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– ARTICLE –

TAUIWI (SETTLER) VISIONING AN ANTIRACIST HEALTH SYSTEM FOR AOTEAROA BEFORE THE NATIONAL-LED COALITION GOVERNMENT

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- Please note, there is a backlog of pending issues for 2024 that will be published during 2025. Apologies for any confusion regarding the dates of ongoing publications.

ABSTRACT

In Aotearoa, systemic ethnic inequities are longstanding and fuelled by the intergenerational impacts of colonisation and systemic racism. Our health system disadvantages Māori (the Indigenous peoples of Aotearoa) while Pākehā (white settlers) are advantaged. This paper addresses a literature gap by describing a Tauiwi (settler) vision of an antiracist health system. It is a companion piece to a Māori-led paper on the same topic.

An exploratory qualitative design, informed by kaupapa Māori research, drew on three virtual wānanga (learning spaces) with twenty-eight Tauiwi health practitioners, activists and academics held in November 2021. A reflexive thematic analysis then generated four themes: i) honourable kāwanatanga and decolonisation; ii) building antiracism infrastructure; iii) understanding privilege and power; and iv) a shared commitment to transformation. Participants described a Tiriti o Waitangi-based health system as just, culturally safe, holistic, and well-being focused. Transforming the health system requires Indigenous leadership and the engaging of settler hearts, heads and hands in solidarity with those targeted by racism.

Keywords: antiracism; Te Tiriti o Waitangi; governance; systems change; health inequities.

INTRODUCTION

Racism is a deep-seated global problem shaped by history, place and people (Dunn and Geeraert 2003), and scholarly effort has been invested into exploring its prevalence and incidence (Dobbie, Hull, and Arnold 2022; Smith *et al.* 2021; Marrie and Marrie 2014; Paradies, Truong, and Priest 2014; Williams 2016). It is a system of power which advantages one group and disadvantages another, and can manifest as inaction in the face of need. It can be unintentional or wilfully enacted and is a key modifiable determinant of health (Waitangi Tribunal 2019; World Health Organization Commission on Social Determinants of Health 2008).

The intergenerational impacts of racism on health are severe (Nwanaji-Enwerem *et al.* 2021; Paradies *et al.* 2015; Williams, Lawrence, and Davis 2019). Exposure to personally mediated, cultural, historical or institutional racism causes cumulative harms (Geronimus 1992; Love *et al.* 2010; Reid, Taylor-Moore, and Varona 2014). Within the health sector, racism permeates policy, practice and governance (Came 2014; Reid 2011; Smith *et al.* 2021). It often manifests as differential access to quality and quantity of care for racialised communities, resulting in unjust and inequitable health outcomes. Where colonial contexts persist, policies and practices of settler societies commonly reproduce institutional racism (Dua, Razack, and Nyasha Warner 2005; Paradies 2016).

From experience in Algeria in particular, Fanon (2004) argued that decolonisation is an inherently violent process that culminates in national liberation. Writing from Aotearoa, Smith (2012, 98), in contrast, describes it is as a 'long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power'. Globally, ideas about justice and liberation are increasingly shared, yet antiracism responses need to navigate unique, complex and dynamic local economic, political and social realities.

Aotearoa New Zealand

In 1835, prior to significant settler presence in Aotearoa, perceived threats from foreign interests inspired rangatira (Māori leaders) to draft He Whakaputanga o te Rangatiratanga o Nū Tīreni (the Declaration of Independence) (Sadler 2015). This Declaration established recognition of Māori sovereignty over Aotearoa within the Western international diplomatic community.

In 1840, rangatira (chiefs) representing hapū (nations) negotiated Te Tiriti o Waitangi (the authorative Māori text) with the British, reaffirming tino rangati-

ratanga (self-determination and authority) (Healy, Huygens, and Murphy 2012). Hapū granted the British the right to govern their own (non-Māori) people and, in turn, the British granted Māori the rights and privileges of British subjects. In addition, it was agreed that all people would have religious and cultural freedom. However, British misinterpretations of Te Tiriti as a treaty of cession contributed to the wholesale colonisation of the country.

Te Tiriti outlines the terms and conditions of British settlement for all immigrants.[7] However, the arrival of diverse groups, including Tauiwi of colour, made racism in Aotearoa increasingly complex. Currently, there are six broad evolving ethnic groupings in Aotearoa: Māori, Pākehā (European), Pacific peoples, Asian, MELAA (Middle Eastern/Latin American/African) and 'Other' ethnicities (Statistics New Zealand 2020).

Racism was imported into Aotearoa through early Pākehā who believed they were inherently superior and had a mission to 'civilise' Māori (McCreanor 1997). The Pākehā colonial project assumed power, land and resources as of right, and used violence, legislation and racist practices to secure them (Yenson, Hague, and McCreanor 1989).

From the pre-settlement position of a strong population with organised health, economic and education structures and systems, colonisation wrought havoc on Māori health outcomes and life expectancy (Graham and Masters-Awatere 2020). Since data collection began, significant health inequities have been revealed which remain today (Ajwani *et al.* 2003; Ministry of Health 2021) and are widely understood to reflect entrenched racism in both the health system and society at large. Efforts to improve Māori health outcomes by exposing breaches of Te Tiriti (Came *et al.* 2019) and attempting to disrupt racism have had little sustained effect to date (Curtis *et al.* 2019).

A study of antiracism interventions in the health and disability sector (Talamaivao *et al.* 2021) found mostly simplistic, educational work with individual clinicians and little follow-up or support. It was concluded that '[l]asting change in health systems can only occur when power imbalances are examined and addressed – for example, by reorienting funding structures, services, access and representation for and partnerships with indigenous peoples' (55).

