Moving beyond institutional racism within the primary healthcare sector in Aotearoa

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ABSTRACT

There are various forms of racism; they are interconnected and have a whakapapa (genealogy). Structural racism is the scaffolding that normalises historical, cultural and institutional practices that benefit white people. Systemic racism stems from this system through the way institutions, structures, and policies work together to perpetuate inequity. This includes whole organisations (political, legal, economic, healthcare) working together to include structures that uphold the system. This then flows through to institutions that further enable the racism within an institution's structures, filtering into interpersonal and internalised racism, where people act and behave in racist ways. In Aotearoa, institutional racism contributes to health inequities between Māori and non-Māori, resulting in poorer health outcomes for Māori and undermining equitable service delivery.

This research is premised on a kaupapa Māori methodology that utilised Māori knowledge and perspectives through pūrākau (story) to understand, (a) how institutional racism manifests in policy and practice within the primary healthcare sector; and (b) how the primary healthcare sector can move beyond institutional racism at a strategic level.

Thirteen manukura Māori (leaders) who had recently/currently worked for health providers in Aotearoa were purposely recruited. Each participant was invited to a wānanga (meeting) to share their pūrākau of experiences and perspectives on solutions. Hui (meetings) were held with individual participants who were unable to attend the wānanga. Data collection used pūrākau and was thematically analysed to communicate three of them.

Three key themes emerged: firstly, the inequity in contracting and resource allocation, where manukura Māori described the Crown's varying contracting processes. Secondly, looking under the hood, where institutional racism is embedded within legislation, policy, strategy, and processes, alongside how people operate and make decisions within organisations. Lastly, the Crown holds the power and control where decisions are made for Māori by non-Māori.

This research demonstrates that the Crown and other non-Māori organisations need to firstly, accept that they hold an imbalance of power, and secondly, be willing to relinquish their power for a true collaborative partnership to exist with Māori. Kaupapa Māori/iwi providers need to be trusted and valued by the Crown, as Māori people have a role to play in reducing inequities for Māori.

Solutions include involving Māori at every level and phase of decision-making- within Crown and other non-Māori organisations, to ensure mātauranga Māori and te ao Māori are recognised and valued. The creation of equal partnerships between Māori and the Crown is required to enable shared governance and decision-making. A form of veto right for Māori is agreed at the establishment of partnerships between Pākehā and Māori to ensure Pākehā do not have the absolute power in decision-making. That the Crown and other non-Māori organisations enable organisations' systems and structures to apply a pro-equity and pro-Tiriti lens to decision-making to support the change of mindsets and behaviours of Pākehā within organisations. To commission kaupapa Māori/iwi providers through long-term, high-trust contracts focused on outcomes; and to support the collective approach of Māori through the Crown organisations, removing competitive tendering and instead implement collective commissioning across localities.

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where this has been explicitly defined in the acknowledgments), nor used artificial intelligence tools or generative artificial intelligence tools, nor material which to a substantial extent has been submitted for the aware of any other degree or diploma of a university or other institution of higher learning.

Signature:

Michelle Murray
Date 16 December 2025

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“Tangohia mai te taura i tāku kakī, kia waiata ai i tāku waiata”

Take this rope from my neck so I can sing my song

Have the strength to speak up, and the truth will not be silenced

Secondly, to my sister Joleen, who left this earth far too soon. Your endless support for me in all my studies has been uplifting, from having the kids to giving me time to think and write, to words like, “You got this Shell.” Thirdly, to my Aunty Cindy who said, “You are never too old to learn.” She led by example in her own pursuit of a PhD.

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He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata

What is the most important thing in the world? It is people, it is people, it is people

GLOSSARY OF KUPU AND TERMS

Ako Māori – Culturally preferred pedagogy

Aotearoa – New Zealand (Land of the long white cloud)

Aroha – Care

Aroha ki te tangata – Care for the participants before the process

AUTEC – Auckland University of Technology Ethics Committee

Ehara taku toa I te toa takitahi engari he toa takatini – My strength is not mine alone but belongs to the many

Hapū – Sub-tribe

Haukāinga – Local people

Hauora – Health

He aha te mea nui o te ao? He tāngata, he tāngata, he tāngata – What is the most important thing in the world? It is people, it is people, it is people

Hononga – Connectedness and trust

Hui – Meeting

Iwi – Tribe

Iwi-Māori Partnership Board – Partnership between Iwi and Māori and Te Whatu Ora (Health New Zealand) and Manatū Hauora (Ministry of Health)

Kai – Food

Kaitiaki – Guardian and advocate

Kanohi ki te kanohi – Face-to-face gatherings

Kapu ti – Cup of tea

Karakia – Prayer

Karakia timatanga – Opening prayer

Karakia whakamutunga – Closing prayer

Kaumātua – Elder

Kaupapa – Topic or subject

Kaupapa Māori – Māori approach or ideology

Kaupapa Māori health provider – Health provider that specialises in a Māori approach

Kawa – Māori values, protocols, customs

Kāwangatanga – Government

Kawenga taumaha – Bearing the emotional burden

Kia piki ake I ngā raruraru o te kainga – Socio-economic mediation

Kingitanga – Māori King movement

Koha – Gift

Kohanga Reo – Māori language pre-school

Kōrero – Discussion
Korowai – Cloak
Kotahitanga – Unity and collectivism
Ko wai au? – Who am I?
Kōwhiringa – Options
Kupu – Words
Mahi tahi – Working together
Mamae – Hurt
Mana – Authority or power or control
Manaaki – Caring for people or support
Manatū Hauora – Ministry of Health
Mana taurite – Equity
Manaakitanga – Hospitality
Mana motuhake – Autonomy, self-governance
Manukura Māori – Māori leaders
Māori – Indigenous people of the land (Aotearoa)
Māori hauora – Māori health and wellbeing
Marae – Meeting house
Mātauranga Māori – Māori knowledge
Mihi – Greeting
Ngā pukenga – Developing skills and sharing expertise
Ngā hua – Outcomes that are equitable
Non-Māori organisation – Non-Māori or Crown owned organisation
Pākehā – English descendant
Pasifika – Peoples originating from various Pacific nations
Pātuitanga – Partnership
Pōwhiri – The formal Māori welcoming process
Pou – Pillar
Pūrākau – Stories
Rangatira – Māori chief
Rohe – District or region or locality
Rongoā – Māori medicine
Rōpū – Group
Taihoa – Hold on
Tangata Whenua – People of the land
Tangohia mai te taura I tāku kakī kia waiata ai ki tāku waiata – Take this rope from my neck so I can sing my song

Taonga – Emphasising status and authority or a treasure

Taonga tuku iho – Cultural aspirations that are Māori

Tauiwi – Non-Māori

Tauriti – Equity

Tautohetohe – Debate

Tauutuutu – Reciprocity

Te Aka Whai Ora – Māori Health Authority

Te ao Māori – The Māori worldview

Te kaikirianga – Racism

Te Ika a Maui – The North Island of New Zealand

Te reo Māori – The Māori language

Te reo Pākehā – The English language

Te tauariki Māori – Cultural identity

Te Tiriti o Waitangi – The Treaty of Waitangi

Te Whatu Ora – Health New Zealand

Tikanga – Māori customs, values, protocols and practices

Tikanga me ngā kawa – Alignment with participants' localised practices or behaviours

Tino rangatiratanga – Self-determination, sovereignty, leadership

Tiriti o Waitangi – A treaty document signed between Māori and Pākehā

Tōhunga – Expert

Wāhine – Women

Waiata – Song

Wairuatanga – Spiritual wellbeing practices

Waitangi Tribunal – A New Zealand commission of inquiry that investigates claims made by Māori relating to the Treaty of Waitangi

Wānanga – Meet, discuss, deliberate

Whāea – Aunty

Whakaaro – Thoughts

Whakamā – Shame

Whakamaru – Active protection

Whakapapa – Genealogy, history

Whakatā – Break

Whakatau – Formal welcome

Whakatauākī – Proverb

Whanaungatanga – Establishing and setting the foundations of relationships

Whānau – Family, including extended family

Whānau Ora – Family wellbeing

Whanongo pono – Values

Whare Wānanga – Houses of learning

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1 INTRODUCTION

In this chapter I will take you on a journey outlining the background and rationale for my research, including an overview of the problem, the questions and aim of the research, an overview of the approach, who I am and why I chose ‘moving beyond institutional racism’ as the kaupapa (topic) for my research.

1.1 Background

Mihi

Tēnā koutou, kua whakaemi mai i te rangi nei. Tēnā ka mihi!
Ko Rangatira Mokomoko tōku matua tīpuna
E tū whakaiti tēnei, he uri o Whakatōhea, Tūhoe

Translation – Greeting

Greetings to all that have gathered here today. Greetings!
Chief Mokomoko is my ancestor
My tribes are Whakatōhea and Tūhoe

Whakatauākī

Ko tētehi whakatauākī e rongonui ana ki tōku whānau o Mokomoko, āra, ko tēnei
“Tangohia mai te taura I tāku kakī kia waiata ai I tāku waiata,” (Rangatira Mokomoko).

Translation – Proverb

My family Mokomoko proverb in whakapākehātanga (translation) is: Take this rope from my neck so I can sing my song. The kurahuna (meaning) is: “Have the strength to speak up and the truth will not be silenced,” (Chief Mokomoko).

Waiata

Te waiata a Rangatira Mokomoko – Tangohia mai te taura i tāku kakī, kia waiata ai i tāku waiata.
Kore te tākiri e tū tēnei ki te moenga.
Kei te hori te tāngata tēnei au kei te raweke. He pono te ki nei tāku rauhia ki te moenga. Koia kei te tāngata mate.
Kau au kia te uira. Whakarewha te titiro te hukinga ia hau utiti.
He wareware noa te eke noa i te kaipuke. He ahi mumura te panga mai o te whakamā.
Me kawe ki tāwhiti hei homai mō te mekemeka. Te rerenga o te rā, ko te kāwana kei Uropi.

Maana e ki mai me tau au ki te Tauwati. Hei tūtaki e mō te kūaha o te pouaka. Haere mai nei au ka turaki mate ki te moenga, eeee.
“Hei kona e Pākehā mā, e mate hara kore au. Hei aha.”

Translation – Song
Chief Mokomoko’s song – Take the rope from my throat so I can sing my song
Violent shaking will not rouse me from my sleep
They treat me like a common thief. It is true that I embrace eternal sleep. For that is the lot of a man condemned to die.
Shielded from the harsh light, with confused view I reflect on the vengeance taken and question the reason why.
Remember how I was taken on board a ship. The memory of the shame burns within me so deep.
Chained and shackled, that to be taken to a place afar, right or wrong I am to die. With the passing of time the Governor of Europe.
They decided that I must hang. With the closing of the lid on my box. Only then will I get peace and eternal rest, eeee.
“Farewell you non-Māori, I die without a crime (I die for nothing). So be it”, (Parliamentary Counsel Office, 2013, s. 2).

The significance of the whakatauākī (proverb) above speaks to institutional racism in the 1800s. It encourages whānau to have the strength to speak up and the truth will not be silenced (Chief Mokomoko). My whānau whakatauākī is and can be an inspiration for Māori (Indigenous people of the land – Aotearoa) to ensure our voices are heard within Aotearoa (also known as New Zealand or Aotearoa New Zealand), where Western thinking dominates organisations. This whakatauākī is my korowai (cloak) that wraps confidence around me to speak up to ensure our people are heard. It has also supported me to focus my research on primary healthcare and to include my whānau experience of unnecessary loss due to a late diagnosis of breast cancer.

The Aotearoa breast screening system offers free screening from the age of 45. However, my sister was 39 years old when she was diagnosed with breast cancer. Our whānau, including my sister, did not realise that breast screening under the age of 45 was necessary due to no whānau history and believing what the breast screening programme promoted; screening from the age of 45. How wrong we were! My sister should have been screened earlier, as according to Lawrenson et al. (2017), Māori women have one of the highest incidences of breast cancer in the world. There are also breast cancer survival inequities between ethnic groups of women

in Aotearoa, with poorer survival rates for Māori and Pacifica women. Whilst Egan et al.'s (2020) research was on prostate cancer in Māori men, the study found that Māori experience the poorest health statistics in terms of cancer incidence and mortality compared to non-Māori. The study goes on to say that timeliness and access to healthcare are essential factors in improving health inequities for Māori. Furthermore, Cassim et al. (2020) found that there are barriers to early prevention and diagnosis of lung cancer within primary healthcare identified by whānau Māori and primary healthcare providers in the midland region of Aotearoa. We can do better! To support Aotearoa to do better, this thesis seeks to understand how institutional racism manifests within the primary healthcare sector, and to provide recommendations on how the primary healthcare sector can move beyond institutional racism.

1.2 Ko wai au? (Who am I)

Over the past 20 years, I have worked strategically and operationally in the health sector. This includes working for organisations such as kaupapa Māori non-government organisation (NGO), primary health organisations (PHO), both generic and kaupapa Māori; district health board (DHB) strategy, planning and funding, both generic and kaupapa Māori; and Crown entities in Aotearoa such as Accident Compensation Corporation (ACC) and for Victoria Health Promotion Foundation (VicHealth) in Australia.

I am passionate about equity for Māori and First Nations people, and a significant component of the work within the roles mentioned above is to influence change and achieve equity for Māori. This includes removing barriers to accessing healthcare for Māori, such as institutional racism. Recently, I have been involved in and witnessed an increase in discussion within organisations, such as the Ministry of Health (MoH), District Health Boards, Primary Health Organisations, Non-Government Organisations, and Crown entities, including Accident Compensation Corporation and VicHealth, about institutional racism. These discussions include what institutional racism is, how to identify it, what to do about it, and the impact of institutional racism. However, there are very few organisations looking to implement systems to move beyond institutional racism. Therefore, this thesis seeks to understand how institutional racism manifests and is experienced within the primary healthcare sector, including ways to move beyond it.

Firstly, I start with my own pūrākau titled, "So many learnings along the way." My pūrākau focuses on examples of structural racism embedded in the health system, such as the contracting process, where the Crown designs contracts in isolation. This includes competitive tendering and audits that did not recognise te ao Māori (Māori worldview), excessive reporting on outputs and valuing large non-Māori health providers to deliver contracts. Furthermore, the

Crown lacked trust in kaupapa Māori providers to deliver hospital-based services previously delivered by the District Health Board in the community.

1.3 The researchers pūrākau – So many learnings along the way

I took on this research as I wanted to tell the pūrākau of institutional racism through the eyes of Māori health leaders (who I refer to as manukura Māori in this thesis), including my own, and to critically unpack the pūrākau to highlight the challenges faced and to share how we can move beyond institutional racism. The journey of my doctorate has had some turbulence, and more about that at the end of my story. My pūrākau highlights that structural racism is embedded in the health system, and whilst this can change, it may be a temporary change. Over the years, I have observed that if you have Māori leaders pushing for the change, either through a Māori health team or an executive Māori role embedded in the organisation, or a Māori leader being at the decision-making table, mātauranga Māori (Māori knowledge) can be considered. However, the moment a Māori leader is not present, we are not heard. I thought that embedding the principles of Tiriti o Waitangi (Treaty of Waitangi) into a Crown organisation's strategy could change institutional racism. However, I have seen how a new leader in an organisation undoes this change. Therefore, I now understand that to tackle institutional racism, the above approach, coupled with a change in behaviours and mindsets, is required, as change relies on people's motivation.

My professional health journey began in 2001 as an administrator for a small kaupapa Māori (Māori approach/ideology) health provider, whose purpose was to empower Māori to thrive through better health and wellbeing. I learnt very quickly the hoops you had to jump through to be rewarded (as the District Health Board called it) with a health contract and to hold on to it. The contractual environment was a competitive one where you were up against non-Māori providers who had more capacity to write tenders, in a way that the assessment panels (predominantly Pākehā) (English descendant) required. The assessment panels struggled to see the value of a tender written from a te ao Māori perspective. Furthermore, the contractual reporting was burdensome, requiring significant time-consuming information gathering.

I later found out, when I moved into a role that included contract management within the District Health Board, that exhaustive information gathering was neither read nor utilised. In contractual reporting, there was little to no room for reporting outcomes. The narrative was not important – it was all about the numbers in terms of 'how many this, how many that.' Yet the service-delivery narrative was where we, as a provider, could tell the story of the difference the service made for the whānau. The annual audits added stress, as they were a non-Māori

tool used to exit contracts rather than for quality improvement. The tool did not value te ao Māori and kaupapa Māori models of care. I commend the great Māori health leaders in kaupapa Māori health providers who created a collective of kaupapa Māori providers and continuously adjusted to kick goals through the ever-changing goalposts the Crown posed. In doing this, the collective of providers continues to deliver kaupapa Māori services and gain outcomes for whānau (extended family) in the communities they serve today.

I then moved onto the District Health Board, and a whaea (aunty) who worked there said to me, “Don’t go over to the dark side, they won’t look after you”. Another whaea who worked for a kaupapa Māori provider said, “I hope you rattle some cages over there”. Both whaea shared the institutional racism they had seen throughout their own professional health journeys.

I was part of the District Health Board’s Kaupapa Māori Strategy, Planning and Funding team, which contracted with and maintained relationships with kaupapa Māori providers and influenced change internally through the provision of kaupapa Māori tools and education on te ao Māori. This went some way to better tendering of services and understanding kaupapa Māori. However, it was not far enough, given a predominantly Pākehā board, executive team, and managers. The District Health Board continually developed services for tender based on statistics that described differences between Māori and non-Māori, but without engaging Māori to design the services. This resulted in poorly designed delivery contracts. However, kaupapa Māori providers were creative and worked outside the contract to achieve the outcomes required for whānau.

The District Health Board continued to request report information that lacked the true essence of the difference the service had made for whānau, from kaupapa Māori providers. In addition, it took years for the District Health Board to trust that a kaupapa Māori provider could deliver services that the District Health Board had previously delivered. For example, when I was leading the devolution of services from the hospital to kaupapa Māori primary care, there was criticism from Pākehā colleagues about their perceptions of kaupapa Māori providers’ ability to deliver a culturally appropriate hospital-based service in the community. My colleague believed that the kaupapa Māori provider needed to pick up the current service and deliver it in the same way it was delivered from the hospital base. They did not consider that the kaupapa Māori provider could do things differently and provide better services from the community base. These colleagues saw the District Health Board’s approach as superior and giving up the power of defining a service was a real struggle for the Crown organisation. This demonstrated the initial resistance from the District Health Board to devolve the services,

followed by an overly prescriptive contract to ensure the same delivery of the hospital-based service in the community.

Over the subsequent six years, I then moved to work in two Primary Health Organisations (PHOs): one non-Māori and one kaupapa Māori. The purpose of these organisations was to strategically and operationally support general practices and health providers to deliver services to their communities. I found it easier to effect change for Māori at this level as we were one step removed from the District Health Board (a Crown organisation). However, we still received Crown funding from the District Health Board and the Ministry of Health. Hence, the tendering, contracting and reporting processes remained the same. During my time with the non-Māori PHO, the District Health Board decided they wanted fewer Primary Health Organisations and pushed for mergers to cut costs. The District Health Board disregarded that relationships and partnerships with rural iwi providers, kaupapa Māori providers, and general practices took time to build and were delivering good outcomes for Māori communities. The District Health Board's push was for a cost-saving approach over a health benefits approach.

During my time at the kaupapa Māori Primary Health Organisation, the District Health Board began to listen and issued a tender for an integrated primary mental health service, that invited collective approaches with iwi or kaupapa Māori leadership. However, the tender rules still required the use of various non-Māori providers for some aspects of delivery. For example, specific training was to be delivered by a national non-Māori provider, therefore, taking the decision-making away from the iwi or kaupapa Māori collective; elements of power and control remained with the District Health Board.

I then joined a Crown entity that had envisioned making a positive change for Māori by creating an executive Māori role to lead change and bring about strategic equity. Existing Māori advisors to the Chief Executive, and the Chief Executive at the time, had good intentions to transform outcomes for Māori through this new role. However, not all the senior leadership team agreed. Whilst some wanted to make a change for Māori, they did not know why or how. There were questions like, "Doesn't this divide us as a race?" Therefore, at the senior leadership table, I had to constantly challenge colleagues' thinking and decisions, as Western thought was the dominant norm. For example, the collection of organisational data was not sufficient to show how we, as an organisation, were making a difference for Māori and Pasifika populations. The organisation had decided what data was necessary to collect and neglected good data about ethnicity.

