher rates of injury than the general population, with Pasifika people working as labourers injured almost twice as often as non- Pasifika people in the same jobs.²
- 2.4. Data for work-related injuries resulting in a claim to the Accident Compensation Corporation (the public no-fault injury compensation fund), summarised in the table below, show elevated rates of injury for Māori and Pasifika workers (101 and 103 per 100,000 respectively), as well as for ethnic minorities including Latin American and African workers (174 per 100,000), compared to European (86 per 100,000) and Asian (62 per 100,000) workers.³

¹ Based on a comparison of three-year averages for age-normalised injury rates reported by Statistics NZ. http://www.stats.govt.nz/browse_for_stats/health/injuries/serious-injury-outcome-indicators-reports.aspx

² Labour and Immigration Research Centre. 2012. In Harm's Way: A case study of Pacific workers in Manukau manufacturing. <http://www.worksafe.govt.nz/worksafe/information-guidance/all-guidance-items/in-harms-way-a-case-study-of-pacific-workers-in-manukau-manufacturing/case-study-pacific-workers-in-manukau-manufacturing.pdf>

³ http://www.stats.govt.nz/browse_for_stats/health/injuries/InjuryStatistics_HOTP15.aspx

Ethnic group	Claims by males	Claims by females	Total claims	Percentage of all claims	Full-time equivalent employees (000)	Incidence rate
	(000)					
European	98.5	36.7	135.1	59	1,567	86
Māori	17.8	6.7	24.4	11	241	101
Pacific peoples	9.0	2.6	11.6	5	113	103
Asian	10.9	5.1	16.1	7	258	62
Other	6.8	2.6	9.4	4	54	174
Not specified	24.0	15.3	39.3	17	0	..
Total claims	162.8	67.4	230.2	100	2,084	110

2.5. A 2011 study found significant ethnic differences in risk factors for occupational ill-health among New Zealand workers, due to ‘both occupational distribution and the distribution of tasks within occupations’:

‘Māori were more likely to report exposure to physical strain (e.g., lifting, standing). Part of these differences remained when Māori were compared with non-Māori in the same job. In addition, Māori women were twice as likely to categorize their job as very or extremely stressful than non-Māori women in the same job, while Māori men were twice as likely to report exposure to dust.’⁴

2.6. MBIE’s 2012 research with Pasifika workers in manufacturing found that understanding of hazards to health and safety needed to be improved by communication and training approaches becoming more responsive to ‘language barriers, learning style differences, and communication style differences.’⁵ The report also suggested that inequality of power in the workplace and the hesitance of workers to challenge authority had negative effects on health and safety.⁶

2.7. These findings are supported by a general survey of 1200 health and safety representatives by the CTU in 2014, which found a number of barriers to the effectiveness of worker participation in health and safety. 13% of health and safety representatives had been bullied by a manager when they raised a health or safety issue. 20% received no paid time to complete their duties as

⁴ Eng et al. 2011. Ethnic Differences in Patterns of Occupational Exposure in New Zealand. *American Journal of Industrial Medicine* 54:410–418.

⁵ Labour and Immigration Research Centre. 2012. In Harm’s Way. P55

⁶ Labour and Immigration Research Centre. 2012. In Harm’s Way. P57-8

a health and safety representative. More than 60% expressed a need for further training to increase their confidence in carrying out their role. The survey included both union members and non-members and found that representatives who were also union members were more likely to be experienced (52% in role for more than 3 years vs. 36% for non-union), confident (54% “very confident” in role vs. 35% for non-union), and democratically elected (61% vs. 24% for non-union).⁷

- 2.8. Health and safety representatives should be entitled by law to paid time off work to conduct their duties in the workplace, and for ongoing training. Specific training and resources should be developed to meet the needs of Māori and Pasifika workers, as well as migrant workers.
- 2.9. Government agencies should recognise and promote the benefits of union involvement in health and safety, including as a support structure for health and safety representatives. Workers and their unions should be fully involved in all health and safety systems in the workplace. Training, networking, and capacity-building opportunities for Māori and Pasifika health and safety representatives should be developed and promoted, with involvement from unions and other community organisations.
- 2.10. The CTU is engaged in ongoing consultation with WorkSafe, the government regulatory body for occupational health and safety. The CTU supported the establishment of WorkSafe as an independent regulator in response to the findings of the Independent Taskforce on Workplace Health and Safety in 2013 (<http://hstaskforce.govt.nz/>), following the report of the Royal Commission on the Pike River Coal Mine Tragedy (<http://pikeriver.royalcommission.govt.nz/>).
- 2.11. The CTU and our affiliate unions actively support the system of workers’ participation in health and safety based on elected health and safety representatives. The CTU established a two-day training program in 2002 in