Health sector

Successive New Zealand government's frequently claim that we have a high-quality, publicly funded health system. Yet during most election cycles, govern-

ments instigate new health reforms. Over the last 40 years there have been four major reforms on the way health services are governed, funded and managed within Aotearoa (Quin 2009), with new structures alternating between centralisation and decentralisation (Goodyear-Smith and Ashton 2019). The 2021 changes, for example, were towards centralisation (Dovey 2021), with a focus on equity, antiracism and implementing Te Tiriti (Came *et al.* 2019; Graham and Masters-Awatere 2020; Harris *et al.* 2006; Reid, Cormack, and Paine 2019; Selak *et al.* 2020; Talamaivao *et al.* 2021).

Unlike the reforms of the 1990s, which were significant for the development of Māori health providers (Cooper 2000), the reforms of the 2000s led to claims by Māori providers to the Waitangi Tribunal (Wai 2575) that primary health care had failed to achieve health equity for Māori (Waitangi Tribunal 2019). The Tribunal recommended the transformation of the health system and the establishment of an independent Māori Health Authority. During the Waitangi Tribunal investigation, the Minister of Health commissioned a review into the health and disability system in 2018 (Health and Disability System Review 2020), which generated 86 recommendations to the Government on the transformation of the health sector. Key amongst these were the retaining of the Ministry of Health as the 'chief steward' of the health and disability system, the creation of the short-lived Te Aka Whai Ora (the Māori Health Authority), and the consolidation of 20 district health boards into one entity: Health New Zealand–Te Whatu Ora.

In November 2023, the reforms were ideologically flipped with the election of a National-led conservative government. A range of progressive equity-related interventions, such as world-leading smokefree legislation, school lunch programmes and, indeed, Te Aka Whai Ora itself, have all been down-scaled and/or disestablished (Came *et al.* 2024b). These and other anti-health changes around removing environmental protections and workers' rights have led to a series of urgent inquiries before the Waitangi Tribunal as well as mass mobilisations.

This paper is part of a wider co-lead study to re-imagine antiracism theory for the health sector in Aotearoa (Came, Kidd, and McCreanor 2022). In spite of the political context, we envision what an antiracist health system might look like from the perspective of Tauiwi health practitioners and academics. Māori perspectives will be published separately. The intention is to bring these two different approaches together at a later date in order to inform re-theorising antiracism and decolonisation for the health sector in Aotearoa.

METHODOLOGY

This qualitative study utilised a caucused (Giles and Rivers 2009) wānanga (learning gathering) method for data collection. This caucused approach emerges from Freire's (1970) insight that the descendants of the colonised have different roles than the descendants of the colonisers. We have previously used caucusing in our research (Kidd *et al.* 2020), and have found that the caucusing of Māori and Tauiwi (Pākehā and Tauiwi of colour) participants provides safer spaces for appropriate learning, development and conscientisation.

This co-lead study is aligned with the political and cultural aims of kaupapa Māori research, the Māori philosophical and values-based approach to knowledge building (Pihama 2010; Walker, Eketone, and Gibbs 2006), as the overall aim of the study is to disrupt racism and reduce health inequities. This approach is demonstrated using tikanga (protocols and customs), such as karakia (opening and closing blessing) and whanaungatanga (active relationship building). During the wānanga, we engaged in whakawhiti kōrero (idea negotiation), a collective process of analysing and critiquing ideas with the intent of actively negotiating a consensus (Elder and Kersten 2015).

This paper focuses on the viewpoints of the Tauiwi participants who had all worked in the health sector (a mixture of policy, public health, clinicians and management) for more than seven years, and brought with them particular expertise in Te Tiriti and antiracism. The twenty-nine participants were purposively recruited through the professional networks of the research team to ensure varied and rich data. Tauiwi of colour were proactively recruited. In November 2021, three caucused three-hour wānanga were held with Tauiwi. Even though it is ideal for wānanga to be conducted in person, kanohi ki te kanohi (face to face), the COVID pandemic, as well as the nature of health professional work, meant we held the wānanga virtually.

The wānanga were opened with a karakia followed by a whanaungatanga round. A Pākehā researcher (HC) facilitated the wānanga while Māori researchers (JK, ZT and HR) supported the process, as did Pākehā researchers in the team (TM, NR and GR). An overview of the study was provided (Came, Kidd & McCreanor, 2022), and we worked through a series of open-ended high-level questions.

Participants were asked:

1) *What's your vision of the health system if the health system wasn't racist?*

What would it be like? What would you hear, see and feel?

2) *If this is our vision of the antiracist health system, what would underpin the vision? What and who would need to change?*

3) *If we're going to do this change, how could we initiate these changes?*

The sessions were recorded and transcribed by the research officer (GR), and transcripts were sent to participants for approval. Institutional ethics approval was granted by the Auckland University of Technology Ethics Committee prior to the recruitment phase. Written and/or verbal approval was obtained from participants.

We used an inductive approach to code data for thematic analysis (Thomas 2006). The authors who attended the majority – if not all – of the focus groups, familiarised themselves with the transcripts and shaped the emerging themes. These were refined and adjusted through the coding process, and selections of the data were chosen for further analysis, which we use here to outline themes as findings.

FINDINGS

The wānanga produced rich data and complex perspectives on the dynamics of racism and privilege. The key themes emerging from the data were: i) honourable kāwanatanga and decolonisation; ii) building antiracism infrastructure; iii) understanding privilege and power; and iv) a shared commitment to transformation. Although these themes are presented as discrete concepts, there are threads of connection between them. Participants brought critical lenses to the wānanga, describing our institutions as western-centric illness systems that are inherently dysfunctional: 'Our [Pākehā] culture, our [Pākehā] world is making people sick instead of looking after them'.