I was the only Māori executive at this time within the Crown entity. I worked with two other senior executives who supported equity, so I was not that lone, annoying voice constantly challenging the decision-making. At this level, it helps to recruit other Māori who bring a te ao Māori and mātauranga Māori (Māori knowledge) to the discussions. However, it does feel like whenever you open your mouth, their eyes say, “Here we go again.” On the other side of this, every thought or decision made by the Māori team required explanation or education at senior leadership and throughout the organisation. For example, the creation of a Māori outcomes framework with Māori engagement was a great start in helping the organisation measure what matters to Māori. However, the feedback gathered throughout the engagement process went beyond the creation of a framework. It was also about how the organisation had not listened to Māori in the past. This rich information provided a place to work through. However, it was personally difficult for Pākehā leaders to hear and address because of the way the organisation needed to change. Throughout the creation of the Māori outcomes framework, the kaupapa Māori team was slowly embedding small change within the system and its processes. In parallel, my team worked with a kaupapa Māori consultant to begin changing mindsets and behaviours by engaging willing colleagues and staff across the organisation to apply an equity lens to their work. For example, a policymaker designing a policy was supported to consider the impact it may have on Māori. Resulting in the policymaker engaging with Māori to design the policy. This two-pronged approach began to gain traction within the large Crown entity.

The Crown entity tended to procure services from large national or regional providers rather than smaller local providers, as the Crown entity believed it was easier to manage a single large provider. The issue was that the large providers were all non-Māori providers. This approach overlooked smaller kaupapa Māori providers who were well connected to the community and instead relegated them to subcontractors under a large provider contract. The issue with being a subcontracted provider was that they were unable to control the resources to support the clients. Kaupapa Māori providers required additional funds to support referred clients who needed time to build rapport and gain trust through whanaungatanga (establishing relationships). This element of care was not built into the contracts, as the value placed on te ao Māori by the large national or regional non-Māori providers and the Crown entity (funder) was minimal. It was a one-size-fits-all approach nationwide.

Further difficulties emerged when the Chief Executive, who had created the executive role and championed change, left. This changing of the guard had a huge impact on embedding change for Māori, it was literally 10 steps forward and 100 steps back. For example, re-education was required, not only about why we are doing it this way, but providing an understanding of te ao

Māori and the importance of mātauranga Māori. For me, this change emphasised the importance of embedding change within the system and its processes, and of working in parallel on mindsets and behaviours that drive the organisation's decisions.

My team and I decided the best way to anchor in transformation was to build a foundation by creating a new strategy grounded in the principles of Te Tiriti o Waitangi. The strategic goals were explicitly dual-ethnicity-focused (Māori and other). They articulated the shifts the organisation needed to make to achieve the goals over the strategy period. Previous feedback received through the development of the Māori outcomes framework (as mentioned above) and further engagement with Māori were utilised to develop the strategy. The challenge from the Pākehā executives and other organisation leaders was constant. “Why, won’t this divide us?”, “I don’t understand it”, “How do I fit in?” It took serious time to educate Pākehā on the importance of embedding the principles of Te Tiriti o Waitangi and the dual-ethnicity focus.

Due to the institutional racism that I had experienced and observed, I was motivated to understand and examine institutional racism within the health system, including understanding how to move beyond institutional racism. I started my doctorate while I was the Chief Executive of a Primary Health Organisation, and started out by wanting to research a Crown entity and apply Critical Tiriti Analysis (Came et al. 2020) on the legislation that governed the organisation and its key strategic documents. I also wanted to understand from Māori leaders about their experience of institutional racism and solutions to move beyond it. A Crown entity was selected, and I subsequently started working for them. However, I could not pursue this approach as the Chief Executive thought my doctorate, with the position I held in the organisation, would bring reputational damage to the organisation. She chose to view my research as a kind of whistleblowing exercise, instead of embracing the potential findings to effect change for Māori. I felt like I had been silenced, so I adjusted my approach to my doctorate by removing the Crown entity and Critical Tiriti Analysis aspects to centre myself in te ao Māori by critically focusing on manukura Māori experiences of institutional racism within primary healthcare and solutions towards moving beyond institutional racism.

1.4 Definitions

This section provides definitions, within an Aotearoa context, that are important for establishing a common understanding of how I use these terms in this thesis.

1.4.1 Te Tiriti o Waitangi (The Treaty of Waitangi)

Aotearoa is governed by the Crown (government) and is made up of Indigenous peoples of the land (Māori), and tauiwi (non-Māori). The founding document of the colonial state of New

Zealand is te Tiriti o Waitangi, which was signed in 1840 between representatives of the British Crown and representatives of Māori iwi (tribes) and hapū (sub-tribes). Te Tiriti established a relationship between the Crown and Rangatira (Māori Chiefs) and conferred a set of rights and obligations on each Tiriti partner. There are two versions of Te Tiriti, the English and Māori texts, with some disagreement between the two versions. Both versions of Te Tiriti consist of a preamble and three articles. In summary, from the Māori text the intent of the preamble is about securing tribal rangatiratanga and Māori land ownership. Article one: Māori gave the British kawanatanga, which is the right of governance; Article two: Māori use the word rangatiratanga to promise to uphold the authority that tribes had always had over their lands and taonga (emphasising status and authority). Article three: the Queen agrees to give Māori the same rights and duties of citizenship as the people of England (emphasising equality and equity) (Waitangi Tribunal 2025). The Human Rights Commission (2025) described Te Tiriti as New Zealand's unique statement of human rights that incorporates universal human rights and Indigenous rights.

1.4.2 Kaupapa Māori Hauora (Health) Provider

Kaupapa Māori hauora providers are not-for-profit organisations that deliver health and wellbeing services steeped in Māori values, knowledge and culture. They are governed and led by Māori, offering holistic care through whānau-centred care.

1.4.3 Iwi (Tribe) Provider

In the context of this research, an Iwi provider delivers health, social and other services that support the sustainability of the iwi and hapū communities and whānau. They are governed and led by iwi with the services steeped in iwi values, knowledge and culture. The health provider is usually an arm of the main iwi organisation.

1.4.4 Crown entity or Crown organisation

A Crown entity or Crown organisation is a public sector organisation operating at arm's length from the government to perform public services and functions. The establishment of these organisations are under the Crown Entities Act 2004 (Parliamentary Counsel Office, 2004), for example, the District Health Boards. After the 2022 health reform, Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Māori Health Authority) were established under the Pae Ora (Healthy Futures) Act, 2022, replacing the District Health Boards. Te Aka Whai Ora was then disestablished in 2024 (Pae Ora (Disestablishment of Māori Health Authority) Amendment Act, 2024). Another example is the Accident Compensation Corporation, established under the Accident Compensation Act 2001 (Parliamentary Counsel Office, 2001).

1.4.5 Non-Māori organisations

In the context of this research, non-Māori organisations are Pākehā-governed and led health organisations that can be national, regional or local. Primary Health Organisations that are Pākehā-governed and led are examples of non-Māori organisations.

1.5 Overview of the problem

Māori have the right and potential to live a healthy life in Aotearoa. However, Māori are significantly over-represented in many health indicators and outcomes compared with non-Māori populations. The *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019) identified health inequities as a longstanding problem, evidenced by statistical trends in Māori health from 1990 to 2015. This report highlighted concerns about the persistent Māori health inequities and the New Zealand Government's failure to address them. Whilst there have been some improvements for Māori, the overall disparity in health outcomes between Māori and non-Māori remains. Years later, the *Tatau Kahukura: Māori Health Chart Book 2024* (Ministry of Health, 2024) highlighted that Māori still have higher rates than non-Māori for some health conditions and chronic diseases, such as cancer, ischaemic heart disease, diabetes, asthma and cardiovascular disease, and experienced racial discrimination in the health system.

Institutional racism contributes to health inequities between Māori and non-Māori (Paradies, 2006; Kidd et al. 2022). The impact of institutional racism contributes to poorer health outcomes, undermines equitable service delivery, and detrimentally impacts the Indigenous workforce (Talamaivao et al., 2020). Racial discrimination is asserted as a critical determinant of health (Talamaivao et al., 2020).

The *Puao-te-Ata-tu (Day Break)* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988) described the failings of non-Māori social services to meet the needs of Māori. The failings resulted from inadequate systems underpinned by colonisation, structural inequity, and racism. This report represents the first officially published recognition of the need for a significant overhaul of organisational policy, planning and service delivery.

Kaupapa Māori providers and health leaders continually battle the primary care and health system to achieve equitable health outcomes for Māori. The Crown-led health system decides who gets what resources, resulting in an unequal distribution that fails to focus on where Māori needs exist. For example, successive New Zealand governments ignored the evidence for lowering the age for bowel screening for Māori, which is detrimental to Māori lives (Scott et

al., in press). The following chapters explore in more depth the problem of institutional racism and its solutions, through literature and the eyes of manukura Māori.

1.6 Questions and aim

The questions that this research sets out to address are:

- How does institutional racism manifest in policy and practice within the primary healthcare sector?
- How can the primary healthcare sector move beyond institutional racism at a strategic level?

1.7 Overview of the approach

This research aimed to find solutions for Crown and non-Māori organisations to disrupt and eliminate institutional racism at a strategic level within primary healthcare. The strategic level refers to the levels within an organisation, such as governance, management and operations, that defines and delivers the organisations strategy and goals.

The research utilises kaupapa Māori as the standalone approach. It incorporates kaupapa Māori methodology, philosophy, theory and practice. Kaupapa Māori has its own culturally based epistemology to conceptualise Māori philosophy and practice. It includes appreciating what has gone wrong in the past and the transformation needed, through critical reflection (Smith, 2015). Furthermore, kaupapa Māori decolonises Western ways of knowing by talking back to power, viewing the Māori world and analysing Māori experiences through a shared way of thinking that reflects Māori (Smith, 2021; Pihama, 2001; Wilson et al., 2021). Kaupapa Māori privileges, values, and normalises te ao Māori, including te reo (Māori language) and mātauranga Māori.

Manukura Māori were invited to wānanga or hui to share their knowledge, experiences of and solutions to move beyond institutional racism. This kōrero (discussion) was captured through pūrākau, which is a form of Indigenous storytelling. The wānanga and hui enabled the capture of collective pūrākau that incorporated the past, explored new knowledge, and contributed to solutions for moving beyond institutional racism.

1.8 Scope of the research

To support you, the reader, with an understanding of the scope of my research and the layout of the chapters that follow, I have provided a brief description of the arrangement of this thesis.

1.8.1 Scope

It has been necessary to set clear boundaries in establishing the scope of this research. The health system has many forms and facets of racism. Therefore, narrowing the scope was important to enable a deep look at the problem of institutional racism within primary healthcare. This research specifically focuses on the expertise and experiences of manukura Māori within primary healthcare, from governance to management. The manukura have a range of experiences that go beyond primary healthcare and healthcare in general. Some of their experiences outside healthcare are mentioned. However, the scope of this project is within primary healthcare. The focus of the research is moving beyond institutional racism, achieved through the voices and experiences of manukura Māori who lead (or have led) kaupapa Māori providers or iwi providers, and/or have led or worked for Crown health or health-related organisations.

1.9 Thesis structure

1.9.1 Background – Chapter One

I have used this chapter to describe who I am by including my whakapapa, whakatauākī, and whānau waiata (family song) to position myself within the research context. I capture my drive and passion for transformative change and share my own pūrākau of my experience of institutional racism as a Māori leader within healthcare and Crown organisations.

1.9.2 Racism – Chapter Two

This chapter introduces the concept of race and the evolution to racism. Then it goes on to describe racism in general and the different forms of racism, such as structural, systemic, institutional, interpersonal and internalised. The chapter also highlights the relationships between the types of racism.

1.9.3 Literature Review – Chapter Three

The literature review chapter describes the literature search strategy that included criteria around racism and its origin: structural racism, systemic racism, institutional racism, interpersonal racism and internalised racism. In addition, there is criteria for racism in the public sector as defined, how it manifests, the policy and practice context at a strategic level, its disruption and elimination, the impact of institutional racism, the experience of institutional racism and racial equity. International institutional racism and institutional racism within primary care (community) and secondary care (hospital) were also included. The search excluded institutional racism outside of the health sector, for example, the education or justice sectors. The strategy then identifies the themes relevant to the kaupapa of institutional racism.

I began with a review of the international literature that highlighted institutional racism from an Indigenous perspective, then moved on to literature from Aotearoa that addressed Māori issues.

1.9.4 Methodology and Research Design – Chapter Four

This chapter provides my reasoning for choosing kaupapa Māori as my research methodology, for privileging manukura Māori voices, and for ensuring the value for Māori, by Māori, and with a Māori approach which underpins this research. The chapter illustrates the whakapapa methodology, including methodologies that inform kaupapa Māori, such as critical theory and constructivism. It then outlines the method used through wānanga and hui, the participants involved, the engagement, data collection and analysis, and ethical considerations. It also includes Māori data sovereignty and reflexivity.

1.9.5 Findings – Chapter Five

The key focus of this chapter is to privilege Māori manukura voices and hear their kōrero. The chapter is presented in two parts, with Part One presenting the findings of institutional racism through the eyes of manukura Māori. Three pūrākau discuss the manukura experiences of institutional racism and their thoughts on solutions about moving beyond institutional racism. Part Two presents a further review of the findings to highlight their significance and the impact on Māori.

1.9.6 Discussion – Chapter Six

This chapter discusses the kaupapa Māori research journey I have taken. It summarises the key findings, drawing on the three pūrākau from Chapter Five. It then moves on to a discussion of how to move beyond institutional racism, ending with a focus on the strength, resilience, and resistance of manukura Māori.

1.9.7 Conclusion – Chapter Seven

The conclusion chapter brings together the research journey to include a concluding statement, the learnings from my research, key points to move beyond institutional racism, and ending with the celebration of the strengths and innovation of the manukura Māori.

1.10 Conclusion

The purpose of this chapter was to provide an overview of the problem, to set the scene for why this research has been conducted, and to introduce the research aim and questions it looks to address. This chapter also seeks to introduce me as the researcher, including my whakapapa and how I have positioned myself within the research context through my pūrākau.

The following chapter will provide a deep dive into racism, including the concept of race and the evolution to racism, describing racism in general and the different forms of racism, such as structural, systemic, institutional, interpersonal and internalised.

2 RACISM

2.1 Introduction

In this chapter, I begin by introducing the concept of race and the evolution of racism. According to the United States Human Rights Careers (2024), the concept of race developed during the transatlantic slave trade in the 1600s. Europeans and Americans used race to justify slavery and, through this practice, created a racial hierarchy that put white people above black people.

The Linnean Society of London (2025) found that racism dates back to the 1700s, and in 1735, Carl Linnaeus discusses the systems of nature, where he divided the world into kingdoms, such as animal (including humans), plant and mineral. Prior to Linnaeus's inclusion of humans in the animal kingdom, humans were seen as separate with some believing that God created humans as higher beings. Linnaeus challenged this concept using the bodily difference between man and ape and, therefore, included humans in the animal kingdom. He then classified humans into four varieties, such as European white, American reddish, Asian tawny and African black, which corresponded with the four continents of the world known at that time. Some years later, in 1758 he added attributes to the varieties, such as physical traits relating to hair colour, eye colour, facial traits, behaviour, manner of clothing and form of government (governed by religion, traditional practices, opinions or by choice), to name a few. Through Linnaeus's observations of the human varieties, he consistently moved them, creating superiority between the varieties with the European white at the top. The African black remained at the bottom of the hierarchy; the descriptions of African black were the most derogatory and the associated negative moral and physical attributes were wedged into societal thinking. Linnaeus's work was described as scientific racism that used science to justify racism, further embedding the foundation for racism.

Furthermore, the concept of race was evident in Charles Darwin's work on evolution, which was influenced by scientific racism, whereby he proposed a hierarchy of people based on race with his work extending to all people. The hierarchy was ranked on their degree of civilization, with Europeans considered more advanced. The foundation of his research is that race was based on natural selection, where characteristics are passed from parents to offspring. The characteristics, the ability to adapt to the environment and compete for limited resources, means that these people are most likely to survive and reproduce. His work evolved over time through incorporating DNA and genetics to link his work to how traits were inherited (Darwin, 1859). Similar to Linnaeus, Darwin proposes a hierarchy of people based on race, with whites as the superior race.

Moreover, Back and Solomos (2009) highlighted that the study of race as a social issue traces back to the early twentieth century, particularly in America. Back and Solomos begin with discussing a prediction made in 1903 by Du Bois, a black American scholar, that the problem with the twentieth century is the problem of the colour line, from darker to lighter races, referring specifically to Asia, Africa, America and Islands of the sea (distant lands or people). The colour line in this context was based on institutional patterns of racial domination. Back and Solomos also describe a black British scholar, Hall in 1993, who asserted that the capacity to live with difference is the question of the twenty first century, as racial categories constantly evolved and changed due to the increasing diversity, social experiences and cultural identities. Changing language over the last two decades, used to describe race and ethnicity, has evolved due to the debates about the analytical status of race and racism and through the shifts in political and policy agendas. Back and Solomos (2009) studies then found that racism was used to analyse race in Britain and the rest of Europe through looking at the role of political, class and ideological relationships that shaped the understanding of racial conflict and change in societies.

Racism was evident through Rex and Tomlinson's (1979) research in Birmingham, where there was a class structure. White workers were granted certain rights and made significant gains in employment, education and housing. Whilst migrant (non-white) workers were placed outside of the working class and known as the 'underclass'. The concept of underclass was where non-whites were systematically disadvantaged when compared to their white peers, and they became a separate underprivileged class.

Racism dates back to the 1600s and has evolved over time to include the language used to describe racism. What has not changed is the structuring of race where whites are at the top of the hierarchy and blacks are at the bottom of the hierarchy. This chapter describes racism in general and the different forms of racism from the literature review, such as structural racism, systemic racism, institutional racism, interpersonal racism and internalised racism and settles on the terms that will be used in this thesis.

2.2 Racism

The evolution of racism as described by Linneaus and Darwin continues to impact the practice of racism today through its hierarchical structuring of race. Even after the United States abolished slavery (Britain had already abolished slavery) in 1864 through the transatlantic slave trade, racism was not over. White people saw themselves as superior to black people,

and this thinking flowed into policies and regulations (United States Human Rights Careers, 2024).

Through Paradies' (2006, p.2) examination of racism, it is described as an "intertwined concept of privilege and oppression" within a societal system in which people are divided along socially constructed dimensions. The power to make decisions (power over others) is unevenly distributed or produced along these dimensions. The societal system is based on worldviews concerning differences between groups and is embodied in beliefs, attitudes, behaviours, laws, norms and practices. Paradies (2006, p.3) goes on to say that a dominant racial group, such as white people, generally "has more power than a subordinate racial group, such as Indigenous peoples".

The Australian Human Rights Commission (2024) described racism similarly to Paradies, in that racism is a process where systems, policies, actions and attitudes create inequitable outcomes and opportunities for people based on race. It occurs when individuals or institutions use this prejudice, through their power, to discriminate against, limit, or oppress the rights of others. Racism is included in laws, policies and ideologies that prevent people from experiencing dignity, justice and equity due to their racial identity. In addition to Paradies, the Australian Human Rights Commission goes on to say that communities can experience racism in many forms, as it shifts and evolves over time – for instance, the surge in anti-Asian racism during the COVID-19 pandemic. The United States Human Rights Careers (2024) organisation described racism as discrimination that is based on an individual's or community's race. It occurs when an individual, community or institution discriminates against someone due to their race or ethnic group, in particular a race or group that has been marginalised. The New Zealand Human Rights Commission (2024) described racism similarly to Paradies in that it stems from cultural and ideological beliefs, prejudice and bigotry. In addition, the New Zealand Human Rights Commission talks about colonisation that holds the Western European culture and society as superior, with Indigenous cultures such as Māori and other societies as inferior, untrustworthy, backward and dangerous. Therefore, racism functions as a means to excuse actions that exploit or damage Indigenous peoples from the perceived benefit of Western societies.

Furthermore, in Aotearoa, Harris et al. (2006) described racism as an ideology rooted in the belief that some racial groups possess inherent superiority over other races. They suggested that racism may be a 'major' determinant of health with significant health consequences. In examining racial discrimination and its relationship to health, it was evident that there was a strong association with various measures of poor health. Years later, Harris et al. (2012) further

investigated racial discrimination and its association with health measures. It was evident that there are stark ethnic disparities in the socioeconomic position and health. For example, Māori and Pasifika peoples experience lower life expectancy and health disadvantage across most morbidity and mortality indicators as compared to Europeans. In addition, Māori and Pasifika peoples experience disadvantage across socioeconomic areas, including education, housing, income, and employment.

Moreover, in Aotearoa, Reid and Robson (2007) go on to say that the concept of race is a simplistic presumption where a hierarchy consists of white people as superior and more advanced than black people.