⁷ NZCTU. 2014. Submission to the Transport and Industrial Relations Committee on the Health and Safety Reform Bill. <http://www.union.org.nz/wp-content/uploads/2016/11/Health-and-Safety-Reform-Bill.pdf>. P132.

partnership with government, which has trained over 30,000 worker health and safety representatives.

- 2.12. The CTU and our representative structures for Māori and Pasifika workers are currently working with ACC on changes to employer partnership programs. Under the current system, involvement of workers and unions in health and safety audits, including under the ACC Accredited Employers Program, is often treated as a formality at the end of the process, rather than as a substantive ongoing relationship. We hope to see more effective promotion of worker participation as outcomes of this review in 2018, together with strategies to engage Māori and Pasifika workers, and migrant workers, to improve health and safety.
- 2.13. Government agencies that engage with employers on health and safety issues, including Worksafe and ACC, should mandate effective worker participation as a more central and substantive part of their interventions and partnerships with firms. Strategies for engaging Māori, Pasifika, and migrant workers in improving health and safety must be developed, with dedicated resources for training, communication and networking.

3. Case Study: Māori workers exposure to Pentachlorophenol (PCP)

- 3.1. The ongoing health effects of exposure to Pentachlorophenol (PCP) used in New Zealand sawmills from the 1950s until 1988 is a specific example of unjust harm resulting from the discriminatory treatment of Māori workers and their communities.
- 3.2. Despite the known toxicity of PCP and its by-products,⁸ the predominantly-Māori workforce of New Zealand sawmills, together with their families and surrounding community members, were recklessly exposed to the chemicals.

⁸ Research on the toxicity and health effects of occupational exposure to PCP was published as early as the 1950s: Truhaut, R.; Lépée, P.; Boussebart, E. 1952. Recherches sur la toxicologie du pentachlorophénol. II.-Intoxications professionnelles dans l'Industrie du bois. Observations de deux cas mortels. *Archives des Maladies Professionnelles de Médecine du Travail et de Sécurité Sociale* 13(6): 567-9. <https://www.cabdirect.org/cabdirect/abstract/19532704044>. By the early 1980s, numerous published studies detailed evidence of severe health consequences of occupational exposure to PCP and recommended actions to prevent exposure. See for instance, Williams, P. 1982. Pentachlorophenol, an assessment of the occupational hazard. *American Industrial Hygiene*

- 3.3. Workers were exposed to PCP without being provided with protective equipment or information about the known toxicity of the chemicals they were handling. Family members were exposed through contact with workers and their clothing, as well as through environmental exposure caused by reckless discharge of toxic waste.
- 3.4. Sawdust and other waste products containing PCP and toxic by-products containing dioxins and furans were dumped in waterways and land areas used by Māori communities for recreation and fishing. In one case, contaminated sawdust from the Whakatāne sawmill was used as landfill for a local Marae (Māori meeting grounds and buildings, serving as the focal point for communities).
- 3.5. The negative health impacts of PCP exposure for Māori workers and communities were revealed through the work of Joe Harawira (Ngāti Awa), a Māori sawmill worker who passed away in January 2017, and the organisation he founded, Sawmill Workers Against Poisons (SWAP). A 2009 academic article summarised the health effects revealed by the group:
- ‘The sawmill workers and their families, the majority of whom are Māori, have suffered severe debilitation from cancer, liver disease, respiratory problems, heart disease, depression as well as high levels of miscarriages. Their children have also suffered with many being born with birth defects or some form of disability (Paul, Harawira, Iopata, & Kohe, 2002). When Joe Harawira and SWAP first started investigating the causes of their illnesses in 1988, the mortality rate averaged around two deaths per year. Today however the mortality rate for the sawmill workers of Whakatāne and their families has accelerated to an alarming average of 12 to 18 deaths per year (J. Harawira, personal communication, January 17, 2009).⁹
- 3.6. A 2008 study by Massey University’s Centre for Public Health Research found that for former sawmill workers with high exposures to PCP:

Association Journal 43(11): 799-810.