Determinants, including income, housing, whānau (family) and whenua (land), were regarded as the building blocks most important to health. Participants saw antiracist health services as relational and culturally safe (Ramsden 2002) for all patients, whānau and health practitioners. Words used to describe this kind of antiracist health system included trust, safety, care, understanding, accessible, familiar and comfortable. Māori providers were seen as strengthening the existing health system. As one participant explained, 'Māori health providers have been providing innovative, integrative social and health care practices, and we [can] hold them up as exemplars of how Pākehā systems could change to deliver mana-enhancing services to people'.

The need for greater acceptance, recognition and investment in Māori providers and Māori health workers at every level was clear, and, in order to achieve this, organisations needed to be ready to create environments where Māori kaimahi (workers) could thrive and not be 'burnt out and overloaded'. Tauiwi participants had witnessed the battles Māori colleagues face: 'Simply to do what they're supposed to do, what's on their position description. Ideally, we want a system where those invisible barriers are unpacked and named, and the powers dissolved from them'.

This participant is referring to the extra cultural labour, over and above job position descriptions, that kaimahi Māori are often called upon to do within the health sector. The detail of the other invisible barriers was not discussed in the wānanga. This participant saw the process of identifying and removing barriers as Tauiwi work, so that kaimahi and users of such services could follow their own priorities. Being proactive would make space for respectful connection whereby people would be seen as a whole persons (body, soul and spirit) rather than fragmented parts. As one participant shared, 'We're really trying to say, what's important is your own spiritual well-being, who you are and how you are, and therefore how you're going to be in your compassionate presence with other people'.

This point was echoed by a number of participants which implies that wairua and/or spirit should be threaded through the entire health system. Professor Sir Mason Durie's (1998) presence was felt in the room. Some explicitly linked wairua and/or spirit to the fourth oral article of Te Tiriti o Waitangi which guarantees religious and cultural freedom. Other participants wanted to see health services that maintain a connection with Papatūānuku (the earth mother) and community; to see themselves reflected in the buildings, and this includes rooms that are big enough to accommodate large whānau. Services and buildings would be co-created with mana whenua. Health premises would genuinely be healing places with the embedded presence of things growing and of rongoā (Māori healing practices).

Participants pointed to the need for new ways of running healthcare, with strength-based approaches and information systems organised around the needs of whānau and communities. The need to embrace whānau ora and recognise the wellbeing interconnections of mothers, fathers, grandparents and their children was also raised. Participants articulated the urgency of the situation; the need to challenge practices that are unhelpful and include affirming healthcare for people of all shapes and sizes (Pause 2017).

HONOURABLE KĀWANATANGA AND DECOLONISATION

There was strong agreement that a future antiracist health system would be predicated on Te Tiriti o Waitangi and its enactment by the Crown and society, would be through the upholding of tino rangatiratanga and the enactment of honourable kāwanatanga (Came *et al.* 2024a; Huygens 2007). Participants articulated notions of Tiriti-based antiracism because, unless 'Te Tiriti is embedded from the very beginning, and honoured from the start, we will never ever see racism and inequities reduce'.

These participants grounded their aspiration for social justice in Te Tiriti, and others added that Te Tiriti needed integration into education, built environments, human resource processes, evaluation systems. and staff consciousness. Māori would lead the transformation while Tauiwi would advocate for relational power-sharing and collaborative engagement with mana whenua (those with territorial authority over lands) within a

> broader context of power-sharing, decision-making and the exercise of tino rangatiratanga by tangata whenua, and the exercise of honourable kāwanatanga with the kāwanatanga Tangata Tiriti sphere. And those commitments being upheld would mean that there would be power-sharing and balance.

This quote reflects the participants' attachment to the vision of Matike Mai (2016), where a transformed or redesigned health system is a useful signpost for a broader set of Aotearoa New Zealand wide processes (Came, Baker & McCreanor, 2021).

There was strong support for the proposal of a fully resourced Māori Health Authority with a brief for social justice. Tauiwi of colour suggested that a health system based on Te Tiriti and Māori-centred values of inclusiveness would feel safer for everyone: 'If we had a Te Tiriti-centred health system in all of those ways, then I think for Asian people that would allow an opportunity for us and our culture and our values to be honoured.'

Here the participant reflected on their marginalisation as Tauiwi of colour within the current system as being to some extent remedied by Tiriti-led change. Other participants said poor outcomes and resistance to public health guidelines clearly exposed the experiential alienation, racism and trauma in the health system reported by many Māori.

Attempting to rebuild or establish a sense of trust and belonging in this space were seen to require time. and the government must take Māori advice on board:

> I've been lucky to be involved [in a strong and exciting Tiriti partnership co-design process […] If the co-design outcomes are implemented [it] will make [that] hospital look like a decolonised hospital […] There are these emerging examples that need to be generalised. How do we learn from an antiracist process like that?

This participant highlighted the value of collaborative approaches and the kinds of progress they could foster. Others pointed to significant contextual actions including constitutional transformation, return of land and resources, breaking down government silos, support for holistic practice models, and decolonising power. There was a strong sense of the need to move to a culture of openness and honourable kāwanatanga that could redress the wrongs and inspire social justice and equity.

Building antiracism infrastructure

Participants recognised the collective need to undertake foundational work to build infrastructure for antiracism. This required a shared consciousness, awareness and commitment to Te Tiriti across the sector. Several participants reported struggling to work in the current system and shared their aspiration to work in an antiracist health context: 'I just think it would feel nice to work in a system that wasn't racist. When you went to work each day, you would feel like you were doing more good than harm […] It would feel so good'.