> This idea of a hierarchy of different 'races', has long been discredited, yet the term 'race' still has popular usage even today, with expressions like 'race-based funding.' This return to discredited terminology suggests that the foundations of white superiority are still alive and well in our country today. (Reid & Robson, 2007, p. 4)

The Aotearoa Human Rights Commission (2024) stated that Māori encountered racism at their first contact with Europeans. Since signing Te Tiriti in 1840, tangata whenua (people of the land) have endured colonisation, racism and white supremacy that was often enforced by the rule of law, government-sanctioned violence and unjust legislation. According to Reid and Robson (2007), colonisation permitted the (mis)appropriation and the transfer of power and resources from Māori to newcomers. Salmond (2017) found that colonisation is premised on the notion of racism, positioning Indigenous peoples as 'other' or man-eating savages and who required the colonisers' paternalistic approaches. These approaches included the use of religion, such as Christianity, in that this religion was superior to Indigenous belief, and the need for 'good men' to civilise the heathens. The destruction of the Indigenous culture played out in various ways, to include annihilation and isolation (forced removal of people from their communities). Also, through assimilation (making Indigenous peoples the same as the settlers and colonisers) activities underpinned by claims that these savages needed taming (Salmond, 2017). The systems created by newcomers, based on new values, enabled this determination of resource allocation, resulting in who would benefit and be privileged.

> Through this process Māori move from being normal to being 'different' from Pākehā, non-Māori, non-Indigenous norms. Māori rights as tangata whenua are appropriated as we become marginalised, reclassified and scrutinised as 'outsiders.' (Reid & Robson, 2007, p. 1.)

In the 1980s, Crenshaw (1989) claimed that intersectionality provided another lens to racism that looked specifically at where the power intersects through combined effects of discrimination of racism and sexism. She talked about how cultural patterns of oppression are interconnected and shaped by intersecting social systems such as ethnicity, race, gender, ability and class. For example, black women or women of colour may experience discrimination and racism, although the experiences of discrimination will be different for white women, and the experience of racism will be different to a black man. Black women experienced combined effects of discrimination and racism, which marginalises them even further.

> Black women can experience discrimination in ways that are both similar to and different from those experienced by white women and black men. Black women sometimes experience discrimination in ways similar to white women's experiences; sometimes they share very similar experiences with black men. Yet often they experience double discrimination, the combined effects of practices which discriminate on the basis of race, and on the basis of sex. And sometimes, they experience discrimination as black women, not the sum of race and sex discrimination, but as black women (Crenshaw, 1989, p. 149).

Intersectionality is a complex concept that refers to the intersection and compounding of forms of oppression. Similarly, through Paradies' (2006) examination of racism, he found that individuals can be affected by different types of oppression; for example, a white woman may be positioned as oppressed in terms of sexism but positioned as privileged in terms of racism. However, white women can also experience poverty, low levels of education and significant income inequities (Paradies, 2006).

There are similarities across all the authors' descriptions of racism, with Aotearoa specifically referencing colonisation, and Paradies' description comes from analysing a number of descriptions of racism over time. Paradies specifically calls out dominant racial groups, such as white people, who generally have more power over Indigenous peoples. Crenshaw brings to light the intersectionality of discrimination and racism that can have a greater level of impact on black women and women of colour. Harris touches on racism as a determinant of health and its impact on poor health for Māori and Pasifika peoples. Thus, creating the racism that I can see today, as evidenced through the inequitable health statistics when comparing Māori with non-Māori.

It is important to understand the origins of racism. The rest of this chapter highlights the whakapapa (layers) of racism, starting from structural and systemic to institutional, and on to interpersonal, then finishing with internalised racism where individuals embrace the dominant culture, often to their detriment.

2.3 Structural Racism

Sumibcay (2024) examined structural racism as the fundamental cause of health inequities among Māori and other Indigenous peoples (native Hawaiian, Pasifika peoples in the United States and Aotearoa) and defined it "as a system of institutions, ideologies and processes that work together to generate and perpetuate racial and ethnic inequities" (p.2). Scott et al., (in press) took this further, they described structural racism within the Aotearoa health system as normalising historical, cultural and institutional practices. These practices benefit dominant cultural practices (described as white by the authors) and disadvantage people of colour, thereby making whiteness both central to society and invisible to advantaged observers. This structural racism establishes and reinforces the unequal distribution of resources, as well as the attendant socio-culturally embedded justifications for such inequalities (Scott et al., In press).

Marmot (2005) commented that inequalities stem from the social determinants of health and these are premised on who receives what resources, which are socially determined. He related policy decisions by policymakers in health and other public sectors to inequalities. This is due to public policies that affect health not benefiting those who are disadvantaged as evidenced through the health status across various countries. In essence, Marmot is expressing that public policy both nationally and globally, should change to address the evidence on social determinants of health. Similarly, and some years later in Aotearoa, Harris et al. (2012) found that racial discrimination impacted health through socially determining the allocation of resources. Harris refers to this as the structuring of societal resources and health determinants, such as education, employment and housing, by ethnicity. Racial discrimination also influences access to healthcare and the quality of healthcare received, leading to poorer health outcomes (cardiovascular disease, smoking, mental and physical health) for Māori and Pasifika people. Racial discrimination, combined with socioeconomic differences, appeared to account for much of the health inequalities between Europeans and Māori (Harris et al. 2012).

Sumibcay and Scott's descriptions also aligned with Jones' (2000) description of structural racism in the United States, noting that this is not unique to the United States. Jones described the structures of institutions that have set customs, practice and law that perpetuate historical injustices. Like Marmot (2005) and Harris (2012), Jones (2000, p.1) went on to say that "the

association between socioeconomic status and race in the United States has its origins in discrete historical events but persists because of contemporary structural factors that perpetuate those historical injustices". In other words, it is because of institutionalised racism that there is an association between socioeconomic status and race in this country.

Jones uses an analogy of "flower boxes" with the structure of two flower boxes that contain different soils, one has rich soil and the flowers flourish. The other box has poor soil, and the flowers do not flourish, some die young thus highlighting the importance of the environment and who creates it. The 'environment' relates to the points from Scott et al. (in press) above regarding the unequal allocation of resources. Jones (2000) also refers to structural racism as unseen by many. The 'many' referred to are the non-Indigenous settlers and those who have experienced colonisation-generated internalised racism, including Indigenous peoples. Internalised racism is where individuals embrace the dominant culture and devalue or reject their own culture to reflect systems of privilege (Jones 2000). This concept is discussed more fully later in this chapter. Braveman et al. (2022) described structural and systemic racism as often being invisible to at least those who are not its victims. In Jones' paper, the creator of the environment is the United States government, however, she notes that government are not the only entity that makes decisions to support the ongoing privilege of the dominant culture. The dominant culture includes the government setting up structures where institutions exist, and institutional racism comes into play through the institution's custom, practice and law. She goes on to say that when the government is not concerned with equity in their decision-making, the dominant race thrives whilst the minority races fail (Jones, 2000).

2.3.1 Neoliberalism

Monbiot and Hutchison (2024) described this concept of 'unseen by many' as neoliberalism, which was conceived and fostered as a deliberate means of changing the nature of power. Neoliberalism is an ideology with a central belief where competition is a path to social improvement where wealth will enrich us all (Monbiot and Hutchison, 2024). In contrast, neoliberals argue that seeking social outcomes through social programmes rewards failures and supports dependency. Any altering of the market allocation of rewards interferes with the emergence of natural order, and governments should eliminate obstacles that prevent the natural hierarchy of winners and losers that benefit individualism. This individualism is fundamental to the neoliberal narrative, where individuals are responsible and accountable for what happens to them. This is a significant factor when you are looking at why things do not change for those most in need, such as Indigenous peoples. For example, a key part of te ao Māori is the collective nature of people, contrasting with the dominant Pākehā (non-Māori) worldview of individualism. This collective approach is shared with Polynesian peoples

(Pasifika) across the world (Kernot 2007). In terms of 'enriching us all', neoliberalism has failed as the rich have grown richer, and the poor have grown poorer (Monbiot & Hutchison 2024). These neoliberal narratives have informed government thinking and practice even through governments change, essentially the neoliberal narrative continues to exist despite its cover being rewritten by various political parties (Monbiot & Hutchison, 2024).

2.3.2 Bureaucracy

The role of bureaucracy and bureaucratic practices contributes to neoliberal decision-making. According to Egeberg (2002), the bureaucratic structures of central government affect policymaking and decision-making. Structures can be cumbersome and not take into consideration the impact on people. Alornyeku (2011) found that bureaucracy negatively impacts the performance of central government through a disconnect between people and the decision-making due to bureaucratic administrative processes. Later, I provide an example of this behaviour through looking at practices performed by the government in Aotearoa in 2024.

In my view, structural racism sets the platform for racism and discrimination where monocultural decision-making inadvertently and sometimes deliberately marginalises those with the greatest need. The decision-makers such as the government and governing bodies, have the power to decide, the power to act and the control over the resources. Coupled with monocultural decision-making is the impact of political ideology where the tenets of neoliberalism, such as individualism and capitalism, create the setting for discriminatory policies that are made as they benefit the majority and marginalise those with high social and health needs by default. Humpage (2011) goes on to say that since the implementation of neo-liberal reforms in the 1980s, the New Zealand public do not appear to adopt neo-liberal ideology with the same enthusiasm as their political leaders and business elites. This is particularly pointed out regarding the user pays policy shift in education and health (Humpage 2011).

2.3.3 Aotearoa health setting

In an Aotearoa health setting this neoliberalism plays out through policies that create inequities for Māori. The *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019), and *Tatau Kahukura: Māori Health Chart Book 2024* (Ministry of Health, 2024) evidence this inequity. According to Hobbs et al. (2019), there is still a persistent health inequity between Māori and non-Māori populations. This raises questions of the effectiveness of policies to date and the calling for a revisit of the deep-rooted historical, cultural and systemic issues to then address inequities.

> Inequity in Aotearoa has been entrenched through colonisation, the ramifications of which have been passed to current generations. Māori have been politically, economically and socially undermined, leading to lower income and life expectancy, poorer education and health outcomes and stigmatisation within healthcare, among other consequences. (Hobbs et al., 2019, p. 1)

Even after evidence within 205 claims in 2019 as part of the Health Services and Outcome Inquiry (Wai 2575) that highlights the social and economic determinants of population health for Māori, the consideration of Māori health inequity through a sociopolitical context remains contentious (Hobbs et al., 2019).

In Aotearoa, Reid et al. (2000) extends the health issue through the lens of disparities by deprivation using nine variables that are measured within the New Zealand 1996 census. The distribution of Māori as an ethnic group is skewed towards the most deprived deciles, showing a distribution gap. Through further analysis, there is also evidence of an outcome gap, where health outcomes for Māori are different from non-Māori. For example:

> Overseas data on life expectancy at birth have demonstrated social class gradients with lower life expectancy among manual workers and increasing life expectancy for trades people, through to managerial and professional workers. This is also evident in Aotearoa with life expectancy at birth decreasing as deprivation increases. (Reid et al., 2000, p. 1)

Furthermore, Reid et al. (2000) found a gradient gap between ethnicity and increasing deprivation. It appears that increasing deprivation compounds the risk for Māori, whereas Pākehā do not seem to be subject to this effect. Reid et al. (2000) go on to say that Māori health development and disparities are interconnected. Therefore, there is a risk of vulnerability for those in deprivation who have special service provision by the government when there are government decisions to cut government expenditure in health and other relevant areas.

In my view, structural racism is a consequence and result of unequal decisions; policies and practices result in unequal rights to access and resources. It is evident that access and distribution of resources are designed to reach the majority and miss those with high needs, creating inequities.

Structural racism goes deeper than neoliberalism within government, the government formation can impact structural racism. In Aotearoa, the country is a democracy, and the people elect the government, giving them the power to decide, act and control the resources. However, there are complexities around government formation as people can elect a government but the government's formation, consequent use of power and decision-making, is not necessarily the government that people thought they had elected. For example, in Aotearoa in 2023 a coalition government went into power through the process of government formation. One of New Zealand's major parties, New Zealand National, required other parties to come into government with them to win the election and selected two minor parties, ACT and New Zealand First to form the coalition government. The minor parties received less votes, yet the parties are now in government. In addition to the formation of government, you could argue that the minority of the population who are Māori, will have the weakest voice in determining who governs Aotearoa. This is backed by Statistics New Zealand (2025) that estimated in 2023 the total Māori population in Aotearoa was 17.8% compared with the total non-Māori population of 82.7%. Māori are a young population compared to the non-Māori population, with 70.9% (of the estimated total Māori population) over the age of 15 years. The median age for Māori was 25.8 years for males and 27.9 years for females as compared to the national median age of 37 years for males and 39 years for females, as of June 2023. Furthermore, in the 2023 elections, of those who voted, 14% of Māori voted compared to 86% non-Māori (Electoral Commission, 2023) thus impacting on who is elected to government. It is important to note that voting is a right for everyone that is eligible, and not all people exercise their right to vote.

According to O'Sullivan (2022), cultural equality that brings Indigenous cultural perspectives and experiences of colonisation into policy discussion has often been couched as prejudice in Aotearoa and Australia. For example, a Labour Member of Parliament (MP) used the occasional Māori word during a campaign debate and received angry shouts from some in the crowd. The message was that the MP was not accepted there as a Māori person using their own language (O'Sullivan, 2022). O'Sullivan goes on to say that democracy exists because Māori think differently, and democracy is here to manage these differences. However, sometimes dominant populations use the democratic system to protect their own self-interest rather than accommodate the rights and interests of others.

Paradies (2006) described racism as a social system that is based on a range of social characteristics such as gender, age, class, sexuality, physical and mental ableness, nationality, criminality, religion, language/accent and so forth. As mentioned at the start of the chapter, the societal system divides people along these socially constructed dimensions, with

power unevenly produced or distributed among them. Therefore, racism is embedded everywhere, including how we live and function in our environment. People vote within this social system that embeds and engrains the dominant ideologies. In Aotearoa, it is a dominant cultural group that supports the superiority of white ways of thinking and behaving. Sometimes, people vote for change, giving little thought to the ideologies that underpin their votes, as votes can be based on how well people are liked. However, Paradies points out that when ideologies are embedded, they influence people's thinking. The people belonging to the dominant culture have removed or ignored Indigenous ways of doing, with their worldview being the norm of how things are done. This is evident in 1907 through the non-recognition of rongoā, a Māori healing method, where the Tohunga Suppression Act 1907 stopped rongoā healers from working as it was not recognised by Pākehā as a healing method (Jones, 2007). Voyce (1989) goes on to say that the Tohunga Suppression Act 1907 was in place to protect Māori health and wellbeing against tohunga (Māori healers) who were allegedly claiming to have supernatural power to cure disease. It is clear from this example that the Western biomedical stance prevailed during this period.

2.3.4 Health reform in Aotearoa

Ashton and Tenbensel (2012) considered New Zealand's health reform in the 1990s to be a radical, incremental, and often under-the-radar structural reform, established with little debate or public scrutiny. Since then, there has been a shift in the direction and performance of the public health system, with many changes to the roles and functions of agencies and service providers. The 1990s health reform shifted away from reducing health disparities and improving population health towards enhancing service providers' performance. Some years later, Lorgelly and Exeter (2023) critiqued this health reform from an equity perspective and found that through the numerous claims heard by the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575), that from 2016 onwards, the Crown had breached its obligations under Te Tiriti across the health sector. Thereby contributing to the pervasive and persistently poor health outcomes of Māori. Lorgelly and Exeter (2023) went on to say that during 2009 and 2017 under the National government, the healthcare system was largely untouched in terms of reforms, and it was significantly underfunded. This, coupled with structural and systematic racism across social institutions, has resulted in creating and exacerbating health inequalities due to inequitable access to healthcare.

In 2019, the Labour government initiated the New Zealand Health and Disability System Review to assess the state of publicly funded health and disability services. The review proposed reforming the health and disability system to ensure equitable health outcomes for all New Zealanders. Furthermore, in 2022, the Pae Ora (Healthy Futures) Act came into effect,

and according to the Ministry of Health (2024), the Act is a foundation for transforming New Zealand's health system, aiming to make quality healthcare accessible to everyone. Lorgelly and Exeter (2023) described the 2022 health reforms as hopeful in addressing inequities for Māori and Pasifika peoples. One of the features of the reform included the establishment of Te Aka Whai Ora (Māori Health Authority) to address Te Tiriti obligations of Māori self-determination (tino rangatiratanga). This organisation was a Māori-led Māori health agency that championed hauora Māori (health and wellbeing), commissioned healthcare through kaupapa Māori providers and worked in partnership with the newly established Te Whatu Ora (Health New Zealand) to address the health and wellbeing needs of Māori. There are other requirements of Te Aka Whai Ora to include monitoring outcomes to ensure the delivery of healthcare is delivered with a Te Tiriti lens, indigenising the healthcare system through growing the Māori workforce, creating iwi-Māori partnership boards that govern the determination of health priorities across localities (regions) and protecting, preserving and supporting rongoā Māori.

The task and challenge for Te Aka Whai Ora were enormous, and Lorgelly and Exeter (2023) pointed out that it required a paradigm shift in how healthcare is delivered, organised and commissioned for Māori. Russell et al.'s (2022) policy brief stated that the establishment of Te Aka Whai Ora was revolutionary. However, this must be coupled with revolutionary solutions, led by an indigenised workforce, that reclaim Indigenous knowledge as the pathway to self-determined health and wellbeing. The policy brief is clear that the reform cannot be more of the same for Māori, as using the same Western paradigm of health will fail to solve issues and continue to make them worse. Moreover, in 2023, the Labour government was overturned by the National government as, according to Harre (2024), they were unable to act on their mandate to create meaningful change, in such as the rising cost of living and strict COVID-19 policies, among other things. However, political ideology has driven this change in the current coalition National-NZ First-ACT government. The coalition government's decision-making appears to be anti-racist and anti-equity; this is their collective ideology. However, they have dismantled the Labour government's system to address equity for Māori. For example, and as mentioned above under the health system reform, Te Aka Whai Ora (independent government statutory entity) was established to manage Māori health policies, services and outcomes to better serve Māori and give expression to Te Tiriti o Waitangi (Ministry of Health, 2024). Systemic racism, as described further on, is about institutions and structures that fail to provide equal opportunities or adequate service provision to people because of their cultural or racial background. Therefore, the Labour government enacting this change to address equity for Māori goes against the colonial and neoliberal ways of thinking and encounters resistance by

the majority of the population as it is not the embedded colonial way of thinking or the way our social system currently works.

According to Tenbensel et al. (2023), since the 1980s, public policy has reflected and complied with the English version of the Treaty. Te Papa Tongarewa (2024) quoted from the English version of the Treaty that “Māori give the British Crown ‘absolutely and without reservation all the rights and powers of sovereignty’ over their lands but are guaranteed ‘undisturbed possession’ of their lands, forest, fisheries, and other priorities”, therefore supporting the notion of ongoing colonisation. It is only recently in 2023, under the Aotearoa health reform, that equity is being addressed for Māori and aligns to the Māori version of Te Tiriti. For example, integrating health and social services locally with Māori and community co-design has led to alignment with the Māori version of Te Tiriti (Tenbensel et al., 2023). In a health system context, the health reform was the Labour government’s mechanism for change, and Tenbensel et al. (2023) go on to say that the change was to address inequitable access to health services and inequitable health outcomes, particularly those affecting the Māori population. Māori experience significant social and health inequities due to the historical and ongoing impact of colonisation. The Wai 2575 Māori Health Trends Report (Ministry of Health, 2019) compared Māori with non-Māori for a number of health indicators from 1990 to 2015, which highlighted an increased overall disparity between Māori and non-Māori health outcomes. Colonialism continues in Aotearoa today as the non-Indigenous have embedded their worldview into Aotearoa, with the majority of the population consciously or unconsciously resisting change and supporting the worldview of the majority. This dominant worldview flows into institutions in the form of institutional racism, where resistance to change outside this dominant view is enacted.

Structural racism establishes a platform for other forms of racism, such as institutional, interpersonal and internalised racism. As described above, structural racism is where the dominant race, that is Pākehā in an Aotearoa context, holds the power and control to make decisions for all people through their worldview. More alarming is that the structural racism is unseen by many, including non-Indigenous settlers and those who have experienced colonisation-generated internalised racism, including Indigenous peoples. This resonates with me in explaining why structural, institutional, interpersonal and internalised racism still exist today. The racist platform is set through structural and systemic racism, and this then flows through to institutions that enable the racism further within the institution’s structures. This then flows on to interpersonal and internalised racism, where people act and behave in racist ways. Internalised racism reinforces structural racism, which in turn undermines social justice initiatives.