<http://www.tandfonline.com/doi/abs/10.1080/15298668291410602>

⁹ Jaram, D.M. 2009. Joe Harawira: The emergence of a mātauranga Māori environmentalist. *MAI Review* 2009(1). <http://www.review.mai.ac.nz/index.php/MR/article/view/211>

‘...strong associations were observed between exposure and chronic respiratory disease, and also ‘unexplained persistent fevers’, ‘recurrent nausea and diarrhoea’, ‘having palpitations of the heart’, ‘sweating for no reason’, ‘reduced libido’ and ‘frequent mood changes without cause’. Similar neuropsychological symptoms have also been observed in an earlier study of PCP-exposed workers in New Zealand.’¹⁰

- 3.7. Following successful court action by SWAP in 2006 that drew attention to the contamination of the Kopeopeo canal¹¹, the Bay of Plenty Regional Council has begun remediation work on the site. However, according to the Ngāti Awa iwi (tribe):

‘There are 36 recorded sites in the Whakatane district that are contaminated with dioxin and PCP, several of which are on Māori land, public land, Māori reserves and private residences and properties.’¹²

- 3.8. Despite government recognition since 2001 of the harm inflicted on Māori workers, families, and community members, only minimal medical support has been offered and no compensation has been received by those affected.¹³

4. Overview: Structural discrimination against Māori education and health workers

- 4.1. ILO Convention 111 on Discrimination (Employment and Occupation) 1958, a core ILO convention ratified by New Zealand, prohibits unequal payment for work of equal value. Article 7(a) of the International Covenant on Economic Social and Cultural Rights (ICESCR), ratified by New Zealand, and article 23

¹⁰ McLean, D et al. 2008. Health Outcomes in Former New Zealand Timber Workers Exposed To Pentachlorophenol (PCP). *Department of Labour* <http://thehub.superu.govt.nz/publication/health-outcomes-former-new-zealand-timber-workers-exposed-pentachlorophenol-pcp-pdf>

¹¹ Sawmills Workers against Poisons Inc v. Whakatane District Council. CIV 2006-463-32 (2006). <https://www.informea.org/en/court-decision/sawmills-workers-against-poisons-inc-first-plaintiff-hohepa-joseph-harawira-second>

¹² Telfer, I. 2016. The Toxic Go-Slow: Has the clean-up of New Zealand's most poisoned places stalled? *Radio New Zealand*. <http://www.radionz.co.nz/national/programmes/insight/audio/201804570/insight-nz-s-most-poisoned-places> Hundreds of other sites across New Zealand also remain contaminated, many on Māori land or affecting Māori communities.

¹³ Radio NZ. 2010. Former sawmill workers angry at ministry offer. *Radio New Zealand*. <http://www.radionz.co.nz/news/national/34165/former-sawmill-workers-angry-at-ministry-offer>

of the Universal Declaration of Human Rights similarly require State Parties to protect the right of everyone to “[f]air wages and equal remuneration for work of equal value without distinction of any kind”. However, funding arrangements for social services in Māori communities, including health services and early childhood education, have exposed Māori workers to unequal pay for work of equal value.

- 4.2. Social services to Māori communities, including early childhood education (ECE) and primary healthcare, are frequently provided by dedicated Māori community organisations receiving government funding. However, funding arrangements mean that Māori ECE teachers working for Kōhanga Reo (Māori language early childhood centres) education providers and Māori nurses working for Māori and iwi (tribal) health providers receive lower pay for work of equal value to that of their counterparts in non-Māori organisations. The following sections address structural discrimination against Māori health workers and early childhood education workers respectively, focussing on pay inequity.

5. Structural discrimination against Māori health workers

- 5.1. The New Zealand Nurses Organisation, a CTU-affiliated union representing nurses and associated health workers, together with Māori and iwi health organisations as employers, have repeatedly raised the issue of pay inequity for Māori health workers with the New Zealand government over the past decade. Despite recommendations from the Health Select Committee of the New Zealand Parliament and the New Zealand Human Rights Commission, the government has taken no action to address structural racial discrimination against Māori health workers in the form of persistent pay inequity.
- 5.2. Supporting and increasing Māori participation in the health workforce has been identified by government as a key target for addressing persistent disparities in Māori health outcomes compared to the general population.¹⁴