Within the broad context of systems change the emphasis is on rewards for Tauiwi, illustrating the benefits of antiracist change for all. The group agreed that health practice needed to focus on systemic racism rather than problematise the people the system fails: 'We've certainly got to embed a long-term cross-party agreement that antiracism is a goal […] and then the funding and the power and institutional structures will have to follow […] it needs to be thought about in that systems way.'

Participants called for interventions – from committed health workers/leaders around the barriers to addressing racism – that were vital to reach a tipping point for systems change. Antiracism competencies also needed to extend beyond health practitioners to administrators, managers and policymakers, and be supported by wider developments: 'It's not just about the health system

changing: it's about the way in which we live together changing. Which means primary education, secondary education, tertiary education also has to change'.

Participants articulated the need for antiracism curricula and teachers at all levels of the education system in order to produce many more antiracist graduates who can advance an antiracist health system. Some participants argued that holistic approaches that considered links and flows of learning were crucial both around and within the health sector. One imagined that such training 'would be built into not just the original qualification, but every single piece of in-service training you get would include something about racism and systemic inequalities and inequities'. However, others argued that best practice needed to be embedded into health practitioner competency documents and the work of regulatory authorities. This would enable 'provider organisations [to be] held accountable [for] ensuring that health practitioners are trained in cultural safety'.

It was made clear that changes should include the monitoring of outcomes and use of institutional levers such as professional re-certification. Pākehā also sought safe places to learn how to change behaviour in ways that supported those targeted by racism. A caucused approach to training (*e.g.*, Māori, Tauiwi of colour, Pākehā) was recommended to contain and change the racism of some Pākehā colleagues.

Participants spoke of the need for co-ordinated action from multiple directions to achieve an antiracist health system. It was noted that terminology and 'language that crosses the political divide could help us have a conversation without turning people off'. Participants also argued that high-level cross party-political support to address institutional racism was required. However, pushback and resistance needed to be anticipated.

Understanding privilege and power

Tauiwi of colour spoke of lived experiences of racism and raised specific concerns facing their communities. They advocated for an antiracist health system that focused both on outcomes and patient experience: 'I do struggle. As a person who looks different, to go into spaces where sometimes I'm the only person that looks different, I find it very challenging. But I always learn from it'. Here the message is about the added complexity for Tauiwi of colour in addressing racism from a racialised position themselves. Compassion, inclusion, belonging and trust needed to be built as some had backgrounds marked by trauma and violence.

Some Pākehā spoke of challenges arising from their privilege including the development of humility, limitations of hierarchy, and acknowledgement that antiracism work is a process not an endpoint. Others saw a role for more assertive measures: 'I'm sick of terms like "cultural competence" and "unconscious bias". I want people to name the "isms" for what they really are […] To be antiracist in my view has always been about acknowledging as Pākehā one's own racism and examining it'.

Here, the need for honesty and the acknowledgement of racism was commended, and many Pākehā saw themselves as needing to embrace the discomfort of the legacy of colonisation and racism while remaining responsive. Participants spoke of investing time to making incremental changes and learning from mistakes.

It was argued that Pākehā needed to consistently challenge poor behaviour amongst other Pākehā and speak critically of system outcomes: 'It's a big deal to name the failure of the systems, full stop. But what if we talked not about Māori dying younger, but about our monocultural health system killing Māori at a rate that it doesn't kill white folk like me'. Here the participant begins to articulate alternative ways of talking about the impact of the health system that re-sets conventional narratives.

The wānanga included several Pākehā men who explicitly spoke about the opportunity and responsibility of their male privilege. They acknowledged that the system treated them well, and recognised the need to ensure others received equivalent care. The importance of intersectionality (Hill, Collins, and Bilge 2020) was stressed, and they articulated that the system needed to embed it. One participant noted,

> We live in a white supremacist culture and our health system is based on white supremacist ideas and values. And unless we are able to talk openly and honestly about what those are, and how those shape all of the structures that we live in, any work we can do to make it a less racist system is only really tinkering at the edges.

For Pākehā and Tauiwi of colour, seeing the racism, white supremacy and monoculturalism was regarded as foundational to visioning work for substantive change. Others argued that the impact and ideological reach of neo-liberalism and capitalism in the health system would need to be eliminated and health recognised as a right not a privilege.

Institutional racism was recognised by the wānanga as a public health crisis. Participants acknowledged that for many this type of racism is hard to identify as it often appears neutral. Some argued for systems thinking and the mapping of racism to disrupt it, and for strengthening the evidence-base around anti-racism praxis along with vigilance and monitoring.

Shared commitment to transformation

Participants shared rich practical strategies to advance an antiracism health system informed by their own activism and/or lived experience. Accountability mechanisms and antiracism evaluation were seen as critical leverages for change. As one participant shared, 'Once it is on paper, and once it's articulated, then you can hold these institutions accountable for what they say they're going to do'.

An evaluative approach built on data and evidence was advocated, using funding mechanisms and performance indicators to incentivise change, with managers assessed on how effectively and efficiently they delivered equity outcomes. There were calls for new holistic measures of performance including consideration of who measured what, whose values were reflected, and how data sovereignty principles could be embedded.

Participants sought collective action around how Māori are prioritised in decision-making, and raised concerns about ethnic pay disparities. Some felt relational and values-based commissioning might resolve some existing sites of racism, while others wanted more courageous conversations about the root of the matter:

> You need a group saying all the radical things and pushing from the outside, and you've got a group who are trying to change from the inside, who look perfectly acceptable in comparison with the radical group […] Then you just need a critical mass.