2.4 Systemic Racism

The Australian Human Rights Commission (2024) described systemic racism as the ways in which institutions and structures deny adequate services or equal opportunities to individuals from different racial groups or cultures. This occurs because historical forces, ideologies, cultural norms, and institutional polices interact in ways that continually reinforce inequity. Furthermore, in Canada, Sanzone et al. (2019) described systemic racism as the disruption of Indigenous traditions and practices by newcomers (non-Indigenous) through imposing their historic worldview through health policies and practices, and are seen as superior to Indigenous viewpoints. An example used by Sanzone et al. (2019) is where Indigenous healing practices are seen as inferior to the non-Indigenous policies and healthcare professionals' practices. This creates systemic issues in healthcare settings that negatively impact Indigenous people creating health inequities at the community and individual level.

Moreover, Banaji et al. (2021) looked at the challenges black Americans face and described systemic racism as an embedded system that shapes and limits life opportunities and outcomes according to race. From an Indigenous health perspective in Aotearoa, Hunter and Cook (2020) described it as an ongoing systemic undergirding of a largely monocultural healthcare structure where it is plagued with the rhetoric that 'diversity matters'.

According to Scott et al. (in press), systemic racism takes the form of inaction or omission in the face of need. For example, successive New Zealand governments have ignored the evidence that the age for bowel screening for Māori needs to be lowered, to capture a disease which is detrimental to Māori lives. This is an example of a one-size-fits-all decision-making process. In my view this is a form of systemic racism through an act of commission, through ignoring the evidence of bowel cancer mortality for Māori and, therefore, unfairly disadvantaging Māori.

According to Braveman et al. (2022), systemic, structural and institutional racism are closely related to both systemic and structural racism, sustaining white supremacy through deeply embedded laws, systems, written and unwritten policies, and entrenchment in its practices and beliefs that oppress people of colour, resulting in adverse health consequences. Braveman et al. (2022) state that structural and systemic racism are often used interchangeably, with the difference being in the emphasis. For example, systemic racism emphasises the involvement of whole systems, such as the justice, legal, political, economic, education and healthcare systems, to include the structures that uphold the systems. Whereas, structural racism puts the emphasis on the role of structures, for example, laws,

policies, entrenched norms and institutional practices that are the systems scaffolding. Furthermore, institutional racism captures the involvement of institutional systems and structures through oppression and race-based discrimination and can refer to racism within a particular institution. Berman and Paradies (2008) described systemic racism as institutional racism, where the control or production of, and access to resources within a society, serves to exacerbate or maintain the unequal distribution of opportunity across groups.

The difference between structural and systemic racism is that structural racism sets up the system that reinforces cultural, historical, and institutional practices that advantage white people (Sanzone et al., 2019), or is the system's scaffolding, (Braveman et al., 2022). Whilst systemic racism stems from the way institutions, structures, and policies work together to perpetuate inequity (Australian Human Rights Commission, 2024), it encompasses the entirety of the system, including its structures that uphold it (Braveman et al., 2022). In this research, it has been important to understand the differences and interactions among structural, systemic and institutional racism in order to explore potential mechanisms to move beyond institutional racism.

2.5 Institutional Racism

Jones' (2000) research in the United States defines institutional racism as differential access to the services, goods and opportunities of society by race. Institutional racism often manifests as an inherited disadvantage in material conditions, such as access to sound housing, quality education, appropriate medical facilities, a clean environment, and gainful employment, and in access to power, such as information, resources, and a voice (Jones, 2000). Institutional racism has also been defined as a social determinant of health and an underlying cause of ethnic inequities (disparities) in Aotearoa and internationally (Paradies, 2006). Kidd et al. (2022) described institutional racism as a key modifiable determinant of health in Aotearoa that contributes to health inequities, and asserts that workers, patients and their whānau experience racism within the health sector every day. In Aotearoa and for Indigenous peoples worldwide, institutional racism has been linked with the enduring and harmful impacts of colonisation through unequal treatment or discrimination based on race, one that is typically a minority or marginalised, arising from structures or systems (Reid et al., 2019).

In 1988, the *Puao-te Ata-tu* report (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988), reviewed the Department of Social Welfare in Aotearoa, bringing to the forefront a Māori perspective. Institutional racism in this report is described as the most destructive and insidious form of racism. It is the outcome of monocultural institutions that ignore and/or freeze out those cultures that do not belong to the

majority. The report recognised that a broader context of colonisation, racism and structural inequity underpinned the failing systems of state provision. Furthermore, the report found that national structures have evolved and are entrenched in their viewpoints, systems and values of a single dominant culture. Participation by minorities is conditional on their suppressing their own systems and values to align with those of the power culture. Boulton et al. (2020) share that three decades on, the *Puao-te Ata-tu* report is referenced within several government-initiated state sector system reviews. The report is credited for providing the foundation for the transformative change that is still required today. Every major state sector system review echoes the report with an overriding message that the same approaches will not produce different outcomes for Māori (Boulton et al., 2020). Through Scott et al.'s (in press) account of advocacy to address bowel cancer for Māori, it was evident that structural racism set up the belief that institutional patterns of racist behaviour are normal and acceptable. Scott et al. (in press) provided evidence that the current bowel screening programme in Aotearoa does not address the inequity faced by Māori, yet successive governments have ignored this evidence. Therefore, creating our healthcare structure is a consequence of a belief system that not only makes it okay to design inequities into the system but also requires it.

Institutional racism flows from structural racism, with the racist platform set by the ingrained white worldview from colonisation. This is then enacted through the government, which normalises Crown and non-Māori organisations to further enact and enforce institutional racism throughout their organisations.

2.6 Interpersonal racism

According to Jones' (2000) research in the United States, interpersonal racism was also described as personally mediated racism. Jones defined it as prejudice and discrimination that is both intentional and unintentional, including personal acts of commission as well as acts of omission. Prejudice is an individual's assumptions about others' abilities, intentions or motives according to their race (racial profiling), whilst discrimination is one's actions towards others according to their race (explicit racism) (Jones, 2000). It manifests as a lack of respect, suspicion, devaluation, scapegoating and dehumanisation and maintains structural barriers that are condoned by societal norms (Jones, 2000). The Australian Human Rights Commission (2024) described interpersonal racism as interactions between individuals that make negative comments about a particular ethnic group through racist name-calling, bullying, hassling or intimidating others because of their race. In the United States, Rodriguez-Knutsen (2023) took this description further to say that interpersonal racism occurs when racial bias consciously or subconsciously influences a person's interactions and perceptions of other people. This bias is often informed by misinformation and stereotypes and can range from microaggressions, to

the use of racial slurs, or even physical violence. Examples of this racial bias behaviour includes hate speech against a group of people or an individual; complimenting Indigenous peoples on their English assuming that they would not speak well because of their race; dismissing expertise as they take up non-Indigenous jobs; security guards or shopkeepers following Indigenous around assuming they are shoplifting; and excluding people from activities like renting a home because of their race. My research has found examples of this behaviour within the Aotearoa health system, specifically where access to resources or opportunities is removed or deemed unimportant by non-Indigenous people. Ochs et al. (2024) discussed how racism is a social determinant of health that contributes to preventable health disparities, which can result in health inequities, such as differences in health resources or health status across populations arising from social conditions. James (2021) goes on to say that the impact of interpersonal racism is associated with poorer mental and physical health outcomes among racial minorities.

In Aotearoa, Barnes et al. (2013), found that interpersonal racism flows on from institutional racism where the organisations condition's, policies, practices and processes continue to produce avoidable and unfair inequalities across ethnic groups. Then, at an interpersonal level, the many direct interactions between people across power differentials endorse and enact inequities that are a collection of the higher-level influences within organisations that reinforce and materialise their impact. Barnes et al. (2013) go on to share examples of interpersonal racism that Māori have experienced, to include those in power using a ‘divide and rule’ tactic where Māori are pitted against each other. Other examples include obtrusive surveillance of Māori families within shops; being judged for speaking te reo Māori; and giving your children Māori names. The impacts on health and wellbeing through the application of interpersonal racism experienced here has manifested in the form of anticipated stress, guilt, anxiety and distress (Barnes et al, 2013). In Australia, Wilkes et al. (2025) found that Aboriginal and Torres Strait Islander peoples experience interpersonal racial discrimination in everyday life and in healthcare settings. The impact of this racial discrimination is evident in almost all health and social outcomes to include reduced life expectancy, ill health, poverty and rates of incarceration. According to Harris et al. (2012), there is a link between racial discrimination and a range of health outcomes for different ethnic groups within various countries. Harris et al. (2012) goes on to say that in Aotearoa, the experience of racial discrimination was associated with a range of health outcomes and risk factors such as poor mental and physical health, cardiovascular disease, smoking and hazardous alcohol consumption. Twelve years later, Harris et al. (2024) found that racial discrimination combined with socioeconomic differences seemed to account for a significant amount of health inequalities between Māori and non-Māori.

Furthermore, Cormack et al. (2020, p.1) discussed that the "right to freedom from discrimination is recognised in international human rights documents and affirmed in legislation in many countries". However, "the lived experience of Indigenous peoples is that discrimination is a pervasive everyday experience".

2.7 Internalised racism

25 years ago, Jones (2000) defined internalised racism as an embracing of the dominant culture to include looking like the dominant culture, reflecting systems of privilege and societal values, devaluing oneself through the rejection of culture and accepting the negative messages regarding their own abilities and intrinsic worth that erodes an individual's sense of value.

> Internalised racism is defined as acceptance by members of stigmatised races of negative messages about their own abilities and intrinsic worth. (Jones, 2000, p. 2)

Some 20 years later, the Australian Psychological Society (2020) described internalised racism as resulting from racist stereotypes and ideologies from a dominant culture about one's culture, leading to self-doubt, disgust and disrespect for one's own culture.

In the United States, Pyke (2010) suggested that internalised racism is linked to oppression, where black Americans are born into a world where they see themselves through the revelation of the other world, which is a world where internalised white racism dominates. The black American experience of racial oppression is linked to internal racism described by the Aotearoa Ministry of Health (2024), where internalised racism is an individual's acceptance and internalisation of the dominant values, beliefs, stereotypes and attitudes about one's own race. In an example of the health consequences of internalised racism, Walker et al. (2022) found that the prevailing views of society led Māori patients to feel that they were undeserving of a kidney transplant and, therefore, they disengaged with the kidney transplant process. These patients had internalised the belief that kidney disease was a consequence of their lack of self-care and lifestyle, sometimes resulting in whakamā (shame).

2.8 Conclusion

This chapter highlights the relationships, interconnections and the cyclical nature of racism, demonstrating how structural, institutional, interpersonal, and internalised forms of racism interact in ways that enable, and at times normalise, racist behaviours, thereby reinforcing structural racism. Systemic racism creates a particular environment and is ingrained in the

environment that we live and function within, which is a dominant Western worldview, whilst internalised racism embraces the dominant culture where individuals operate according to the dominant culture. I liken it to ‘the way we do things around here.’ In this research on racism, it has been important to understand the definitions of racism to inform the scope of my research. I have settled on three types of racism such as structural, institutional and interpersonal racism to explore potential mechanisms to move beyond institutional racism.

3 LITERATURE REVIEW

3.1 Introduction

Te Tiriti (as described in Chapter One) is the founding document of Aotearoa and has informed the scope of this research in that it is important to understand racism and all its forms. Chapter Two discussed the origin of racism and described the many manifestations of racism, such as structural, systemic, institutional, interpersonal and internalised. This was from both an international and Aotearoa perspective and provided an example of institutional racism through examining the bowel cancer screening programme within the Aotearoa healthcare system today. This chapter goes on to explore the literature relating to the research focus of moving beyond institutional racism within primary healthcare in Aotearoa. Firstly, the search strategy is described, a background is presented, then the themes from the literature are presented: the impacts of institutional racism, how institutional racism manifests in policy, the experience of institutional racism by healthcare providers, and the impact of institutional racism within New Zealand's health system. Lastly, the chapter concludes with a discussion of the research gaps this project seeks to fill.

3.2 Search Strategy

Firstly, a literature search plan was created that identified inclusion and exclusion criteria which was crucial as it ensured I was using applicable literature for the research and that it was suitable for review. My inclusion criteria included international and national (Aotearoa) literature from 2000 onwards, around racism in the public sector, such as its definitions, how it manifests, the policy and practice context at a strategic level, its disruption and elimination, the impact of institutional racism, the experience of institutional racism and racial equity. Government reports on health data dated back beyond 2000 to ensure I could compare health data with new health data after 2000. International institutional racism and institutional racism within primary care (community) and secondary care (hospital) were included in the search plan. The search plan excluded institutional racism outside of the health sector, for example, education or justice sectors (Table 1, p. 34).

Table 1: Literature Review inclusion and exclusion criteria

Inclusion	Exclusion
Geographic: International and national (Aotearoa)	
Date: Articles from 2000 onwards and Government reports with open dates to	

Inclusion	Exclusion
ensure I could capture health data dating back beyond 2000, to then compare with new health data after 2000	
Indigenous participants	Any research involving non-Indigenous participants
Subject: Racism definitions, manifestation of racism, policy and practice context, disruption and elimination, impact of institutional racism, experience of institutional racism and racial equity	
Settings: Health settings (primary care – general practice, community and secondary care – hospital)	Settings: Private healthcare, education sector, justice sector and commercial sector
Grey literature: Government reports	Grey literature: Social media and other non-government sources

Secondly, I undertook a literature search during February 2021 and December 2024 using the following electronic databases: EBSCOhost, Google Scholar, CINAHL, Scopus and Business Source Complete. Search terms were derived from the critical ideas and included the following:

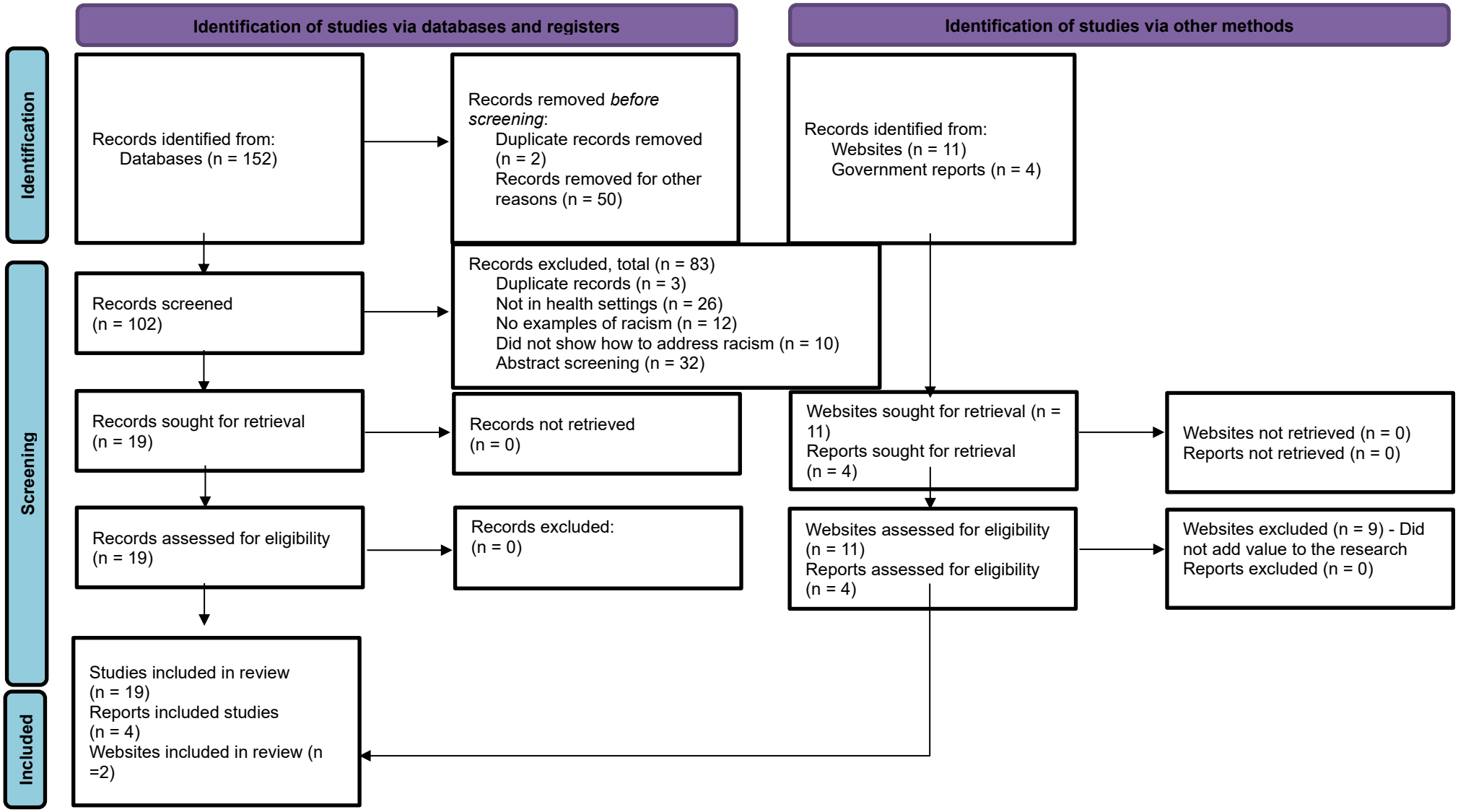
- institution OR organisation OR racism OR racist AND policy OR policies OR manifest OR strategy OR strategic;
- management OR manager OR strategy OR strategic OR institution OR organisation OR organization OR plan OR level OR planning OR policy OR policies;
- institutional racism OR systemic racism OR structural racism AND Māori OR Māori OR Indigenous AND impact OR effect OR influence OR outcome OR result OR consequence; and
- institutional racism AND healthcare OR “primary care” AND “New Zealand” OR Aotearoa OR NZ.

A combination of queries using Boolean strategies was used to find additional research. The searches were refined when other keywords from articles appeared such as 'racial equity' and/or if the searches were finding too many or not enough articles to consider. The search

resulted in 283 titles; however, a large number were excluded by title alone as they were irrelevant before I applied the inclusion and exclusion criteria.

Thirdly, abstracts and/or the full articles (a total of 19), government papers as these reports influence policy (a total of four) and websites (a total of two) were screened to determine their value and relevance to the literature search topics. Social media was excluded as it is difficult to assess for credibility. If the research was of value or relevant (a total of 25 across articles, government papers and websites) the PDFs and references were saved into Endnote. A total of 19 articles, two websites and four government papers were utilised for this literature review. Figure 1 demonstrates the literature papers identified from databases and other sources, the number screened for eligibility and the number of papers included and excluded (to include the reasons why) in this study.

Figure 1: Modified PRISMA flow diagram to illustrate literature search



Adapted from “The PRISMA 2020 statement: An updated guideline for reporting systematic reviews,” by Page et al. (2021), PLoS Medicine 18(3): https://doi.org.10.1371/journal.pmend.1003583

3.3 Background

The problem of racism in primary care for Indigenous peoples is an international one, where structures such as policy, processes, programmes and models of care generate racial disparities (Thackrah et al. 2021). Such structures exclude Indigenous models of health and healing methods, which signal a disinterest or even hostility towards Indigenous wellbeing, resulting in delays in seeking health assistance (Sanzone et al. 2019). Similarly, in Aotearoa the Western-biomedical administration and development of the health system (policy, processes and systems) has been identified by Hunter and Cook (2020) as a key contributor towards institutional racism through the exclusion of te ao Māori.

There is rich data in Aotearoa that evidences the health disparities between Māori and non-Māori. The *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019) highlighted concerns over persistent Māori health inequities and the failing of the New Zealand Government in addressing the inequities. The report presents statistical trends in Māori health from 1990 to 2015, comparing Māori with non-Māori across a number of health indicators. The indicators include three areas. Firstly, health indicators such as smoking, hospitalisation and mortality for adults aged 35 year and over are present in all types of cardiovascular disease, assault and homicide mortality for females aged 15 years and over, and asthma hospitalisation for those aged 5-34 years. Secondly, socioeconomic indicators, for example, school completion 15+ years, unemployed 15+ years, and receiving income support 15 + years. Lastly, racial discrimination that is self-reported, experience of any racial discrimination, ethnically motivated personal attack and unfair treatment based on ethnicity. The report shows that there have been some improvements in Māori health over time and that the inequity between Māori and non-Māori in some areas has narrowed, such as lung cancer registration and mortality rates, low birthweight rates, infant and child mortality rates and tuberculosis disease notification rates. Even though improvements for Māori may have occurred, there has been an increase in the overall disparity between Māori and non-Māori health outcomes. The report also highlighted some indicators that remain constant or have worsened over time, such as cardiovascular disease mortality rates and hospitalisation, youth smoking in girls, adults currently smoking daily, youth obesity, and self-reported experience of any ethnically motivated personal attack or unfair treatment based on ethnicity for those 15+ years, to name a few. Years later, the *Tatau Kahukura: Māori Health Chart Book 2024* (Ministry of Health, 2024) highlights that Māori still have higher rates than non-Māori for some health conditions and chronic diseases, such as cancer, ischaemic heart disease, diabetes, asthma, cardiovascular disease and experiencing racial discrimination.