¹⁴ Ministry of Health. 2016. Te Ara Tuarua – Pathway 2: Māori participation in the health and disability sector. <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/pathways-action/te-ara-tuarua-pathway-2-maori-participation-health-and-disability-sector>

However, there is insufficient data to adequately track the determinants of Māori workforce development and retention in the health sector.¹⁵

- 5.3. The development of the Māori health workforce is hampered by structural discrimination, including lower pay for work of equal value performed by Māori health workers employed by Māori health organisations, due to discriminatory funding by government.¹⁶
- 5.4. Advice on Māori health practice issued by the Medical Council of New Zealand (a government regulatory body for doctors, appointed by the Minister of Health) acknowledges the disparities in Māori health outcomes and notes:

‘This is compounded by lower rates of diagnosis and lesser access to effective treatment. Avoidable death rates are almost double for Māori than for other New Zealanders, and Māori die, on average, eight–ten years earlier. In summary, Māori are sicker, for longer periods, but have less access to care and die earlier than Pākehā [non-Māori/European New Zealanders]. These disparities in overall Māori health persist even when confounding factors such as poverty, education and location are eliminated, demonstrating that culture is an independent determinant of health status.’¹⁷

- 5.5. Culturally appropriate health-care has been demonstrated to improve health engagement and outcomes for Māori, Pasifika, and other ethnic minority patients. As the Human Rights Commission of New Zealand notes:

‘Better representation of Māori and Pacific peoples in the health workforce would have significant benefits. Māori patients have higher rates of visits and increased engagement with Māori healthcare providers and likewise for Pacific patients and Pacific providers. A report commissioned by the Ministry

¹⁵ See NZNO. 2013. New Zealand Nurses Organisation submission on the 18th Sessions of the Human Rights Committee - Universal Periodic Review for New Zealand 2013.

<https://www.hrc.co.nz/files/9514/2406/3097/New-Zealand-Nurses-Organisation.pdf>

¹⁶ Human Rights Commission. 2012. A fair go for all? Rite tahi tātou katoa? Addressing Structural Discrimination in Public Services. https://www.hrc.co.nz/files/2914/2409/4608/HRC-Structural-Report_final_webV1.pdf, p22

¹⁷ Medical Council of New Zealand. 2008. Best health outcomes for Māori: Practice implications. <https://www.mcnz.org.nz/assets/News-and-Publications/Statements/Best-health-outcomes-for-Maori.pdf>

of Health shows that where patients and healthcare professionals are of the same ethnicity, there are better health outcomes for patients.¹⁸

- 5.6. The government strategy for Māori health *He Korowai Oranga* identifies Rangatiratanga¹⁹ as a key thread, emphasising the importance of Māori health workers and Māori-controlled health providers providing health services to Māori communities:

‘Māori institutions, including Māori health providers, are a key part of what makes the New Zealand health system effective. Māori health providers are generally described as Māori owned and Māori governed. While the government and DHBs put in place service and contract requirements for these providers, Māori owners and governors set the overall direction and shape of these organisations.’²⁰

- 5.7. Unfortunately, government has used the devolution of health services to Māori community organisations to avoid responsibility for funding pay equity for Māori health workers employed in these organisations, compared to their counterparts employed directly by District Health Boards and Primary Health Organisations (such as General Practices).
- 5.8. In 2008, the New Zealand Nurses Organisation (NZNO) joined with Māori health organisations to present a petition with 11,371 signatures to parliament as part of Te Rau Kokiri, the campaign for pay equity for Māori nurses and associated health workers.²¹ The Health Select Committee of Parliament considered the petition in July 2009 and unanimously resolved:

¹⁸ Human Rights Commission. 2012. p21; See also: Ministry of Health. 2004. Māori Providers: Primary health care delivered by doctors and nurses. <http://www.health.govt.nz/publication/maori-providers-primary-health-care-delivered-doctors-and-nurses>; and Ministry of Health. 2010. Lalaga: Pacific Providers Making a Difference. Ministry of Health, Wellington. [http://www.moh.govt.nz/moh.nsf/Files/pacifichealth/\\$file/Lalaga-Jun2010.pdf](http://www.moh.govt.nz/moh.nsf/Files/pacifichealth/$file/Lalaga-Jun2010.pdf)