In terms of disrupting practices, another participant had successfully applied a concept called 'radical democracy'. This is a process where 'everyone at the decision-making table is able to say what they think about stuff, even if others don't like it, provided no-one feels personally attacked'. When introduced, the process was initially combative, but, as people kept talking and opening up, there was a change in how issues were resolved.

DISCUSSION

Our perception is that there the participants managed to weave together an informal theory of antiracism change that includes educating Tauiwi about racism, history, politics and civics, resulting in conscientisation and power analyses that will ultimately transform society. Upholding Te Tiriti holds the potential to fracture monoculturalism within the public sector (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare 1988) which would foster a more inclusive authentically bicultural Māori-led space. It would also open up possibilities around engaging in incremental decolonial action (Smith 2012). Such goals and actions represent the bare minimum of what participants felt were required for Aotearoa to meet its national and international human rights commitments, areas in which our collective efforts at decolonisation are under regular scrutiny.

The discussion in the Tauiwi wānanga about visioning an antiracist health system brought to the fore multiple viewpoints regarding the critical elements of antiracism praxis while also providing a glimpse into a possible future without racism. There was consensus that Te Tiriti needed to be at the heart of antiracism praxis in Aotearoa as it defines the relationship between hapū and all the settlers here in 1840 as well as those yet to come.

The structural constitutional transformation presented by Matike Mai (2016) and frequently shared by participants in the wānanga consists of a tricameral vision of honourable kāwanatanga, rangatiratanga and a shared or relational sphere. Drawing on this structure, Tauiwi recognised our responsibilities within the kāwanatanga sphere to make sure that governance and leadership were developed in ways that went beyond equity in order to support social justice, Māori leadership and aspirations. This is supported by Came, Baker and McCreanor (2021) who identified actions within the kāwanatanga sphere in two broad areas: those related to policy, strategy and monitoring, and Tiriti and antiracism training programmes – all within the domain of governance and leadership.

Analyses of power and privilege were regarded by participants as essential to antiracism praxis. Racism, as a system of power that benefits one group of people while disadvantaging another (Came, McCreanor, and Simpson 2017), manifests as action and inaction, and is intersected by oppression based on gender, sexual orientation and disability. Since the 1980s, neoliberalism has shaped our health system, encouraging the business ethos of maximising profit (Skegg 2019). Many participants maintained that neoliberalism and capitalism were an anathema to an antiracism health system.

Participants were clear that ethnicity and socially assigned race (Cormack, Harris, and Stanley 2013) shape our experiences of racism and antiracism. Antiracism praxis was seen as relational and requiring accountability to Māori and those targeted by racism. Māori, Tauiwi of colour and Pākehā are on different journeys, and experience both privilege and historical and contemporary racism differently. This tripartite complexity is only just being articulated within the local literature (Dam 2022; STIR: Stop Institutional Racism and New Zealand Public Health Association 2021).

Moana Jackson was frequently quoted through the wānanga. Participants agreed the 'white supremacist culture' we live with in Aotearoa is a manifestation of our colonial history (Jackson 2019). We all agreed that Pākehā are the primary beneficiaries of racism and colonisation and therefore have a particular responsibility to act. Participants described engaging with 'radical groups' and 'radical democracy' that act as disruptions to racism, founded on notions of distributive power. Participants emphasised the importance of Tauiwi pursuing courageous conversations whilst being conscious of tone and language to keep people engaged. Participants spoke of Jackson's (2019) paraphrased analysis: Until we accept that the current constitutional, political, economic and social structures and the respective systems of government, finance, health and education etc. are colonising artefacts we cannot rid ourselves of racism.

A continuous vein throughout the participants' kōrero was the need to focus on systemic change. Systems change requires reflexive relational practice, sociopolitical education, structural power analysis, systems change, and monitoring and evaluation through evidence and data (Came and Griffith 2018). All of these components were discussed by participants and are evident in the themes above.

CONCLUSION

The wānanga were rich with images of a world without racism but also with the sobering awareness that the Pākehā-centric health system has thus far failed Māori. An antiracist health system would be just, culturally safe, and welcoming, and would exist in a physical space that was connected to the physical environment and reflected the cultures of those that used the service. It would be about keeping people well together with treating trauma, illness and injury. There would be a strong focus on ensuring everyone had access to the prerequisites of health. Māori providers, practitioners and leaders would be central, and there would be significant investment in Māori health. Wairua

and/or spirit would be normalised, and whānau would be central to the design, delivery and evaluation of health services.

The wānanga in this study did not explicitly identify the details of a new antiracism theory, and we believe this remains an impediment to progress on antiracism and decolonisation in Aotearoa. Matike Mai provides a Māori vision of what is required at the level of the constitutional arrangements of the country, calling into view a decolonial social movement that works constructively, collaboratively and peacefully to transform our current social order. The work of theorising the visioning of these knowledgeable, grounded and committed Tauiwi health experts into a coherent, inclusive and achievable whole will be another key milestone on our road to social justice in Aotearoa and the international community of interest.

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NOTES

1 Dr Heather Came is a seventh generation Pākehā New Zealander. Her background is in public health and social justice activism. Her research focuses on critical policy analysis, Te Tiriti o Waitangi, antiracism and institutional racism. As an activist scholar, Heather is a founding member and co-chair of STIR: Stop Institutional Racism and has prepared expert evidence for Waitangi Tribunal and United Nations human rights committees. She runs her own consultancy Heather Came & Associates specialising in Tiriti and racial justice.