There is also evidence that institutional racism contributes to health inequities between Māori and non-Māori in Aotearoa (Paradies, 2006; Kidd et al. 2022), as discussed in the previous chapter. According to Talamaivao et al. (2020), there are associations between self-reported experiences of racial discrimination and a wide range of health indicators, contributing to poorer health outcomes, reduced access to and quality of healthcare. Talamaivao et al. (2020) asserted that racial discrimination is an important determinant of health both in Aotearoa and internationally. Similarly, in Australia's healthcare system, Thackrah et al. (2021) found that the impact of institutional racism contributed to poorer health outcomes, undermined equitable service delivery, and had a detrimental impact on the Indigenous workforce. Furthermore, in Aotearoa, Harris et al. (2024) found that experiences of racism potentially lead to poorer healthcare outcomes through higher unmet needs, more negative experiences of healthcare and lower satisfaction with healthcare.

As discussed in Chapter Two, the report, *Puao-te-Ata-tu (Day Break)* (Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare, 1988) described the failings of non-Māori (dominant culture) social services to meet the needs of Māori. The failings were a result of inadequate systems underpinned by colonisation, structural inequity and racism. Highlighting the need for an overhaul through significant changes to organisational policy, planning and service delivery. According to Boulton et al. (2020) the *Puao-te-Ata-tu* provides the blueprint for how systems in Aotearoa can work towards fairness, justice and equity.

An example of a successful Māori led model of care in Aotearoa, that brings in Māori aspirations, worldviews and cultural practices is Whānau Ora (family wellbeing). In 2010, Whānau Ora was launched after extensive consultation with Māori communities across Aotearoa. Whānau Ora is an innovative approach to Indigenous health and social services policy in Aotearoa (Smith et al., 2019). It is a model of care that places whānau at the centre and empowers them to realise their own solutions towards wellbeing that are more holistic and culturally grounded (Accident Compensation Corporation, 2023). Whānau Ora supports self-determination with a Whānau Ora Outcomes Framework that sets the direction, identifies priorities and monitors progress of achievement towards improved outcomes for whānau (Te Puni Kōkiri, 2016).

> Whānau Ora puts whānau and families in control of services and supports the need to build on their strengths and achieve their aspirations. Whānau Ora uses a kaupapa Māori approach to improve the wellbeing of whānau as a group, addressing individual needs with the context of whānau or families and their culture. (Te Puni Kōkiri, 2025, p. 1)

In Aotearoa history, the Whānau Ora model was the first time a Māori worldview approach that looked to address social service delivery had been funded and implemented nationally. It is important to note there were many localised initiatives resembling Whānau Ora that paved the way

prior to the launch of Whānau Ora (Smith et al., 2019). Dame Tariana Turia was instrumental in establishing Whānau Ora politically through policy entrepreneurship capable of delivering major social value impacts for Māori whānau (Smith et al., 2019). Dame Tariana Turia said Whānau Ora was about empowering whānau to take control of their future (Te Puni Kōkiri, 2023).

The Whānau Ora approach has gained momentum, as evidenced by a programme, Ngā Tini Whetū, established in 2020. Three Government agencies and entities (Te Puni Kōkiri, Oranga Tamariki and Accident Compensation Corporation) collaboratively partnered with Te Pou Matakana the Whānau Ora Commissioning Agency, to provide additional early support to whānau across Te Ika-a-Māui (North Island) to strengthen whānau and improve the safety and wellbeing of children (Te Puni Kōkiri, 2021).

This approach moves beyond the monocultural organisations operating as barriers to progress for Māori (*Puao-te-Ata-tu)*. During COVID-19 it was evident that approaches such as Whānau Ora were successful as it was led by Māori, prioritising wellbeing. In their chapter about Whānau Ora more than four decades later, Smith et al. (2019) wrote that it remained clear to Māori leaders and policymakers that new ways or solutions that reflected Māori aspirations, worldviews and cultural practices were needed.

Aotearoa needs more self-determined approaches such as Whānau Ora, as institutional racism still exists in the healthcare sector today. The following literature review provides insights to move beyond institutional racism within primary healthcare through understanding the impacts of institutional racism, how institutional racism manifests in policy, the experience of institutional racism by healthcare providers and the impact of institutional racism within New Zealand's health system.

3.4 Findings

3.4.1 The impact of institutional racism in healthcare

The authors below described the impact of institutional racism in healthcare as detrimental to Indigenous peoples, whether they are the recipients of healthcare or the Indigenous workforce delivering healthcare.

Thackrah et al. (2021) found that the impact of institutional racism within the Australian maternity healthcare system contributes to poorer health outcomes for Aboriginal people (Indigenous to Australia), undermines equitable service delivery and has a detrimental impact on the Aboriginal workforce. The importance of cultural practices surrounding childbirth is often not recognised. There have been efforts to include Aboriginal content in training programmes for the workforce in an attempt to address health disparities experienced by Aboriginal people. However, there is little known about its application to clinical practice. Thackrah et al. (2021) identified that a focus on

institutional racism within education programmes alone will not address institutional racism as it stems from organisational procedures and policies that increase power differentials between racial groups. The focus must be on the structures such as processes, programmes and models of care that generate those racial disparities. These can include practitioners recognising the key indicators of poorer health outcomes and then implementing change within their healthcare organisation (Thackrah et al., 2021). The limitations of this research are that it has focused on the maternity healthcare system only. Further research could be done with other healthcare workforce areas within hospitals and in primary or community settings.

Sanzone et al. (2019) found that healthcare in Canada had been significantly impacted by colonisation with Indigenous communities citing their experience of prejudice and systemic racism within the healthcare setting. The hospital procedures and policies in conjunction with healthcare professionals' attitudes posed barriers to Indigenous healing methods. The impact of this approach resulted in delays in seeking health assistance with Indigenous peoples becoming critically ill. Sanzone et al. (2019) also reported a lack of cultural competency and safety, based on a survey of nursing students among some critical care settings (fast-paced hospital units) across Canada. Furthermore, the survey showed that the responsibility to gain an understanding of colonial history and its power imbalances was assumed to be the responsibility of the non-Indigenous nurses caring for Indigenous patients. Sanzone et al. (2019) found that key elements to improve Indigenous wellbeing are based on mental, physical, emotional and spiritual factors being in balance, which is inseparable from culture, family and community. However, healing practices that provide the wellbeing balance, such as ceremonies, counselling by community members and the wisdom of the community elders, are frequently marginalised and oppressed. In my view, institutional racism is apparent within critical health settings across Canada through the significant gaps in providing culturally competent healthcare. It is apparent that structures such as policies and procedures are required to incorporate cultural training programmes to ensure the importance of the Indigenous culture. The limitations of this research are that it has focused on some critical care settings only. Further research could be done within other hospital units and in primary care or communities.

Talamaivao et al.'s (2020) systematic review of quantitative research confirmed that in Aotearoa there is a consistent link between a range of poor physical and mental health outcomes for Māori, Pasifika and Asian ethnic groups, negative experiences of healthcare interactions, less access to healthcare, and the experience of racism. Furthermore, Talamaivao et al. (2020) argued that identifying and implementing policy interventions is required to address the irrefutable negative impact that racism has on health. The limitation of the research was that the findings did not include interventions to address the impacts of racism on health, instead it calls out the need for this research to be done. However, an advantage was that the review was not limited to a particular health outcome or condition.

In the international research both Thackrah et al. (2021) and Sanzone et al. (2019) found that by including cultural practices and methods within healthcare, it has had an impact on better health outcomes for Indigenous people. Both parties state that the focus needs to be on the structures (policies and procedures) that generate the racial disparities to include the responsibility of practitioners taking action. Similarly, in Aotearoa, Talamaivao et al. (2020) found a consistent link between a range of negative health measures for ethnic groups, such as physical and mental health, experiences of healthcare interactions and access to healthcare; and the experience of racism that may impact on ethnic inequalities. Furthermore, Talamaivao et al. (2020) found that policy interventions were needed to address the negative impact racism has on health. It is clear from the papers that to address institutional racism, policies and practices need to support cultural practice and methods coupled with education programmes for the non-Indigenous workforce to improve health outcomes for Indigenous people.

3.4.2 How institutional racism manifests in policy

In the United States, Bailey et al. (2020) described the manifestation of institutional racism in policy and practices goes all the way back to African enslavement. In 1933 federal government brought in policies to support racialised residential segregation, mass incarceration and police violence, and unequal medical care. The enduring racist cultural beliefs and practices were the basis of the unequal treatment. This was evidenced in 2016 through research that assessed racial attitudes where white medical students and residents had unfounded beliefs about intrinsic biologic differences between white and black people (Bailey et al. 2020). However, individual discrimination and prejudice alone did not drive substandard care. Segregated black neighbourhoods faced systematic disinvestment in private and public sectors resulting in under-resourced health facilities (Bailey et al. 2020).

Came (2014) examined how institutional racism in Aotearoa manifests in public health policy development and funding practice. This was inspired after dialogue with Māori who were concerned with the health system failing to meet their needs due to institutional racism or breaches of Te Tiriti. Came (2014) identified five forms of racism within health policy-making through counter-narratives from Māori leaders and a Pākehā. Firstly, decision-making in relation to setting the policy agenda in Aotearoa is through majoritarian decision-making (governed by or believing in decisions of the majority). Secondly, the privileging of biomedical Western evidence over Indigenous knowledge. Thirdly, influence is through the government officials writing and/or reviewing the policy to include variable political and cultural values and competencies. The fourth form of racism is during the development of policy; the consultation process is flawed as the wrong questions are often asked of the wrong people in the wrong timeframes. Finally, during the organisational signoff process, Māori and Pasifika content is masked or eliminated. In summary, the manifestation of institutional

racism in the healthcare sector is through decision-making practices, the misuse of evidence, the impact of Crown filters and the deficiencies in both consultation and cultural knowledge.

According to Came et al. (2019a), inaction in the face of need is one of the ways racism manifests, and this is seen throughout the health sector. Came et al. (2019a) found that inequity is generated through the administration of the health system; through policies, processes and systems. The development of most health policy in Aotearoa is through bringing together advisory groups and those groups usually have one or two Māori and/or Pasifika individuals. However, Came et al. (2019a) argued that the marginalisation of Māori and Pasifika voices through health advisory groups was evident, and that their presence on these groups was tokenistic. Came et al. (2019a) maintained that the New Zealand Public Health and Disability Act 2000 (Parliamentary Counsel Office, 2020) required the health sector to work towards eliminating health inequities, including addressing contributors to health inequities such as racism. In addition, a report by Treasury (2004) determined that Crown Ministers need to place priority on initiatives and policy that will most likely improve outcomes for Māori and Pasifika populations. This Treasury report concluded that policies would be more successful if they were developed, designed and implemented by Māori and Pasifika peoples. Further work needs to occur to ensure health advisory groups are more culturally and politically responsive to Māori and Pasifika members to ensure their contributions are captured within the policies.

Furthermore, Came et al. (2019b) identified institutional racism as a complex issue which is difficult and highly resistant to change. Anti-racism interventions are weakly supported through the lack of funding to support and focus on addressing personal upskilling, such as strengthening cultural competencies of Pākehā. Came et al. (2019b) found that Te Tiriti as the founding document of the colonial state of Aotearoa is not always referenced, included, or acknowledged in health policy. Came et al. (2019b) identified that addressing the manifestation of institutional racism effectively required both practice and policy interventions to include a systems change strategy and plan to eradicate institutional racism; quality assurance practices throughout all levels of the health system; and alignment with Te Tiriti within all health policies.

Moreover, Kidd et al. (2021) looked at the primary healthcare system in Aotearoa and applied a critical analysis of the application of Te Tiriti in primary health organisations in Aotearoa to assess the extent the participating primary health organisations were Te Tiriti compliant. Both Came (2014) and Kidd et al. (2021) discuss the Crown breaches of its obligations under Te Tiriti. These breaches contributed to the pervasive and persistently poor health outcomes of Māori, (Lorgelly & Exeter, 2023). Kidd's et al. (2021) critical analysis found poor to fair compliance with most components of Te Tiriti. However, engagement with equity was good. To strengthen the system, suggestions were made to examine relationships with Māori, structural mechanisms, utilise a planned approach,

normalise Māori worldviews, and ensure consistent application. To enable culture change and power sharing to uphold Te Tiriti the onus needs to be on non-Māori (Kidd et al., 2021).

In summary, the research above found that manifestation of institutional racism is through inaction in the face of need. Focusing on education alone to upskill the workforce's cultural competencies is not enough. The biomedical Western administration and development of the health system (policy, processes and systems) is a key contributor towards institutional racism. Policy development and review by advisory groups may include Māori and Pasifika members. However, advisory groups have found to be not culturally and politically responsive to Māori and Pasifika as they marginalise Māori and Pasifika voices (Came, 2014). To address institutional racism, it was found that advisory groups must be more culturally and politically responsive to Māori and Pasifika members in that their contributions to the development, design and implementation of policy is captured. Furthermore, both practice and policy interventions are required to include a systems change strategy and plan; quality assurance practices throughout all levels of the health system; and alignment or reference to Te Tiriti within all health policies.

3.4.3 How institutional racism is experienced by healthcare providers

According to Serafini et al. (2020), institutional racism is experienced by physicians of colour in the workplace across parts of America in a number of ways, including microaggressions whereby assumptions by white people that physicians of colour were actually not physicians; structural biases that led to significantly fewer advancement opportunities; and inappropriate comments about their race. Serafini et al. (2020) found that the experience of microaggressions at work was significantly correlated with secondary traumatic stress, impacting their mental health and wellbeing. Furthermore, the institutions did not address institutional racism in the areas where the survey participants resided, with the participants recommending that institutions need to do more to provide an inclusive environment and embrace diversity. It is unclear whether the research was within secondary and/or primary care environments, and in what parts of America the health providers were situated. However, the study did note that there has been relatively little research on the effects of racism on healthcare providers.

Insightful research by Hunter and Cook (2020) deserves close review. The researchers examined experiences of Māori nurses across different healthcare settings and their struggle to integrate cultural priorities into their clinical practice. From the Indigenous narrative inquiry on nurses' experiences, four themes emerged. Firstly, pertaining to te tauakiri Māori (cultural identity), nurses experienced tension between the values, beliefs and relationships that drive Māori cultural identity and the tauiwi (non-Māori) nurses' concepts of appropriate professional boundaries. Nurses reported experiencing social stigmatisation through being challenged about being a nurse (stereotyping); the dilemma of offending Māori when the expected Westernised professional

boundaries clashed with cultural practices; and identity challenges through representing a tauiwi worldview that compromised their own cultural values. In response, nurses incorporated kotahitanga (unity) to enable a collective approach to care and whanaungatanga (establishing connections) to develop rapport with patients and whānau before interventions were made. This resulted in Māori nurses being sought out by Māori patients/whānau for their care.

Secondly, pertaining to kawenga taumaha (bearing the emotional burden), nurses reported experiencing a deep sense of obligation to be the kaitiaki (guardian and advocate) over all Māori accessing services within their organisations. Under the kaitiaki approach the provision of holistic care was looked upon as disorganised, resulting in alienating the Māori nurses. End-of-life care in respect to wairuatanga (spiritual wellbeing practices) were at odds with Western practices, whānau did not receive the care they should from tauiwi nurses, and there was a lack of support from colleagues for Māori nurses to provide culturally appropriate care, creating tension for Māori nursing staff.

Thirdly, te kaikirianga (racism) was reported through the marginalisation, cultural disregard and actions that reinforced inequality, such as maldistribution of resources. Nurses shared how tauiwi colleagues were unaware that racial biases underpinned decisions such as the allocation of appropriate medicines and wait list prioritisation. Nurses' educational and clinical pathways were limited and predetermined due to their Māori identity. This behaviour was justified with opinions that Māori nurses' services were best utilised in primary care or the community. These examples of actions and assumptions reinforce inequalities and represent discrimination.

The fourth theme was tauutuutu (reciprocity), in which nurses reported biculturalism in practice through the shared learnings from other cultures that led to an improved sense of cultural safety and the incorporation of Indigenous values and beliefs in conjunction with professional practice. The researchers reported that for Māori, healing comes from immersion in a cultural environment where te ao Māori and mātauranga Māori are embraced. However, to enable this approach, current healthcare structures need to enable the integration of cultural priorities.

The experiences reported under the four themes provide clear examples of the manifestation of institutional racism and how it reduces culturally appropriate healthcare provision. Nurses reported having their capabilities questioned due to non-conformity to Western norms; high levels of emotional labour and stress in holding differing expectations in balance; and reduced opportunities and support due to race-based assumptions about their capabilities and roles. The Western development and administration of the health system reinforced policy, processes and systems that alienated Māori nurses and increased the burden on their practice, reflecting embedded institutional racism through the exclusion of te ao Māori. However, nurses also reported ways that the health

system does or could be more inclusive and flexible, specifically through recognising the importance of holistic care for Māori patients and using a team approach to meet their needs, and by embedding reciprocal cultural learning and appreciation.

Both Serafini et al. (2020) and Hunter and Cook's (2020) studies had similarities in that they were conducted on the workforce (physicians and nurses) across various healthcare settings. The similarities in the experiences included the questioning of whether people of colour or Māori were actually a physician or a nurse (stereotyping); that there were fewer opportunities for career advancement; and racial comments (micro aggressions, cultural identity) and assumptions made. All of this results in secondary traumatic stress impacting mental health and wellbeing or bearing the emotional burden (the need to watch over all Māori accessing the services). Serafini et al. (2020) recognised that an inclusive environment that embraces diversity is required. Similarly, Hunter and Cook (2020) recognised the need to integrate cultural practices into clinical practice, as well as reciprocity to improve cultural safety, and the incorporation of Indigenous values and beliefs is necessary. Hunter and Cook (2020) also emphasised the need for a cultural environment that embraces te ao Māori and mātauranga Māori.

3.4.4 The impact of institutional racism within the New Zealand public health system

The experience and impact of racism on Māori registered nurses within the Aotearoa health system is described by Huria et al. (2014). The participants of the research described their experience of racism on an institutional, internalised and interpersonal level, which led to marginalisation and being overworked but undervalued. From an institutional perspective, the Māori participants described the institutional racism starting from the education system, in that career paths were not developed for participants, and that there was no encouragement to take science subjects or expectations to complete secondary schooling. The Māori secondary school students went on to nursing education, and it was evident that the nursing curriculum was developed within non-Māori frameworks. This led to marginalisation of their Māori beliefs, experiences and values. The students were expected to undertake nursing practices that conflicted with their tikanga (Māori cultural protocols), which suppressed wider thinking. Furthermore, participants were isolated in various ways, as they were expected to be experts in traditional Māori knowledge and the application of Māori health within the nursing curriculum (Huria et al., 2014).

Huria et al. (2014) also described the participants' experiences as nurses within non-Māori institutions, such as hospitals, and the impact of institutional racism on their roles, which resulted in an increased workload connected to their identification of Māori cultural values and the undervaluing of their dual clinical and cultural skill sets. There was a lack of awareness for the work environment to be culturally competent. Regular flippant comments made by colleagues included, 'Why don't Māori just get over it,' and other negative generalisations which were made about Māori health,

wellbeing and lifestyle. Furthermore, a lack of resources to address Māori health disparities; a shortage of Māori nurses; the need to justify dedicated Māori positions; and the ignorance of Te Tiriti were experienced. The research showed that many tauiwi staff were comfortable with the current Western system, which did not challenge their limited understanding of Te Tiriti, the need for cultural competencies, and the lack of understanding or acknowledgement of the experiences and skills that Māori registered nurses brought to the health system. Huria et al. (2014) research concluded with the findings that the nursing profession in Aotearoa needs to acknowledge the issue of racism within clinical environments and training, and the need to support Māori registered nurses to professionally develop and to implement dual cultural and clinical competencies.