¹⁹ Rangatiratanga could be translated as Māori self-determination in the full sense, as guaranteed to all peoples by the international human rights covenants and the UN Declaration on the Rights of Indigenous Peoples. Rangatiratanga also refers to the sovereign rights of Rangatira (Māori chiefs) guaranteed in Article Two of Te Tiriti o Waitangi 1840 (the Māori text of the Treaty of Waitangi signed between Rangatira and the British Crown). <https://teara.govt.nz/en/treaty-of-waitangi>

²⁰ <http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/key-threads/rangatiratanga>

²¹ NZNO. 2008. Te Rau Kokiri: NZNO Māori and Iwi MECA [Multi-Employer Collective Agreement]. Submission of the New Zealand Nurses Organisation to the Health Select Committee Providing

'We agree with the petitioners that there is an equity issue regarding pay rates for Māori and iwi health service workers. We recommend that the Government establish a working group to address the issues raised in the petition and report publicly on its findings within six months. In addition, we recommend that the Government instruct the working group to provide us with a report on its progress within three months of its implementation.'²²

5.9. However, the New Zealand government rejected the findings of its own select committee in August 2009 and took no further action.

5.10. The New Zealand Human Rights Commission report of July 2012 remains accurate:

'No further progress on this issue was therefore made, although the need to address pay inequity remains.

Additional government funding is needed to recruit and retain a skilled and culturally competent workforce. Māori nurses and primary health workers play a vital role in the Māori community health sector and in improving health outcomes for Māori. They have the essential skills, qualifications and experience but are being paid significantly less than their colleagues in other sectors. This is an issue of equity and needs to be addressed.'²³

6. Structural discrimination against Māori education workers

6.1. In its 1986 report on WAI11: The Te Reo Māori Claim, the Waitangi Tribunal ruled that the Māori language was a Taonga, or valued possession, covered by the guarantee of state protection under the Treaty of Waitangi/Te Tiriti o Waitangi 1840.

6.2. The Tribunal reported that the decline in the Māori language fluency of Māori schoolchildren, from 90% in 1913 to below 5% by 1975, was in large part a result of a state education system that deliberately discouraged and punished

Further Information on the NZNO National Petition to the House of Representatives.

<https://www.parliament.nz/resource/0000170298>

²² Human Rights Commission. 2012. p22

²³ Human Rights Commission. 2012. p22

the speaking of the Māori language. The tribunal reported the evidence of Sir James Henare, whose experience it found to be typical:

‘[Sir James] told us of being sent into the bush to cut down a piece of supplejack with which he was punished for breaking the rule that te reo Maori must “be left at the school gates”.’²⁴

- 6.3. In the course of more general recommendations for reform of the education system, the tribunal noted the emergence of the Kōhanga Reo movement as an initiative of Māori families and communities. The tribunal declared that ‘Te Kohanga Reo is indeed a remarkable success story’²⁵, having expanded from a single centre in 1982 to a nationwide movement of 416 centres educating 6000 children by 1985, and noted that ‘although the Maori language today is suffering from the effects of decades of opposition to its propagation many Maori parents are making valiant efforts to repair the damage that it has suffered.’²⁶
- 6.4. Kōhanga Reo have primarily been funded by government since 1990, with around 95% of funding currently provided by government. However, funding for early childhood centres are split into two categories: teacher-led centres employing registered teachers; and family-led centres without the minimum number of registered teachers. The criteria to differentiate these two categories do not recognise Māori language expertise or the Tohu Whakapakari qualifications issued by Te Kōhanga Reo National Trust Board, meaning that Kōhanga Reo are funded at similar rates to parent-run playcentres, at below the rates of other early childhood education providers.²⁷
- 6.5. In response to the WAI 2336 claim on behalf of Te Kōhanga Reo National Trust Board, the Waitangi Tribunal stated:

²⁴ Waitangi Tribunal. 1986. Report of The Waitangi Tribunal on The Te Reo Maori Claim (WAI 11). Department of Justice.

https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_68482156/Report%20on%20the%20Te%20Reo%20Maori%20Claim%20W.pdf. P9

²⁵ Waitangi Tribunal. 1986. P33

²⁶ Waitangi Tribunal. 1986. P12

²⁷ Waitangi Tribunal. 2012. Matua Rautia: Report on the Kōhanga Reo Claim.