2 Professor Jacquie Kidd (Ngāpuhi) has almost two decades of expertise in qualitative, whānau-focused Māori health equity research. Her research is usually based in a co-designed kaupapa Māori approach in the areas of community-focused solutions to health inequities and organisational health literacy. Her current work includes lung cancer screening for Māori, whānau hauora assessment in the cancer pathway, and anti-racism praxis in healthcare.

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5 Garrick Rigby is a writer and former research officer on the Marsden-grant funded project 'Re-Imagining anti-racism theory for the health sector'. His education was in Fine Arts followed by a Master of Arts in film theory, with a focus on colonial discourse and racial representation in New Zealand film. After working as a filmmaker, Garrick briefly studied psychotherapy during which he published his first article, *Therapist and Coloniser: Pākehā Approaches to Māori Historical Trauma* (2017). He was a contributing writer for STIR: Stop Institutional Racism, and the STIR and New Zealand Public Health Association (NZPHA) briefing paper on the National Action Plan against racism.

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7 In the context of this paper, Tauiwi is an inclusive term for all non-Māori citizens. We also refer to Pākehā (meaning white settlers), and Tauiwi of colour (meaning non-white settlers).

REFERENCES

Ajwani, Shilpi, Tony Blakely, Bridget Robson, Martin Tobias, and Martin Bonne. 2003. *Decades of Disparity: Ethnic Mortality Trends in New Zealand 1980–1999*. Wellington: Ministry of Health and University of Otago.

Came, Heather. (2014). 'Sites of Institutional Racism in Public Health Policy Making in New Zealand.' *Social Science & Medicine* 106: 214–220. https://doi.org/10.1016/j.socscimed.2014.01.055

Came, H., Baker, M., & McCreanor, T. (2021). Structural racism, constitutional transformation and the New Zealand health sector: Learnings from the Matike Mai Aotearoa report. *Journal of Bioethical Inquiry* 18(1), 59-70. https://doi.org/10.1007/s11673-020-10077-w

Came, H., Kidd, J., & McCreanor, T. (2022). Re-imagining anti-racist theory for the health sector. *The New Zealand Medical Journal*, 135(1554), 105-110.

Came, Heather, Tim McCreanor, and Trevor Simpson. 2017. 'Health activism against barriers to indigenous health in Aotearoa New Zealand.' *Critical Public Health* 27(4): 515–521. https://doi.org/10.1080/09581596.2016.1239816

Came, Heather, and Derek Griffith. 2018. 'Tackling Racism as a 'Wicked' Public Health Problem: Enabling Allies in Anti-Racism Praxis.' *Social Science & Medicine* 199: 181–188. https://doi.org/10.1016/j.socscimed.2017.03.028

Came, Heather, Tim McCreanor, Leanne Manson, and Kerri Nuku. 2019. 'Upholding Te Tiriti, Ending Institutional Racism and Crown Inaction on Health Equity.' *New Zealand Medical Journal* 132(1492): 61–66.

Came, Heather, Maria Baker, and Tim McCreanor. 2021. 'Addressing Structural Racism Through Constitutional Transformation and Decolonization: Insights for the New Zealand Health Sector.' *Bioethical Inquiry* 18: 59–70. https://doi.org/10.1007/s11673-020-10077-w

Came, Heather, Jacquie Kidd, and Tim McCreanor. 2022. 'Re-Imagining Anti-Racist Theory for the Health Sector.' *The New Zealand Medical Journal* 135(1554): 105–110.

Came, Heather, Mershen Pillay, Clive Aspin, and Tim McCreanor. 2024a. Honourable Kāwanatanga: A Prerequisite for Constitutional Transformation. *Ethnicities* https://doi.org/10.1177/14687968241290840

Came, Heather, Clive Aspin, Nicole Coupe, and Tim McCreanor. 2024b. 'Pae Ora (Disestablishment of Māori Health Authority) Amendment Act 2024: Further Crown Breaches of Te Tiriti o Waitangi.' *New Zealand Medical Journal* 137(1595): 94–98. https://doi.org/10.26635/6965.6554

Cooper, Rob. 2000. 'The Role of the Health Funding Authority in Maori Health Development.' *Pacific Health Dialog* 7(1): 101–106.

Cormack, Donna M., Ricci B. Harris, and James Stanley. 2013. 'Investigating the Relationship Between Socially-Assigned Ethnicity, Racial Discrimination and Health Advantage in New Zealand.' *PLoS ONE* 8(12):e84039. https://doi.org/10.1371/journal.pone.0084039

Curtis, Elana, Rhys Jones, David Tipene-Leach, Curtis Walker, Belinda Loring, Sarah-Jane Paine, and Papaarangi Reid. 2019. 'Why Cultural Safety Rather than Cultural Competency is Required to Achieve Health Equity: A Litera-

ture Review and Recommended Definition.' *International Journal for Equity in Health* 18(1): 1–17. https://doi.org/10.1186/s12939-019-1082-3

Dam, Lincoln. 2022. Be(com)ing an Asian tangata Tiriti. *Kotuitui: New Zealand Journal of Social Sciences* 18(3): 213–232. https://doi.org/10.1080/1177083X.2022.2129078

Dobbie, Will, Peter Hull, and David Arnold. 2022. 'Measuring Racial Discrimination in Bail Decisions.' *American Economic Review* 112(9): 2992–3038. https://doi.org/10.1257/aer.20201653

Dovey, Susan. 2021. 'Will we Learn from History or Repeat It? The New New Zealand Health System.' *Journal of Primary Health Care* 13(2): 93–95. https://doi.org/10.1071/HCv13n2_ED1

Dua, Enakshi, Narda Razack, and Jody Nyasha Warner. 2005. 'Race, Racism, and Empire: Reflections on Canada.' *Social Justice* 32(4): 1–10.