Supplementary to the impact of institutional racism on Māori staff I now go on to describe the impact of institutional racism on patients within the public health system. Graham and Masters-Awatere (2020) conducted a systematic review drawing on 14 studies which described the impact of institutional racism through the broader perspectives of Māori patients and their whānau regarding their treatment within the Aotearoa public health system. The characteristics reviewed included barriers and facilitators (whānau support) to health, such as organisational structures, staff interactions and practical considerations. This research involved 372 participants, comprising 326 patients, 27 whānau, and 19 health workers from across Aotearoa. The publicly funded health system in Aotearoa supports free inpatient and outpatient public hospital services, subsidised primary healthcare, and subsidised prescription items. It also provides a range of community support services for people with disabilities. However, Graham and Masters-Awatere argued that the funded public health system is designed to privilege individualistic approaches, as individuals with financial means tend to benefit more from the health system. Māori are disadvantaged through this form of service provision as the Māori way of being is through a collective nature of people. In support of these findings, the Wai 2575 Māori Health Trends Report (Ministry of Health, 2019) provided evidence that tauiwi fare better than Māori through the statistical trends in Māori health from 1990 to 2015 that compare Māori with non-Māori for a number of health indicators. Graham and Masters-Awatere (2020) also note that prior to colonisation, Māori had developed health systems and structures that were aligned with their environment and themselves. Colonisation disrupted these systems, and health systems were designed that primarily served tauiwi, with the health needs of Māori not being met.

3.5 Introduction

The questions that this research set out to address were how does institutional racism manifest in policy and practice within the primary healthcare sector? And how can the primary healthcare sector move beyond institutional racism at a strategic level? In essence, this research aimed to find solutions for Crown and mainstream organisations in disrupting and eliminating institutional racism at a strategic level within primary healthcare.

Graham and Masters-Awatere (2020) captured two decades of health experiences through their review, and categorised these into organisational structure, staff interactions and practical barriers. Firstly, grouped under organisational structure, it was found that Māori patients and their whānau were aware of the negative perceptions of health professionals. This was experienced through the differences in facial expressions and body language, of which was interpreted as discrimination and perceived as racist. Māori reported hostile experiences, including being treated with scepticism. Furthermore, experiences of discrimination and overt racism were expressed through being interrogated due to being brown and through the mispronunciation of names. This led many Māori to mistrust and view health practitioners as disinterested in their wellbeing. Furthermore, many Māori patients and their whānau found that the focus of care was on the physical nature of the problem, with the cultural practices and spiritual health (mental wellbeing) devalued. Participants described this as a compromise in that to receive hospital care, the participants had to accept that the care would be delivered in a Western way, which ignores the cultural practices that were important to them. This approach resulted in patients feeling worried and anxious and sometimes led to requests for early discharge from the hospital. Patients never discussed rongoā (traditional medicinal and healing treatment) in the hospital due to the domination of the biomedical approach and instead reverted to the use of rongoā when they returned home. In parallel to these issues, whānau and Māori providers were not recognised for their patient support. The patient support consisted of navigation of services, advocacy, interpretation of the healthcare advice and transportation, to name a few, which was all at a cost to the whānau and Māori providers.

Secondly, staff interactions highlighted an inability of health professionals, particularly nurses, to build a rapport with Māori patients. Māori patients reported that they experienced difficulties in building a relationship due to the utilisation of many locums and the ongoing staff turnover. These difficulties left patients feeling alienated, with inconsistencies of care and the inadequate provision of information. Furthermore, Māori patients were attuned to the stress levels of the health practitioners, which led patients to not ask questions or disturb the health professionals, as they did not want to be seen as a nuisance and instead minimised their pain and the severity of symptoms. These experiences resulted in poorer health outcomes for Māori (Graham and Masters-Awatere, 2020).

Thirdly, Graham and Masters-Awatere (2020) described practical barriers for low-income whānau that typically avoided accessing healthcare for as long as they could and often waited until it was no longer avoidable. The main contributor to the avoidance of attending appointments or accessing clinics to receive appropriate levels of healthcare was financial costs (fees associated with after-hours care, prescription co-payments, dental care, and the cost of general practice visits). Other contributors were practicalities such as organising childcare and/or leave from work (the disapproval

about children in the waiting rooms and healthcare only being available during work hours was a barrier). Furthermore, transportation issues, such as rural patients' access to healthcare in urban settings, were a significant barrier, along with the insufficient options for public transport, which contributed to the avoidance of attendance.

Furthermore, Abraham et al. (2018) studied the experiences of adult Māori patients within an emergency department (ED) of a district health facility in Aotearoa. The main findings were that kaumātua (elders) had unique challenges, such as the lack of sufficient information from healthcare professionals and the language barrier. The ED environment negatively impacted experiences due to the lack of privacy and the layout of the room. In addition, there was a lack of integration of the Māori view of health in the practice of healthcare professionals, leading to a negative influence on Māori. Whilst the study only had four participants, the research offers ways to improve experiences for Māori through whanaungatanga, acknowledging the process ahead, asking for the patient's preference around whānau being present in decision-making, the offer of a Māori cultural support person, ensure the layout respects privacy, compulsory Māori health training for healthcare professionals, the appreciation of mātauranga Māori and shared decision-making, the incorporation of te reo Māori in the medical setting and the correct pronunciation of Māori names.

3.6 Discussion

There is underlying evidence indicating an overall disparity between Māori and non-Māori outcomes for several health indicators highlighted in the *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019). There are literature and data around the contributions towards the overall disparity between Māori and non-Māori outcomes, including institutional racism (differential access to services, goods and opportunities of society by race). Specifically, Talamaivao et al. (2020), Thackrah et al. (2021) and Harris et al. (2024) highlighted that institutional racism contributes towards poorer health outcomes for Māori and Indigenous Australians, which was due to prejudice (negative attitude towards a group) and discrimination (unfair treatment of people based on their group membership) that is embedded in Western structures and systems (policies, processes and models of care). The literature review found that institutional racism manifests through the administration of the health system within the development of policies, processes and systems (Came et al. 2019a).

Furthermore, Graham and Masters-Awatere (2020) described the impact of institutional racism and stated that for many Māori, their experience of the current public health system is hostile and alienating. Whānau members go some way to mitigate this when supporting their family member in the health system. However, this comes at a cost to whānau. Consideration needs to be given to the broader context of the collective Māori memory of multiple decades of second-rate treatment, patronising interactions and active discrimination. Health providers need to find ways to ensure

Māori have high-quality healthcare interactions and positive experiences that support Māori ways of being, such as tikanga Māori practices being supported within Western healthcare systems. It could be argued that the findings are clinical and/or cultural incompetence of the health professionals; however, the health system built on Western structures and systems has enabled the behaviour of the health professionals described in the research. The literature reviewed is unable to answer whether health system contracts align with Te Tiriti, and if so, whether the obligations of Te Tiriti are fulfilled at the service delivery level through decision-making, design, implementation, and delivery of services. In addition, the literature review indicated that there is limited literature on how Māori hauora providers or manukura Māori within the primary healthcare sector experience institutional racism.

Huria et al. (2014), Graham and Masters-Awatere (2020), Abraham et al. (2018) and Kidd et al. (2021) all described ways that the health system can do better, such as acknowledging the issue of racism within clinical and management environments and training. Huria et al. (2014) described the need to support Māori registered nurses to develop professionally and to implement dual cultural and clinical skill sets. Graham and Masters-Awatere (2020) described that the health providers need to find ways to ensure Māori have high-quality healthcare interactions that support emotional wellbeing and positive experiences that support Māori ways of being. Furthermore, the recognition of the support that whānau and Māori providers provide (including navigation of services, advocacy for patients' needs, and interpretation of healthcare advice) to Māori patients is important. Abraham et al. (2018) described the importance of recognising what is important to Māori and outlines the steps to improve experiences for Māori. Kidd et al. (2021) described ways to be compliant with Te Tiriti and that the onus needs to be on non-Māori to enable culture change and power sharing. There are some gaps in the literature review that my research will look to address, including a deeper understanding of the inequities as a result of institutional racism. My research in Chapter Five provides inequities within the healthcare system that have been experienced by manukura Māori, such as resource allocation, the power imbalance between the Crown and Māori hauora, and not valuing the Māori voice, to name a few. In addition, my research looks to address the inequities, including how to meet the Tiriti obligations through embedding and valuing a Māori worldview in Western healthcare structures.

3.7 Conclusion

To conclude, the literature reviewed in this chapter took a deep dive into institutional racism to better understand the manifestation in policy, experiences within healthcare providers, the impacts within the New Zealand public health system, and offers ways to improve institutional racism. However, further research is required to understand how primary healthcare can move beyond institutional racism through understanding the experiences of institutional racism by manukura Māori.

4 RESEARCH DESIGN AND METHODOLOGY

4.1 Introduction

In the planning and design of this research, I aspired to find out how institutional racism manifested in policy and practice within the primary healthcare sector, and how the primary healthcare sector can move beyond institutional racism at a strategic level. In essence, this research set out to find solutions to disrupt and eliminate institutional racism at a strategic level within primary healthcare. Therefore, I sought to develop an understanding of manukura Māori views of institutional racism within primary healthcare in Aotearoa through listening to their experiences of institutional racism and solutions.

To achieve these aspirations, I needed to identify a suitable methodology, specifically one that would celebrate and privilege the voices of manukura Māori and capture these voices appropriately. The methodology also needed to position the views of manukura Māori within the context of a Māori worldview; a methodology that honoured the voices and respected the values of manukura Māori, ensuring they were heard and acknowledged in a way that respected their mana. For these reasons, I have chosen kaupapa Māori as my research methodology for this qualitative study, as it provides a guide to conducting research safely and respectfully, both for the Māori participants and the researcher. In addition, this methodology enabled me as a Māori to be Māori and answer the research questions through traditional Māori approaches, such as wānanga and hui, where tikanga (Māori customs), te reo Māori and mātauranga Māori were privileged.

In addition to the kaupapa Māori research methodology, I have considered components of critical theory and constructivism to inform the research. In this chapter, I explain the use of a kaupapa Māori methodology and my reasons for choosing kaupapa Māori as a standalone methodology. This chapter also includes the methods used, such as the participant criteria, recruitment process, informed consent, and ethical approval; as well as the research methods that incorporated the use of wānanga and hui (interviews) that bring through the rich kōrero and pūrākau from manukura Māori in Aotearoa. Lastly, the chapter discusses the methods of data analysis that forms two parts: (1) the findings as discussed by manukura Māori, and (2) a further review of two key issues supported by the literature, that highlights the significance of the findings and the impact on Māori. The ethical considerations and reflexivity are also presented.

4.2 Kaupapa Māori Philosophy

According to Graham Smith (2015), kaupapa Māori has its own cultural epistemological base to conceptualise Māori philosophy and practice. It includes appreciating what has gone wrong in the past and what needs to be transformed through critical reflection. The critical reflection is important as it provides an opportunity for Māori to be heard and to ascertain meaningful, transformative

strategies to understand how the primary healthcare sector can move beyond institutional racism at a strategic level. This is important for my research as it values the manukura Māori experiences of institutional racism before moving to discussing solutions.

Furthermore, Linda Smith's (2021) work on *Decolonising methodologies: Research and Indigenous peoples*, highlights how Western ways of knowing have been privileged in research, simultaneously dehumanising Māori practices and invalidating Māori knowledge, te reo Māori and culture. Smith also found that decolonising approaches open different possibilities for research that centre Māori ideologies.

> Decolonising methodologies are about forcing us to confront the Western academic canon in its entirety, in its philosophy, pedagogy, ethics, organisational practices, paradigms, methodologies and discourses and importantly, its self-generating arrogance, its origin mythologies and the stories that it tells to reinforce its hegemony. (Smith, 2021, p. xiii)

Pihama (2001) shared how kaupapa Māori methodology is a vehicle to speak the truth to those in power such as the Crown who embrace the Western way of knowing, as described above by Smith. Kaupapa Māori methodology provides distinctive tools that enable people to view the Māori world and analyse Māori experiences within that context.

Similarly, Wilson et al. (2021) highlighted that underpinning Indigenous research is a shared way of thinking and viewing the world that reflects the unique Indigenous worldviews, values, beliefs, and ways of living.

> Utilising a paradigm that privileges Indigenous epistemologies and ontologies enables culturally relevant engagement and approaches for analysing data and interpreting the findings that reflect participants' realities better, which then produces evidence of greater relevance and meaning to inform transformational policy and practice. (Wilson et al., 2021, p. 2)

Moreover, Cram (2019) discussed how kaupapa Māori research is about informing an agenda of Māori being Māori or the Māori way. For example, kaupapa Māori research provides a way to analyse Māori health disparities structurally and, in doing so, moves away from the victim-blaming approach and towards understanding people's lives and the systemic determinants of their wellness and health. The approaches of Smith (2021), Pihama (2001), Wilson et al. (2021), and Cram (2019) all inform the current research, as they support an approach that privileges, values, and normalises te ao Māori to include Māori worldviews and knowledge.

Walker et al. (2006, p333) stated that “kaupapa Māori research has been defined as research by Māori, for Māori and with Māori”. This is where kaupapa Māori research gives full recognition to Māori systems and cultural values, challenging Pākehā constructions of research. It determines the assumptions and priorities of the research through a process that puts Māori values, self-determination and community needs at the centre. In this research, the manukura Māori identified the priorities as they are aware of their community's concerns. Walker et al. (2006) asserts that Māori also maintain conceptual, interpretive and methodological control over the research, ensuring that Māori protocols are adhered to during the research. Walker et al. (2006) also highlighted that kaupapa Māori redresses power imbalances to benefit Māori and found that some researchers believe that if Māori do not benefit from the research, then there is little point in conducting it, particularly if it fails to enhance the quality of life for Māori.

The kaupapa Māori methodology used in my research encompasses many of the elements described above, specifically addressing the concept of talking back to power and preceding this is the need to understand the past before moving towards transformation. Within this transformative process, the methodology privileges Māori practices, values, beliefs, knowledge, te reo Māori, culture and te ao Māori. It comprises Māori being Māori or the Māori way, with research conducted by Māori for Māori with Māori. This kaupapa Māori methodology is important to me as a Māori as it has boosted my confidence to conduct the research from a te ao Māori perspective – for example, using tikanga (Māori customs, values and practices) throughout the research practice. It has also supported the manukura Māori participants in sharing their experiences and solutions for addressing institutional racism within primary healthcare from a te ao Māori perspective, utilising traditional approaches such as wānanga and hui.

4.3 Elements of Kaupapa Māori Philosophy

After describing kaupapa Māori methodology above, it is important to understand elements of kaupapa Māori philosophy that have guided my thinking and action throughout my research. The literature that I have used to describe the elements is almost 30 years old. However, they remain relevant today as customary practices and protocols (tikanga) evolve, while their core values and principles continue to be applicable over time.

As part of kaupapa Māori philosophy, Bishop (1996, p.ii) found that whanaungatanga (establishing and setting the foundations of relationships) is an important element that gives a voice to “collaboratively constructing research stories in a culturally connected manner”. Bishop maintained that whanaungatanga within research involves three fundamental components. Firstly, establishing relationships that address the control and power issues; this requires participatory or participant-driven research. Secondly, researchers must be ethically, physically, spiritually and morally involved in the research process. This can be demonstrated in the use of culturally appropriate language and

framing by the researcher when describing lived experiences or stories, and in adhering to Māori tikanga. Thirdly, relationships must be established and maintained throughout and beyond the research process. This requires a process of establishing whānau of interest that have had similar experiences of injustice.

For the purposes of this paper, tikanga as described by Graham Smith (1997) included pōwhiri (the formal Māori welcoming process), whanaungatanga (relationship), manaakitanga (hospitality), kaupapa, aroha (care) and kotahitanga. Bishop's (1996) description of whanaungatanga has shaped my intentions for my research, firstly through an approach that gives the power to the participants through listening to participants mamae (hurt) from the past before looking to solutions. Secondly, through the utilisation of Māori processes (tikanga) throughout the research and lastly pulling together participants who have had similar experiences of institutional racism. This approach supported the connection between me and the participants, creating relationships that will endure beyond the research process. Smith's (1997) description of tikanga is important. However, I was also guided by the haukāinga (local people) on the appropriate tikanga during the sessions with participants.

Furthermore, Graham Smith (1997) stated that the kaupapa Māori philosophy, the foundation for kaupapa Māori research, includes six principles. Firstly, tino rangatiratanga in terms of autonomy, independence, sovereignty and seeking control over one's own cultural wellbeing and life. Secondly, taonga tuku iho (cultural aspirations that are Māori), which encompasses Māori language, knowledge and culture. Thirdly, kia piki ake I ngā raruraru o te kainga (socio-economic mediation), a principle which acknowledges that values and practices provide a collective responsibility to ensure an overall wellbeing of whānau, despite difficulties or socio-economic disadvantages that some Māori may experience. The fourth principle of ako Māori (culturally preferred pedagogy) draws on cultural capital to overcome barriers to see the realisation of collective goals. The fifth principle of whānau (extended family management) encompasses the cultural values, practices and customs that are organised around whānau collective responsibility. The final principle of kaupapa (collective vision) is a collective commitment and vision that is connected with Māori aspirations to social, political economic and cultural wellbeing. Smith (1997) says these principles set a foundation for kaupapa Māori research. Complementary to the research principles are Te Tiriti principles described in the *Hauora report on stage one of the health and services outcomes kaupapa inquiry WAI2575* (Waitangi Tribunal, 2021), such as rangatiratanga (self-determination), pātuitanga (partnership), mana taurite (equity), whakamaru (active protection) and kōwhiringa (options). These principles guided my research practice through a wānanga approach where collectivism and independence will be important to support the free-flowing kōrero and tautohetohe (debate) around solutions from the participants. The approach embraces Māori culture, values, and language while privileging mātauranga Māori.

4.4 Critical Theory and Constructivism

Whilst I am comfortable that kaupapa Māori methodology will underpin my research as a standalone methodology, I also wanted to understand whether critical theory and constructivism would support the kaupapa Māori methodology. Eketone (2008, p1) described kaupapa Māori as a "philosophical approach to a field of practice or theory that focuses on challenging well-established Western ideas about knowledge".

In academic circles 'Kaupapa Māori' usually refers to a Māori philosophical approach to a field of practice or theory that focuses on challenging well-established Western ideas about knowledge. These two are often talked about as though they are the same thing: but are they?

Eketone (2008) suggested that there are two key components that underpin kaupapa Māori philosophy i) Critical Theory, and ii) Constructivism (Native Theory). These theoretical perspectives sometimes compete as critical theory aims to challenge and transform oppressive structures, while constructivism validates knowledge through a social construction of the world. According to Shannon and Young (2004), both theories describe why the world is like it is, with each theory providing values or concepts that are important for implementation. The following section explores the strengths and limitations of critical theory and constructivism with respect to supporting my research methodology.

4.4.1 Critical Theory

Eketone's (2008) framework outlined the key concepts of critical theory to include emancipation, resistance, empowerment and power analysis. According to Pihama (2015) kaupapa Māori theory is a theoretical framework that contributes cultural integrity when analysing Māori issues. There has been some assertion by Eketone (2008), that kaupapa Māori theory is grounded on critical theory. However, it has been argued that kaupapa Māori theory asserts "key elements of critical theory as a theory that challenges dominant systems of power may also be seen within kaupapa Māori theory" (Pihama, 2015, p.11). Pihama (2015, p11) stated that "critical theory is grounded on Western notions, whereas kaupapa Māori is grounded in mātauranga Māori as it derives from te reo and tikanga Māori". In my view, critical theory and kaupapa Māori theory are different, in that critical theory focuses on challenging power structures or systems to transform society. Whereas kaupapa Māori theory seeks to transform society, based on tikanga which is entrenched in mātauranga Māori, te reo Māori and Māori values.

Graham Smith (2015) discussed the limitations of critical theory in that emancipation can be idealistic when it has a singular vision as it carries the risk of inflexibility, being disconnected from reality and the inability to consider alternative perspectives such as kaupapa Māori. However, understanding critical theory is important, as it can inform observations and assist with interpreting

kaupapa Māori theory and transformative practices. Similarly, Eketone (2008) found limitations of critical theory through its modernist approach in that there is one answer to a problem and that, in his research, a Western mindset was to have everyone educated to be the same as Pākehā, resulting in an equal society. The other limitation is that research can become about Pākehā, where Māori are looking at ourselves in relation to Pākehā.