<https://www.waitangitribunal.govt.nz/assets/Documents/Publications/WT-Matua-Rautia-Report-on-the-Kohanga-Reo-claim.pdf>. P202-230

'We fail to understand why the Ministry has been able to devise an elaborate framework of rates for other parts of the ECE sector, but has been either unable or unwilling to design, in consultation with the Trust, a funding structure better tailored to the way kōhanga reo actually deliver their service. This failure has persisted despite the need to do so being clearly identified, as we described above, in the report of the Early Childhood Care and Education working group more than a decade ago, despite being the subject of repeated requests from the Trust to address the issue, and despite featuring prominently in the mandate of the Funding, Quality and Sustainability Working Group. As a result, kōhanga reo have remained bracketed by default with playcentres, from which their service configuration differs in major respects.'²⁸

The Tribunal further states (at p331):

'... the Crown's funding regime is inequitable and unfair. It does not provide kōhanga reo with the same level of support as other ECE services. Kōhanga reo cannot achieve the higher levels of funding available to teacher-led ECEs. The current funding system incentivises kōhanga reo to become teacher-led in order to obtain higher levels of funding. We acknowledge that the funding model does provide for some limited recognition of the Tohu Whakapakari by having a higher rate of funding available for 'quality' kōhanga reo. The indicator for quality is at least one staff member with a Tohu Whakapakari qualification. However, the two tier quality funding system for kōhanga reo has a lower maximum value than the top of the second tier on the four-tier teacher-led funding model. Kōhanga reo employees have not enjoyed the same salary related funding increases as the ECE sector since 2005. Salary costs are around 70 to 75 per cent of overall service costs. Since 2005 kōhanga reo have struggled to offer equivalent rates of pay as teacher-led ECE centres, because they cannot access the same funding rates. The Crown considers that a costs reimbursement policy provides a mechanism to reimburse kōhanga reo for the shortfall in salary costs. However, this is an inferior funding option. In practice, kōhanga reo try to manage their costs

²⁸ Waitangi Tribunal. 2012. P230

within the income provided so as not to operate in deficit. They reduce their operating and capital expenditure to try and achieve pay parity rather than bear the risk associated with overspending and taking a chance on being reimbursed. As a result there has been a significant decline in the maintenance of kōhanga reo buildings. The key challenge for the Crown and the Trust is to design a funding model that will effectively support the efforts of kōhanga reo to increase participation and thus to improve the numbers of children learning te reo Māori.’

- 6.6. The government has not responded to the findings of the Waitangi Tribunal or made any substantial change to the funding model for Kōhanga Reo. As a result of continued systematic underfunding, Māori early childhood education workers in Kōhanga Reo are generally paid less for work of equal value than their counterparts in non-Māori education providers.

7. Summary of recommendations

- 7.1. That the New Zealand government ratify ILO Convention 169 on Indigenous and Tribal Peoples and all fundamental labour conventions including Convention 87 on Freedom of Association.
- 7.2. That the New Zealand government take steps to ensure the health and safety of Māori, Pasifika, and other ethnic minority workers and communities are protected. This should include further culturally specific and appropriate efforts to involve workers and their unions in workplace health and safety systems.
- 7.3. That the New Zealand government recognise and take steps to manage, mitigate, and compensate for the continuing impact on the health of Māori workers, their families and communities of the reckless and racially discriminatory exposure of these groups to toxic pentachlorophenol in New Zealand sawmills from 1950 until 1988.
- 7.4. That the New Zealand government: commit to the principle of equal pay for work of equal value in all funding and contracting relationships with Māori

social service providers; recognise that early childhood educators at Kōhanga Reo and nurses and allied health workers at Māori and iwi providers have been underpaid for their work; and commit to negotiating redress for these workers with a fair process involving workers and their unions.

- 7.5. That the New Zealand government recognise the importance of Kōhanga Reo early childhood educators in promoting the Māori language and take steps to rectify the racially discriminatory pay inequity for Māori early childhood educators resulting from underfunding of Kōhanga Reo.
- 7.6. That the New Zealand government recognise the importance of Māori health workers in improving health disparities for the Māori population and take steps to rectify the racially discriminatory pay inequity for Māori health workers resulting from underfunding of Māori and iwi health providers.
- 7.7. The NZCTU endorses the recommendations of the New Zealand Nurses Organisation that:
 - 7.7.1. Urgent action and leadership be taken by the Minister of Health and/or the Ministry of Health to reconfigure contracting and funding processes to ensure pay parity for nurses working in Māori and iwi health providers and elsewhere in the health sector; and
 - 7.7.2. The government develop, fund and resource a comprehensive Māori nursing workforce development strategy by December 2018