Dunn, Kevin M., and Pierrick Geeraert. 2003. 'The Geography of Race and Racisms.' *GeoDate* 16(3): 1–6.

Durie, Mason. 1998. *Whaiora: Māori Health Development*. 2nd ed. Oxford: Oxford University Press.

Elder, Hinemoa, and Paula Kersten. 2015. 'Whakawhiti Kōrero, a Method for the Development of a Cultural Assessment Tool, Te Waka Kuaka, in Māori Traumatic Brain Injury.' *Behavioural Neurology* 2015: 1–8. https://doi.org/10.1155/2015/137402

Fanon, Frantz. 2004. *The Wretched of the Earth*. New York: Penguin Books.

Freire, P. (1970). Pedagogy of the oppressed Continuum.

Geronimus, Arline T. 1992. 'The Weathering Hypothesis and the Health of African-American Women and Infants: Evidence and Speculations.' *Ethnicity and Disease* 2(3): 201–221.

Giles, Rebecca, and Shirley Rivers. 2009. 'Caucusing: Creating a Space to Confront our Fears.' *Aotearoa New Zealand Social Work Review* 21(1/2): 60–71. https://doi.org/10.11157/anzswj-vol21iss1id321

Goodyear-Smith, Felicity, and Toni Ashton. 2019. 'New Zealand Health System: Universalism Struggles with Persisting Inequities.' *The Lancet* 394(10196): 432–442. https://doi.org/10.1016/S0140-6736(19)31238-3

Graham, Rebekah, and Bridgette Masters-Awatere. 2020. 'Experiences of Māori of Aotearoa New Zealand's Public Health System: A Systematic Review of Two Decades of Published Qualitative Research.' *Australian and New Zealand Journal of Public Health* 44(3): 193–200. https://doi.org/10.1111/1753-6405.12971

Harris, Ricci, Martin Tobias, Mona Jeffreys, Kiri Waldegrave, Saffron Karlsen, and James Nazroo. 2006. 'Racism and Health: The Relationship Between Experience of Racial Discrimination and Health in New Zealand.' *Social Science & Medicine* 63(6): 1428–1441. https://doi.org/10.1016/j.socscimed.2006.04.009

Health and Disability System Review. 2020. *Health and Disability System Review: Final Report–Pūrongo Whakamutunga*. Wellington: Health and Disability System Review.

Healy, Susan, Ingrid Huygens, and Takawai Murphy. 2012. *Ngāpuhi Speaks*. Whangarei, New Zealand: Te Kawariki and Network Waitangi Whangarei.

Hill Collins, Patricia, and Sirma Bilge. 2020. *Intersectionality*. 2nd ed. Cambridge: Polity Press.

Huygens, Ingrid. 2007. 'Processes of Pakeha Change in Response to the Treaty of Waitangi.' PhD diss., University of Waikato. https://hdl.handle.net/10289/2589

Jackson, Moana. 2019. 'The Connection Between White Supremacy and Colonisation.' Accessed 29 November 2022 from https://e-tangata.co.nz/comment-and-analysis/the-connection-between-white-supremacy/

Kidd, Jacquie, Heather Came, Sarah Herbert, and Tim McCreanor. 2020. 'Māori And Tauiwi Nurses' Perspectives of Anti-Racism Praxis: Findings from a Qualitative Pilot Study.' *AlterNative: An International Journal of Indigenous Peoples* 16(4): 387–394. https://doi.org/10.1177/117718012097467

Love, Catherine, Richard J. David, Kristin M. Rankin, and James W. Collins. 2010. 'Exploring Weathering: Effects of Lifelong Economic Environment and Maternal Age on Low Birth Weight, Small for Gestational Age, and Preterm Birth in African-Amerian and White Women.' *American Journal of Epide-*

miology 172(2): 127–134. https://doi.org/10.1093/aje/kwq109

Marrie, Adrian, and Henrietta Marrie. 2014. *A Matrix for Identifying, Measuring and Monitoring Institutional Racism within Public Hospitals and Health Services*. Gordonvale: Bukal Consultancy Services.

Matike Mai. 2016. *The Report of Matike Mai Aotearoa–The Independent Working Group on Constitutional Transformation*. Auckland: Matike Mai Aotearoa.

McCreanor, Tim. 1997. 'When Racism Stepped Ashore: Antecedents of Anti-Maori Discourse in Aotearoa.' *New Zealand Journal of Psychology* 26(1): 36–44.

Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare. (1988). *Puao te ata tu (Day break)*. Department of Social Welfare website: http://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/archive/1988-puaoteatatu.pdf

Ministry of Health. 2021. *Health and Independence Report 2020: The Director-General of Health's Annual Report on the State Of Public Health*. Wellington: Ministry of Health.

Nwanaji-Enwerem, Jamaji C., Chandra L. Jackson, Mary Ann Ottinger, Andres Cardenas, Katherine A. James, Kristen M. C. Malecki, Jiu-Chiuan Chen, Andrew M. Geller, and Uchechi A. Mitchell. 2021. 'Adopting a 'Compound' Exposome Approach in Environmental Aging Biomarker Research: A Call to Action for Advancing Racial Health Equity.' *Environmental Health Perspectives* 129(4): 45001. https://doi.org/10.1289/EHP8392

Paradies, Yin. 2016. 'Colonisation, Racism and Indigenous Health.' *Journal of Population Research* 33(1): 83–96. https://doi.org/10.1007/s12546-016-9159-y

Paradies, Yin, Mandy Truong, and Naomi Priest. 2014. 'A Systematic Review of the Extent and Measurement of Healthcare Provider Racism.' *Journal of General Internal Medicine* 29(2): 364–387. https://doi.org/10.1007/s11606-013-2583-1

Paradies, Yin, Jehonathan Ben, Nida Denson, Amanuel Elias, Naomi Priest, Alex Pieterse, Arpana Gupta, Margaret Kelaher, and Gilbert Gee. 2015. 'Racism as a Determinant of Health: A Systematic Review and Meta-Analysis.' *PloS One* 10(9):e0138511. https://doi.org/10.1371/journal.pone.0138511

Pause, Cat. 2017. 'Borderline: The Ethics of Fat Stigma in Public Health.'