Linda Smith (1999) argued that because critical theory embodies emancipation and empowerment aims, kaupapa Māori research is seen as localised critical theory. A local critical theory means that mātauranga Māori is entrenched in kaupapa Māori research, local histories, realities and contexts, bringing forward an alternative perspective to the Western world. When kaupapa Māori research is used in this way, it can be used to critique racist, dominant and Westernised hegemonies whilst advocating for Māori to become self-determining. According to Eketone (2008), critical theory provides a rationale and pathway for addressing the frustrations over the marginalisation of Māori people and their knowledge. However, in my view kaupapa Māori has the use of critical theory but it does not define kaupapa Māori, as critical theory tends to oversimplify power through grouping the dominant and non-dominant by race. In doing this, it ignores the alternative perspectives, capabilities, experiences and knowledge of the non-dominant group, that are Māori people.

4.4.2 Constructivism

According to Chand's (2024) examination of Piaget, Vygotsky and Bruner's work dating back to the 1960s, 1970s and 1980s, constructivism is a learning theory that educators have used to support students to acquire knowledge. Constructivism is premised on individuals bringing their prior knowledge, experiences and ideas into a learning environment where they are required to evaluate and reevaluate their understanding. Piaget asserts that the processes involved include assimilation, where an individual integrates a new concept into their existing knowledge to create a new meaning. This also includes both accommodation, where individuals adapt to a new concept that may conflict with an existing mental structure, and equilibration which maintains the status quo to ensure there is no conflict between new and existing ideas. Vygotsky argues that constructivism is more social constructivism as a cognitive and intellectual development; it is dependent on social interactions. Bruner defined constructivism as a learning theory and like Piaget and the influence of Vygotsky, asserts that learning is an active, social process where individuals generate new ideas and concepts based on their prior knowledge. In my view, applying constructivist theory to an individual Māori within a Western learning environment (Western worldview), may remove or distort the foundations of mātauranga Māori, te reo Māori and tikanga.

Eketone (2008) described constructivism, where knowledge is validated through a social construction of the world. For example, through language and practice, people construct realities that are influenced by culture, history, politics, economic factors, and interpersonal interactions

between people and the environment. Within a community, knowledge is socially constructed, and it can be argued that the interactions within the community contribute to the construction of a shared reality. Therefore, based on a constructivist approach to knowledge, Māori are within their own reality based on their worldview and values. Even though Māori knowledge was not valued and dismissed as a legitimate way of knowing by Westerners, many Māori still believe in the validity of te reo Māori and tikanga, specifically when they relate to kaupapa Māori. The reason for this is that kaupapa Māori embraces mātauranga Māori, te reo Māori and tikanga as it is founded on te ao Māori. It is important to note that within kaupapa Māori methodology te reo Māori and tikanga do not need to be validated as it is an uncontested space through Māori being Māori.

Alanazi (2016) examined critiques of constructivist theory, and found that constructivism promotes group thinking, ignoring the individuality of students. The dominant students tend to control the interactions and, therefore, drive the average students towards their thinking. Another concern is that constructivism views learners as interpreting the world differently. However, the learning environment which includes the teachers and curriculum does not support this thinking. Common curricula are ineffective for learners with different interpretations of the world. In my view a Māori student with a Māori worldview would not be supported in this environment due to the dominance of the Western environment (non-Māori teachers, standard curricula and dominant students, particularly if they have a Western ideology of the world).

Furthermore, Eketone (2008) has described constructivism as a Native Theory and has cited the explanation from Russell (2000, p.10), as "…the rights of indigenous people to make sense of their time and place in this world". In my view this means that Māori have the freedom to be Māori and do not need Pākehā to confirm their way of being, knowledge or practice, for it to be acceptable. The use of the word 'native' in this context refers to certain knowledge, values and behaviours that are present from birth and when this is applied to kaupapa Māori it is about mātauranga Māori (Māori knowledge systems). From a research perspective native theory is described as enabling Māori research for Māori people utilising Māori terms and processes, and that these may not be acceptable to Pākehā.

> Indigenous people do not need the west to acknowledge, research, record and affirm their knowledge for it to be valid and useful in research, in practice and in life. Neither do indigenous experiences need Western civilisation for them to exist or to define themselves. (Eketone, 2008, p. 7)

Moreover, Eketone (2008) described the key values of constructivism, such as self-determination (tino rangatiratanga and mana motuhake), where people have the right as individuals and groups to make choices and have control over their own lives. It centres Māori processes – for example,

whanaungatanga, which is a process for establishing relationships and reflects Māori values and protocols (kawa), for example, incorporating traditional customs such as pōhiri to welcome people to a meeting or an event. Lastly, Māori knowledge is centred, which is the traditional knowledge that encompasses the Māori worldview, cultural practices and perspectives.

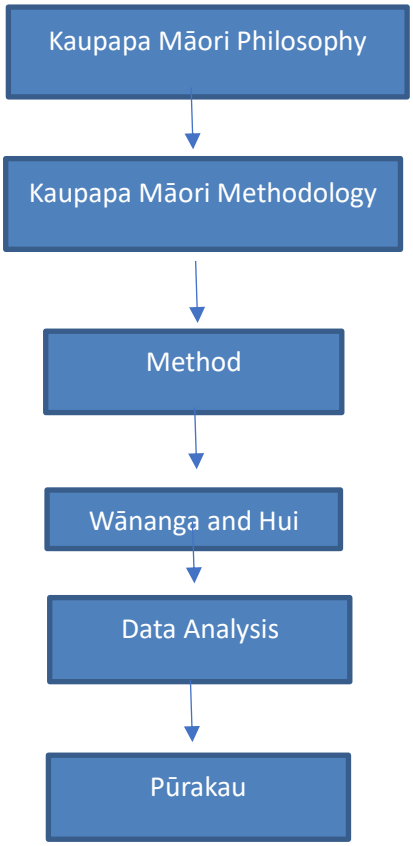
4.5 Conclusion

Key components of critical theory and constructivism can flow into kaupapa Māori research and look to achieve a just society, Māori advancement and development as Māori. Critical theory and constructivism can work together where critical theory challenges the structural and system power differences that looks to create social justice. This can be done within a constructivist context where Māori research is for Māori, and culturally, Māori are Māori in te ao Māori. Constructivism is also where Māori are within their own reality based on their worldview and values to include te reo Māori and tikanga, particularly when they relate to kaupapa Māori. However, it has been argued by Linda Smith (1990) that critical theory is seen as localised critical theory where mātauranga Māori is entrenched in kaupapa Māori research, local histories, realities and contexts, bringing forward an alternative perspective to the Western world. When kaupapa Māori research is used in this way, it can be used to critique racist, dominant and Westernised hegemonies whilst advocating for Māori to become self-determining. Both Pihama (2015) and Graham Smith (2015) stated that critical theory is grounded in Western notions, with an inability to consider alternative perspectives, such as kaupapa Māori. Kaupapa Māori is grounded in mātauranga Māori which is embedded in tikanga Māori and te reo Māori. In addition, limitations were found with constructivism, particularly when applying constructivist theory in a Western environment, with the potential for Western ideologies to dominate the thinking.

After reviewing kaupapa Māori methodology, critical theory and constructivism I decided that kaupapa Māori is now stronger as a standalone methodology. I landed on this position after the consideration of components of both critical theory and constructivism that may inform the kaupapa Māori methodology, such as critical theory's emancipation and empowerment through challenging the Western way of doing things and shifting the power to Māori. Constructivism empowers Māori ways of doing research through its components, such as self-determination, mātauranga Māori, Māori processes and Māori values. However, kaupapa Māori methodology does all of those things in an uncontested space; Māori do not need the power to be handed over by the Westerners (Eketone, 2008). Kaupapa Māori holds its own power. Kaupapa Māori methodology brings together elements that are important to Māori such as research that is by Māori, for and with Māori; a vehicle to speak the truth to those in power (Crown); and understanding the past before transforming. In addition, the Western ways of knowing have been privileged in research simultaneously dehumanising Māori practices and invalidating Māori knowledge, te reo Māori and culture (Smith, 2021). Therefore, my research will be founded on kaupapa Māori methodology in its own right.

Figure 2 below shows the methodology whakapapa of the kaupapa Māori philosophy that I have used in this research.

Figure 2: Methodology Whakapapa



The next section moves onto the method which brings together the kaupapa Māori methodology and connects me as the researcher, introduces the research whānau and demonstrates the kaupapa Māori principles shared by Smith (1997) and Bishop (1996).

4.6 Method

4.6.1 Introduction

The methodology described above reflects kaupapa Māori and in following this methodology, the method I use starts with me as the researcher and moves from reflecting on my individual experiences to understanding shared experiences. This section will describe the methods used to further explore these questions from the perspective of manukura Māori within primary healthcare settings through wānanga and hui. The research offers the potential for significant benefit to Māori through being heard and understood, and in supporting a change in the way healthcare is structured and therefore delivered. Manukura Māori voices are at the forefront of the research, co-creating solutions to move beyond institutional racism.

4.6.2 My research motivations

As a wahine (woman) Māori, I chose kaupapa Māori methodology as it aligns to my worldview, values and experiences that are driven through my whānau whakatauākī, “Tangohia mai te taura I tāku kakī kia waiata ai ki tāku waiata” (Take this rope from my neck so I can sing my song) as this talks about speaking up and not being silenced. I was also personally motivated to explore these issues through the loss of my sister to breast cancer at a young age, where the healthcare structure did not support early detection of breast cancer. The tragedy my family and I faced was not isolated, but a pattern embedded in a colonial healthcare system where breast screening options are not promoted to those under the age of 45. Furthermore, in my experience, I’ve realised that if you have manukura Māori pushing for change – either through a Māori health team, an executive Māori role embedded in the organisation or a Māori leader being at the decision-making table – mātauranga Māori can be considered in decision-making. However, the moment a manukura Māori is not present, the decision-making reverts back to the dominant Western paradigm, further enforcing institutional racism. I also found that embedding Te Tiriti principles into Crown strategies, policies, or legislation, can go some way towards removing institutional racism. However, I have seen firsthand this progress being undone, for example through a new leader of an organisation coming in or a change in government. My whānau whakatauākī, personal loss, and experience of institutional racism during my professional background in primary healthcare, drives my passion to improve outcomes for Māori through supporting others to be heard.

4.6.3 Process

The research was conducted from my mātauranga Māori, the support from a tikanga tōhunga (expert) and through te ao Māori. This was supported by the fundamental components of the research described by Bishop (1996), the kaupapa Māori philosophy foundation described by Smith (1997) and Te Tiriti principles as described in the *Hauora report on stage one of the health and services outcomes kaupapa inquiry WAI2575*, (Waitangi Tribunal, 2021). Specifically, through the research fundamentals and philosophy foundation, I conducted the research as a Māori researcher, with Māori participants, and for Māori in Aotearoa, providing a Māori voice by listening to the past before moving to solutions. Furthermore, through the application of tikanga, an ethical approach was taken to ensure that participants trusted the wānanga and hui process to protect their identity and to trust me as the researcher to be accountable for accurately and sensitively representing the participants' discussions in my research findings.

Moreover, Te Tiriti principles guided my research practice through the participants' self-determining (tino rangatiratanga) the process in partnership (pātuitanga) with me. Participants committed to achieve equitable (mana taurite) outcomes for Māori based on the solutions to move beyond institutional racism. Whakamaru (active protection) was also adhered to through participants being well-informed of the extent and nature of outcomes to achieve equity, the manukura were

exceptionally knowledgeable around the achievement of equitable outcomes. The principle of kōwhiringa (options) was supported through ensuring the research process was resourced and provided in a culturally appropriate way. I respected the tikanga and kawa of the haukāinga (kaupapa Māori health provider where the wānanga was held or individual participant online hui). This included karakia (prayer) to open and close the wānanga and hui; whanaungatanga to establish, build and enhance relationships with the participants and myself; allowing the participants to steer the research process during the wānanga and hui; providing the option of the kōrero to be either in te reo Māori or te reo Pākehā (English language); demonstrating respect for the participants' views, which encouraged everyone to kōrero and share their experience through pūrākau and acknowledging the valuable kōrero and pūrākau at the wānanga and hui. Participants were respected for their time and knowledge provided to the research through koha (gift) and kai (food).

In addition, I used a qualitative research approach as it supports differing perspectives to be shared through social interactions that builds a mutual understanding of the kaupapa being discussed.

> Qualitative research is an important tool for indigenous communities because it is the tool that seems most able to wage the battle of representation; to weave and unravel 50 competing storylines; to situate, place, and contextualise; to create spaces for decolonising; to provide frameworks for hearing silence and listening to the voices of the silenced; to create spaces for dialogue across difference; to analyse and make sense of complex and shifting experiences, identities, and realities; and to understand little and big changes that affect our lives. (Smith, 2005, p. 103)

Qualitative research aligns with the kaupapa Māori method of wānanga and hui that is underpinned by tikanga and provides a culturally safe environment for discussion of experiences and deliberation of solutions. Also, qualitative research engages participants in reviewing and verifying the raw data (Creswell & Creswell Baez, 2021).

4.6.4 Wānanga and hui

I chose the methods of wānanga and hui as a culturally safe way to bring together manukura Māori to discuss and deliberate on their experiences of institutional racism and solutions to move beyond it. According to Mahuika and Mahuika (2020), wānanga is a traditional method for Māori knowledge transmission, derived from the whare wānanga (houses of learning). Wānanga has been traditionally used by iwi drawing on tikanga, kawa, and the collective to create, transmit and maintain tribal knowledge. More recently, wānanga has also been referred to as hui, and both have been used as a method for research, with the ability to neutralise the power imbalance created in the Western relationship between researcher and those researched. Mahuika and Mahuika (2020) have cited an explanation of wānanga from Anaru Bidois within their research.

> It's the participants who run the show, not the facilitator, even if they think so. Because if the participants choose not to participate you don't have a wānanga. Or you don't have the same depth of the wānanga…. (Mahuika & Mahuika, 2020, p. 5).

I ensured that there was no power imbalance within the application of my research method through the researcher being Māori and the participants leading the discussion, with prompts from me at times. The wānanga and hui embraced tikanga, enabling an open and honest discussion. In the context of my research, I have used the term 'hui' for the participants who were unable to attend the wānanga; these were between the researcher and individual participants. In both wānanga and hui, the participants started with the participant experience and observations of institutional racism before moving on to solutions. This was an important process to follow as it recognised and acknowledged the past to include institutional racism as a result of colonisation. It opened the discussion further to include the impact of the participant experience of institutional racism on the participant, on others such as patients or whānau, and on the health system. I also provided an open-ended approach, where following the wānanga and hui, participants had the option to further share their experiences or solutions if other thoughts had come to mind or if they wanted to contribute individually outside of the group setting. The informed discussion shared by participants through their experience and observations has enabled me to critically analyse what was shared, interpret, evaluate and present back the findings from the wānanga and hui in Chapter Five.

4.6.5 Research Whānau

A research whānau was established to guide and support my safety throughout the research. This included reflections and guidance on the research and tikanga practice. Bishop (1996) highlighted the importance of establishing a whānau of interest that has had similar experiences of injustice. The research whānau included the thesis supervisors, peer students, research colleagues and a tikanga tōhunga (Explain the term 'tohunga'). Regular contact was established with supervisors around ethical practice. This included the recruitment and selection process, informed consent, protection of participant identity, recording and transcribing processes, wānanga and hui, Māori protocols and challenges around consent for the research from my employer at the commencement of the research. Likewise, regular contact was established with peer students and research colleagues who were either conducting similar research through wānanga or had an understanding of these research methodologies; this allowed us to share our approaches, problem-solve together and learn from each other's experiences. The tikanga tōhunga was instrumental in guiding me first to understand the haukāinga tikanga and kawa, thus enriching the relationship between me and the haukāinga.

4.6.6 Participant recruitment and selection

I set out to recruit participants using my established health networks of Māori health manukura within primary healthcare. My established health network spans District Health Boards (later on known as Te Whatu Ora and Te Aka Whai Ora), Primary Health Organisations, general practice, a Crown entity and kaupapa Māori providers. The established network also shared the invitation to other Māori health manukura within primary healthcare, providing a broad base of manukura.

The participants were invited through email (refer to Appendix A) to share their lived experiences of institutional racism and aspirations to move beyond institutional racism in relation to the delivery of health services in the primary healthcare sector. Alongside the invitation, an information sheet describing the purpose of the research, consent form (in person and oral) and an agenda were provided to the participants (refer to Appendices B, C, D, and E, respectively).

The criteria for inclusion in the wānanga and hui were manukura Māori who had recently and/or currently worked for, led or governed health providers in Aotearoa. All participants who accepted the invitation were included in the research. Participants who were unable to make the wānanga were offered kanohi ki te kanohi (face-to-face) or online hui. Some participants sent other manukura Māori on their behalf to the wānanga. The participants had a myriad of health experiences to include strategy, planning, policy and legislation, funding providers, purchasing, service provision, advocating, coordinating, nursing, social work, management from chief executives to team leaders, leadership of organisations, projects and initiatives, governance and consulting. The participants also worked across several organisations, such as the Ministry of Health, District Health Boards, kaupapa Māori and non-Māori Primary Health Organisations, Kaupapa Māori and non-Māori health providers, Crown entities, general practice and private business.

4.6.7 Engagement

Two in-depth wānanga (a total of 13 participants) were held with manukura Māori to understand their lived experiences of institutional racism through pūrākau from the perspective of what happens at the health service delivery level and in the context of the health sector. The wānanga were held kanohi ki te kanohi, and two online hui (one participant per hui) were held for those who were unable to attend the wānanga. Both methods enabled participants to share their pūrākau and kōrero. The wānanga and hui included kōrero on institutional racism as a result of colonisation and its impact on the participant, others such as patients or whānau and on the health system. In addition, kōrero focused on solutions for moving beyond institutional racism. This entailed kōrero where participants listened to others' experiences and debated and agreed on ways that the health system can move beyond institutional racism. Whilst the focus was on primary care, the discussion was centred around changing the health system to enable change within the primary care sector.

The two wānanga were held at two different kaupapa Māori health provider premises; one based in Hamilton on 3rd March, 2023 (six participants), and the other based in Tauranga on 10th March, 2023 (seven participants). The two hui were held separately online on the 20th and 27th March, 2023 and lasted between 60 and 90 minutes. Both the wānanga and hui were free-flowing discussions, with each participant sharing their experiences of institutional racism and building upon the kōrero of others. After each wānanga and hui, I reviewed my written notes to ensure that I had captured the data correctly and that it aligned with the participants' intent behind their discussion. Participants were offered follow-up discussions, with two participants taking up this offer to provide further context for their contributions. Following the wānanga and hui, the recorded notes were checked against the transcribed notes, and all identifying features, such as names, were removed; a pseudonym was then assigned. Each participant received a koha and kai (apart from the online participants) as an expression of appreciation for their time and contribution. At the completion of this thesis, participants will be presented with a hardbound copy of the thesis as an acknowledgement of their efforts to effect change within the primary healthcare sector in Aotearoa.

4.6.8 Data Analysis

The analysis of the findings from the wānanga and hui is based on the assumption that institutional racism exists in primary healthcare, as discussed in Chapter Two. It was also informed by Braun and Clarke's (2014; 2017) thematic analysis method for the initial data analysis process as it provided a flexible approach in its application being an interpretive method. For example, I familiarised myself with the raw data through reading and rereading the data and making notes on patterns that were appearing. This method allowed me to go back and forth between raw data patterns and themes.

Each transcribed wānanga and hui was used to search for recurring words or discussions by manually highlighting these on the computer. I began to look for patterns and identified early themes within each wānanga and hui transcript, such as procurement or commissioning, valuing the voice of Māori and te ao Māori, policy, strategy, legislation, outcomes, high-trust contracts, behaviours, power, and control of government, to name a few. I then split the themes of experiences and solutions within each wānanga and hui transcript under the themes. For example, the theme 'policy' was split into the experiences of policy and then the solutions towards transforming policy. Some themes interlinked or grouped together, for example, legislation, policy and strategy. The grouping of themes led to my decision to present the themes through three pūrākau that described the manukura Māori stories via narratives. In essence the themes guided the pūrākau as I was able to pull the information together under each theme.

According to Lee (2009), pūrākau provides an understanding of historical narratives through traditional storytelling. Pūrākau, as described by Wirihana (2012), are traditional life story narratives

that she used as an analytic tool. Wirihana breaks down the origins of pūrākau, for example, pū as the source, rā as enlightenment, ka as encompassing the past, present, and future, and ū as originating from within, and uses these as the basis for developing themes in her doctoral research. Through the three pūrākau, I have applied the breaking down of the pūrākau in the following way:

- pū (source) is the mātauranga (knowledge) driven from the manukura Māori;
- rā (enlightenment) is the strength and energy from the manukura Māori;
- ka (past, present and future) is through the representation of the manukura Māori whakaaro (thoughts) and kōrero from the past, present and future; and
- ū (within) is the essence or quality of the kōrero from the manukura Māori.