Journal of Law, Medicine and Ethics 45(4): 510–517. https://doi.org/10.1177/1073110517750585

Pihama, Leonie. 2010. 'Kaupapa Māori Theory: Transforming Theory in Aotearoa.' *He Pukenga Korero* 9(2): 5–14.

Quin, Peter. 2009. *New Zealand Health System Reforms. Parliamentary Library Research Paper 09/03*. Wellington: Parliamentary Library.

Ramsden, Irihapeti Merenia. 2002. 'Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu.' PhD diss., Victoria University of Wellington. https://ir.wgtn.ac.nz/handle/123456789/26651

Reid, John, Karyn Taylor-Moore, and Golda Varona. 2014. 'Towards a Social-Structural Model for Understanding Current Disparities in Māori Health and Well-Being.' *Journal of Loss and Trauma* 19(6): 514–536. https://doi.org/10.1080/15325024.2013.809295

Reid, Mary-Jane. 2011. 'Good Governance: The Case of Health Equity.' In *Always Speaking: The Treaty of Waitangi and Public Policy*, edited by Veronica M. H. Tāwhai and Katarina Gray-Sharpe, 35–48. Wellington: Huia Publishers.

Reid, Papaarangi, Donna Cormack, and S.-J. Paine. 2019. 'Colonial Histories, Racism and Health–The Experience of Māori and Indigenous Peoples.' *Public Health* 172(6): 119–124. https://doi.org/10.1016/j.puhe.2019.03.027

Sadler, Hone. 2015. Legitimacy of Sovereignty in Aotearoa New Zealand was it Ceded or Usurped The Ngāpuhi Tribunal Claim. *International Journal of Arts & Sciences* 8(3): 97–105.

Selak, Vanessa, Jamie-Lee Rahiri, Rod Jackson, and Matire Harwood. 2020. 'Acknowledging and Acting on Racism in the Health Sector in Aotearoa New Zealand.' *New Zealand Medical Journal* 133(1521): 7–13.

Skegg, David. 2019. *The Health of the People*. Wellington: Bridget Williams Books.

Smith, Cherryl Waerea-i-te-Rangi, Rāwiri Tinirau, Helena Rattray-Te Mana, Makareta Tawaroa, Helen Moewaka Barnes, Donna Cormack, and Eljon Fitzgerald. 2021. *Whakatika: A Survey of Māori Experiences of Racism*. Whanganui, New Zealand: Te Atawhai o Te Ao–Independent Maori Institute for Environment and Health.

Smith, Linda. 2012. *Decolonizing Methodologies: Research and Indigenous Peoples*. 2nd ed. London: Zed Books Ltd.

Statistics New Zealand. 2020. 'Ethnicity.' Accessed 11 June 2024 from https://datainfoplus.stats.govt.nz/Item/nz.govt.stats/7079024d-6231-4fc4-824f-dd8515d33141

STIR: Stop Institutional Racism and New Zealand Public Health Association. 2021. *Briefing paper on the Forthcoming National Action Plan Against Racism*. Auckland: STIR: Stop Institutional Racism, New Zealand Public Health Association, and Auckland University of Technology.

Talamaivao, Natalie, Gabrielle Baker, Ricci Harris, Donna Cormack, and Sarah-Jane Paine. 2021. 'Informing Anti-Racism Health Policy in Aotearoa New Zealand.' *Policy Quarterly* 17(4): 50–57. https://doi.org/10.26686/pq.v17i4.7319

Thomas, David R. 2006. 'A General Inductive Approach for Analyzing Qualitative Evaluation Data.' *American Journal of Evaluation* 27(2): 237–246. https://doi.org/10.1177/1098214005283748

Waitangi Tribunal. 2019. *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry. WAI 2575*. Lower Hutt, New Zealand: Waitangi Tribunal.

Walker, Shayne, Anaru Eketone, and Anita Gibbs. 2006. 'An Exploration Of Kaupapa Maori Research, its Principles, Processes and Applications.' *International Journal of Social Research Methodology* 9(4): 331–344. https://doi.org/10.1080/13645570600916049

Williams, David R. 2016. 'Improving the Measurement of Self-Reported Racial Discrimination: Challenges and Opportunities.' In *The Cost of Racism for People of Color: Contextualizing Experiences of Discrimination*, edited by Alvin N. Alvarez, Christopher T.H. Liang, and Helen A. Neville, 55–83. Washington: American Psychological Association.

Williams, David R., Jourdyn A. Lawrence, and Brigette A. Davis. 2019. 'Racism and Health: Evidence and Needed Research.' *Annual Review of Public Health* 40: 105–125. https://doi.org/10.1146/annurev-publhealth-040218-043750

World Health Organization Commission on Social Determinants of Health. 2008. *Closing the Gap in a Generation: Health Equity Through Action on the Social*

Determinants of Health: Commission on Social Determinants of Health. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization.

Yensen, Helen, Kevin Hague, and Tim McCreanor, eds. 1989. *Honouring the Treaty: An Introduction to the Treaty of Waitangi*. Auckland: Penguin Books.