The participant quotes were used to demonstrate the themes and provide contextual explanations that captured the participants' experiences of institutional racism and their thoughts on how to move beyond it. The quotes were edited to remove or explain superfluous wording to make them easier to read. Pūrākau One focuses on the inequity in contracting and resource allocation – it moves beyond it by embedding strategic and collective commissioning. Pūrākau Two focuses on structural racism within non-Māori organisations – it moves beyond it by tackling behaviours and mindsets. Pūrākau Three focuses on the power and control of government – it moves beyond it through tino rangatiratanga.

4.6.9 Ethical considerations

The framework Te Ara Tika, developed by Hudson et al. (2010), resonates with me in terms of ethics being about values and the ethical behaviour that reflects such values. This also aligns with my theoretical positioning to honour the voices and respect the values of manukura Māori, ensuring they are heard and acknowledged in a manner that respects their mana. Te Ara Tika was developed in response to the adverse experiences or outcomes reported by participants in previous research. Hudson et al. (2010) described Māori ethics as being about tikanga, reflecting Māori values, beliefs, and the way they view the world. A te ao Māori view was used to inform an ethical approach to research that ensured that my and the participants' behaviours were aligned through understanding the haukāinga tikanga, kawa and whanonga pono (values) and to ensure that the research was beneficial for Māori. This process allowed me to remove any ethical issues prior to data collection, and as a result, I did not encounter any ethical issues during the wānanga and hui. However, I did encounter ethical issues prior to undertaking the research, and the following text describes the ethical issues and how I mitigated them.

Initially, this research was to focus on a Crown entity as the micro-organisation within the macro-environment of primary healthcare. However, I encountered an ethical issue where the national senior Māori and equity position I held within a Crown entity had the potential to influence

participants, particularly those who worked for the same organisation. In addition, the potential findings around institutional racism could have an impact on the organisation's reputation. I mitigated this ethical issue in a few ways, including through discussion with the organisation's Ethics Council, Chief Executive, my research supervisors, and the Auckland University of Technology Ethics Committee, which led to a pivot in the research focus from a micro-organisation to the primary healthcare sector more generally. After pivoting the research, the revised final ethical approval from the Auckland University of Technology Ethics Committee was received on 2nd December, 2022, before the recruitment of participants (refer to Appendix F).

Furthermore, I was mindful of potential participants who worked for the same organisation as I did, considering the potential impact on their career progression. I ensured there was a balance of power at the wānanga in that I was not in my professional organisation role, I was in a researcher role. I also protected the participants identity as described above. The Crown entity I worked for also insisted that the thesis was to be embargoed for 36 months to protect the organisation. However, I have been released from the embargo as I no longer work for this organisation.

4.6.10 Māori data sovereignty

I have adhered to the relevant principles of Māori data sovereignty, as outlined by Te Mana Raraunga (2018), to ensure the ethical use of data enhances Māori culture, language and wellbeing. The key principles include control over the data, where participants agreed to the collection method through wānanga and hui. Data disaggregation involves using the data to prioritise Māori needs and aspirations. In terms of accountability, respect, consent, guardianship, and ethical principles, to protect participants, informed consent forms were signed and stored in a locked filing cabinet, where they will be destroyed after six years. The consent forms did not record the participants' current workplaces to ensure their anonymity. I am the only person authorised to access the raw data, which is aligned with the informed consent provided by participants and the ethical approval, noting that this data will also be destroyed within six years. Participants' anonymity was also protected by removing all identifying features from the transcripts. Confidentiality has been maintained by quoting participants in an unidentifiable manner, through framing the quotes, and assigning pseudonyms.

Moreover, to mitigate any potential ethical issues within the wānanga and hui, such as the research becoming more important than the participants, I ensured an aroha ki te tangata (care for the participants before the process) approach was taken. This was done through working with the individuals within the hui and the haukāinga of the kaupapa Māori provider where the wānanga was held to ensure the tikanga, kawa and whanongo pono were understood and followed. For example, at the wānanga, the haukāinga opened the wānanga with a mihi and karakia, followed by whanaungatanga.

I then shared the purpose of the wānanga and discussed the information that the participants had received within the participant information sheets and answered any questions. I particularly emphasised the confidentiality of their kōrero to be protected by participants; that there would be no identifying features of the participants within my research findings; that I would ensure everyone had a chance to speak and be respectfully heard; that the participants could break at any time or discontinue participating. I then circulated the consent forms for signing. This approach created a culturally safe and welcoming environment for the participants to share their whakaaro comfortably. As the researcher, through facilitation, I ensured everyone had an opportunity to speak on the kaupapa at hand before moving to the next kaupapa. The participants set the pace, allowing for a free-flowing discussion where they built on kaupapa shared or introduced new ones.

4.6.11 Reflexivity

According to Barbarich-Unasa (2019), reflexivity is a pou (pillar) that highlights the potential influence a researcher may have on their research and includes their position held. It is a key element within qualitative research that relates to various levels of impact that the researcher (intentionally or unintentionally) can have on the overall findings of the research. Barbarich-Unasa goes on to say that, in essence, it involves cultivating sensitivity toward oneself and others while fostering mindful awareness of the emotional dimensions of the research.

This led me to consider how I would address reflexivity in my research practice. I was mindful not to drive the direction of the discussions and findings, resulting in the manukura Māori taking the lead. However, I was able to understand the experiences shared and share some of my own similar experiences. I utilised my research whānau who provided cultural and mindfulness guidance and emotional support with respect to the nature of the research. I was also transparent about what I had heard and how I would share the findings, which supported a strong relationship with the participants. It was important for the participants to know my professional background. However, I also needed to understand that my experience was not all that was required in the research. As the researcher and facilitator of the wānanga and hui, I made it clear that I was working alongside the participants to hear their experiences of and solutions to move beyond institutional racism. Based on the assumption that institutional racism exists in primary healthcare, the experiences of institutional racism must be heard before moving towards solutions. Smith (2015) explained it as appreciating what has gone wrong in the past before moving to transformation.

4.7 Conclusion

This kaupapa Māori research celebrates and privileges a Māori worldview that talks back to power or the Western way of doing things, to include institutional racism as a social injustice influenced by structures and standard approaches. Institutional racism has been linked with the enduring and harmful impacts of colonisation through unequal treatment or discrimination based on race, typically

affecting those who are usually a minority or marginalised group, arising from structures or systems. This research also improves the understanding of the realities of institutional racism from a manukura Māori perspective based on their experience within primary healthcare. Wānanga and hui were held, with participants drawing on kaupapa Māori research fundamentals and philosophy from Māori researchers, Te Tiriti principles, and my passion for improving outcomes for Māori. The findings from the wānanga and hui were themed and transformed into pūrākau, providing rich kōrero based on the participants' experiences of institutional racism within primary healthcare and solutions to move beyond it. The next chapter presents these findings utilising participant quotes to emphasise key points.

5 FINDINGS

5.1 Introduction

This chapter is divided into two parts, with Part One presenting the findings through three pūrākau. Part Two presents a further review of two key issues identified in Part One, drawing on the content of the pūrākau and literature.

The findings portrayed through three pūrākau share the manukura experiences of institutional racism and their thoughts on solutions to move beyond institutional racism. Furthermore, in the introduction to this thesis, Chapter One captured my own pūrākau of my experience as a health professional.

The three pūrākau are composite stories that combine kōrero of two wānanga and two hui, for example, Pūrākau One, titled “The inequity in contracting and resource allocation,” is drawn predominantly from hui one (Mereana) and wānanga one with some kōrero from wānanga two. Pūrākau Two, titled “Looking under the hood,” is drawn predominately from hui two (Tutiana) with some kōrero from wānanga two. Pūrākau Three, titled “The Crown holds the power and control,” is drawn from the first and second wānanga.

5.2 Part One – Institutional racism through the eyes of manukura Māori

5.2.1 Pūrākau One: The inequity in contracting and resource allocation

A snapshot of this pūrākau, which focuses on how institutional racism is embedded into the health system through varying contracting and resource allocation processes for services by the Crown, resulting in challenging and varying processes between non-Māori and kaupapa Māori providers to access funding for communities.

In Mereana’s experience, the Primary Health Care Strategy (Ministry of Health, 2001) was viewed as a robust strategy, as it provided equal opportunities for primary care providers. However, the political pressure from general practices resulted in funding for only enrolled service users. This approach created an uneven playing field between general practices and kaupapa Māori providers of primary health care services.

> The bulk of primary care funding, which is significant, went to Primary Health Organisations that fund a collective of general practices. The general practice is funded regardless if the general practice sees an individual within three years. Whereas on the other side of this kaupapa Māori, providers are funded based on tendering for services and providers are required to achieve certain numbers, or the funding is clawed back, or contracts are cut, and, in some cases, given to Primary Health Organisations to deliver. Kaupapa Māori providers

> are always chasing contract renewals. There needs to be a more equitable approach. (Mereana)

In addition, kōrero from the rōpū (group) from wānanga one discussed how tangata whenua are frustrated with the Crown's decision-making on health system resource allocation.

> We are sick of hearing about the mainstream general practices giving the system grief about more resources for them! What about us, what about our power, our control, our money? Try delivering on the smell of an oily rag. (W1)

> If you confront unhappy mainstream general practices, most of the time they are objecting to kaupapa Māori organisations holding the purse strings, too much power. (W1)

> Primary Health Organisations use taxpayers' money, how to ensure that this goes back to the people. This is where it counts. We need to influence here. Don't know how much is being spent on the people and how much is in reserves earning interest for Primary Health Organisations. (W1)

The equity issue here is that the process of funding distribution and allocation varies. General Practices are funded through Primary Health Organisations on evergreen contracts (non-contestable and ongoing) and kaupapa Māori providers have a competitive tendering process (formal bidding for contracts) of which the competition is not just kaupapa Māori providers but non-Māori providers too. Mereana states that this process resulted in kaupapa Māori providers not starting from the same point in respect to funding received and in the way the funding is monitored.

Furthermore, the rōpū from both wānanga discussed the competitive tendering environment in that Crown organisations are renowned for creating competition between providers as part of their commissioning approach. One of the inequities is that smaller kaupapa Māori providers do not have the infrastructure to compete with larger providers in relation to tenders.

> What's the environment and the systemic things that create the inequities? One is the competitive environment that the Crown have created, bidding for tenders and the large organisations have the manpower to respond, kaupapa Māori providers are on the back foot. (W2)

> It's a competing environment even with the establishment of Te Aka Whai Ora (Māori Health Authority) as they are within a Crown system and tenders are being used for procurement. The tenders have all gone out at once, putting pressure on kaupapa Māori providers to

> respond, timelines are not in our favour. We need to get in the room with the rohe (region) versus a tender process, it's an unsophisticated and lazy process compounded by the Crown system that is putting pressure on Te Aka Whai Ora to show their worth. A rohe (locality) approach to tino rangatiratanga works. (W1)

The rōpū from wānanga one discussed that the solution is to have a strategic and collective approach towards commissioning to remove the competitive approach.

> There needs to be more strategic thought around commissioning from the Crown and from providers. Under a collective strategic commissioning approach, the Crown need to ensure there are opportunities for co-design from planning through to implementation. Kaupapa Māori providers need to ensure that the kaupapa aligns with the purpose of the kaupapa Māori or iwi organisation and benefits our people. (W1)

Furthermore, the rōpū from wānanga one discussed the latest commissioning approach by the District Health Boards, which involves collective tendering for Integrated Primary Mental Health contracts focused on Māori, Pasifika, rangatahi (youth), and rural communities. The intent of the District Health Board in this instance was good, but it did not go all the way towards tino rangatiratanga, as the District Health Board still controlled an element within the contracts. The District Health Board included in the tender and contract that a non-Māori organisation with a Māori name was to deliver the health improvement practitioner training for staff.

> The non-Māori provider knows nothing about Māori and have deemed that an enrolled nurse can't be a Health Improvement Practitioner. The decisions are driven by the centre, once again, power and control. You can't make non-Māori organisations Māori just because of a name or putting in a few Māori faces on the Board. (W1)

> In Article 3 of the Tiriti o Waitangi it is about outcomes. However, under the Integrated Primary Mental Health contracts, how do you know that the Health Improvement Practitioner training delivered by non-Māori is going to achieve the outcomes needed for the service that will be kaupapa Māori driven? (W1)

Moreover, Mereana shared that funders focus on making contracting more efficient by funding large providers that cover regions, rather than investing in smaller providers that serve localities with the highest needs.

> Contracts that were previously with kaupapa Māori or iwi providers, for example the smoking cessation contracts, were given to Primary Health Organisation's so there is one large provider instead of a number of smaller kaupapa Māori providers.

Whilst the management of one larger contract might be seen as cost efficient, the kaupapa Māori and iwi providers had the reach into their communities. This approach valued cost efficiency over health outcomes. There were similarities shared through wānanga one, about a Crown entity which funds large non-Māori providers who own the referral system.

> The large non-Māori providers receive contracts from ACC and then sub-contract to smaller kaupapa Māori providers like us, and we receive minimal referrals or the very complex referrals which require a Māori way of doing things like whanaungatanga, which takes time. However, there is no recognition for this process in terms of funding. Why not adequately fund smaller kaupapa Māori providers directly for services where the referrals can be better managed and the Māori way of doing things is valued? (W1)

> The procurement strategy of non-Māori providers needs to include the direct transfer of funding to Māori entities. (W1)

The rōpū from wānanga one agreed that the approach by Accident Corporation Compensation is a cost-over-health-benefits approach, which raised the question for them of whether the organisation trusts kaupapa Māori providers to deliver.

The rōpū then moved on to discuss the way contracts and reporting were developed by non-Māori organisations. Kaupapa Māori providers value high-trust contracts as they bring together all the health funding into one contract versus a number of contracts from a variety of funders. This approach results in kaupapa Māori providers delivering a range of services through a high-trust contract that focuses on achieving outcomes for our people. The delivery of the service is determined by the provider based on the need in the community, as long as the results are achieved. Coupled with contracting for outcomes, in this approach, the whānau or individuals determine the outcomes to be achieved based on what is important to them or is valued by Māori.

> Te Aka Whai Ora and Te Whatu Ora (Health New Zealand) have a lack of high-trust contracts with kaupapa Māori organisations. They should be piloting high-trust contracts within localities. There is a difference between the Crown and Māori. Crown officials don't do enough off the radar, too vanilla. Whereas Māori do things behind the scenes to get the outcomes, regardless of whether they are contracted for outcomes. We know that working with our people to determine and achieve outcomes works. (W1)

> The Crown are wanting relationships with iwi, we need a high trust contracting relationship, and if the Crown wants to make a difference, then they need to invest in outcomes. (W1)

The issues identified in this pūrākau provide evidence of structural inequities affecting kaupapa Māori providers through the Crown's power in how contracts and funding allocations are distributed, creating a competitive contracting environment and favouring large non-Māori providers to deliver services over smaller kaupapa Māori providers. In addition, the Crown determines how contracts are developed and reported against, which are generally based on outputs versus meaningful outcomes.

5.2.2 Pūrākau Two: Looking under the hood

A snapshot of the second pūrākau, which emphasised that institutional racism within non-Māori organisations is embedded through legislation, policy, strategy and processes and alongside this is how people operate and make decisions within organisations. This pūrākau highlights the importance of Māori voices and valuing te ao Māori, including being at the decision-making table. Moreover, this pūrākau shares that there are pro-Tiriti and pro-equity tools available for non-Māori organisations, and a measure of the use of such tools is through an organisation's distribution of power. Finally, the pūrākau provides insights into how to tackle behaviours and mindsets.

This is the pūrakau of Tutiana, who described institutional racism as systemic racism that is embedded within non-Māori organisations through legislation, policy, strategies and processes. However, this is coupled with other forms of racism, such as interpersonal, internalised and discrimination, and this comes into effect through the actions of the people operating within an organisation. Tutiana goes on to describe solutions to move beyond institutional racism through addressing systemic racism with varying levers and a method to change behaviours and mindsets. This includes addressing the behaviours and mindsets of Pākehā and interpersonal racism, where individuals operate according to the Pākehā culture.

> Racism is the power to put prejudice into practice, whenever Pākehā have the power to put their prejudice into action, people miss out. It is a power dynamic, who holds the power, who makes the decision?

From Tutiana's experience to tackle institutional racism, you need to "look under the hood", which means to dig into an organisation to truly understand the root cause of institutional racism. She believed it was about how we interacted as people and how that manifested itself in certain behaviours.

> The institutional racism setting is from a dominant culture applying their cultural lens and mindset in a way that does not recognise the importance of diversity, the difference between equity or equality, the application of differential investment between Māori and non-Māori, and it does not value te Tiriti o Waitangi or indigenous worldviews.

However, Tutiana goes on to explain that looking at institutional racism in isolation is a mistake, as sometimes it is easier to diagnose an organisation by labelling the issue as institutional racism rather than recognising the fact that organisations are made up of people. People make decisions that lead to particular behaviours. Tutiana explained that institutional racism is created by Pākehā and becomes ingrained in the structure of organisations and the system within which the organisations operate. In parallel with this, there are the behaviours and mindsets of the people who operate within those organisations and systems.

Tutiana talked about unpacking the root cause of institutional racism, which included reviewing legislation, policy and strategy development and processes across organisations, for example, the recruitment processes that do not recognise te reo me ōna tikanga (Māori language and its customs) or value mātauranga Māori.

> Policy development does not respond to the root causes of institutional racism. Māori need to be part of writing the policy to meet the root cause of institutional racism.
>
> Māori may not apply for roles or are not culturally supported during the recruitment process. (W2)

Furthermore, the rōpū from wānanga two concurred that legislation and policy need to embed accountability to gain outcomes for Māori.

> We play around the edges, change happens when legislation and policy accounts for Māori. (W2)

Tutiana has been at many local, regional and national health governance tables where equity is not prioritised, the indigenous voice is not enabled to be heard, and te ao Māori is not valued.

> I’ve heard many times, that the organisation cannot afford equity.
>
> Māori are asked to say the karakia to open and close the meeting and that is it. I have been made to feel unwelcome through mispronunciation of names, no consideration of the circumstances of our people, no recognition of the complex needs, the workforce is culturally

> unsafe and there is no recognition of the impact that the back-office functions of an organisation have on the delivery of services.

The rōpū from wānanga two had a similar discussion. To effect change in the health system, Māori needed to be part of the change through being at the decision-making table to ensure equity is valued, which can then disrupt the flow of racism and keep people accountable to achieving outcomes for Māori. This approach includes being listened to during discussions and decision-making. Te ao Māori embodies values that can lead to strategic thinking and finding solutions; this is what Māori can bring to the table.

> Culture is the add-on, we need to be at the design, implementation and review of every service with an equipped Māori voice. Māori in every layer of decision-making. (W2)

> My experience as a Chief Executive around mostly white tables is it's, one Māori versus nine others we need to have the veto right. One Māori at the decision-making table is tokenistic. (W2)

> We need to be at the decision-making table and backed by our communities. It can feel toothless and tokenistic when there is one Māori at the table as we are not heard, or the input is interpreted through a Pākehā lens resulting in a decision that hasn't captured the Māori view. (W2)

> Hauora providers have huge communities to service and need to be at the decision table. No one knows our people better than us, we know the hapū, the community as we are part of this community. We are 24/7, we don't switch off at 5:00pm, we are here to make things better for our mokopuna. Be who we are as Māori and we do what's right for Māori. (W2)

Tutiana talks about the failings in processes as described above, which leads to a common approach where Māori are always trying to fix something or bolt on an indigenous perspective after something is implemented.

> The ultimate is to get in on the ground floor and start designing so Māori do not have to unravel. To do this, Māori need to be trusted and valued as indigenous people, and Pākehā need to understand the role we have to play to craft a better Aotearoa.

Unfortunately, Tutiana believed, we are still pushing for recognition, voice and consideration of all things Māori. However, in her view, a good example of a Māori organisation that has excellent leadership is Te Aka Whai Ora.

> It is just a given that your indigeneity is a blessing. You do not have to turn up and reiterate te Tiriti o Waitangi. It is about how we effect positive change and invest in the goodness that is indigenous. In those situations, there is not an issue as there is no dominant culture shift.

Furthermore, there have been some instances within organisations where co-governance or co-ownership were being considered; this is a start.

> When Māori are in the room, good decisions are made for Māori, but when you are not in the room, it is back to a monoculture approach. However, there are not enough of us; we cannot be everywhere all the time. Therefore, a cumulative of levers for change is required, such as reviewing everything from governance, management, leadership, policies, procedures, external-facing products and workforce in collaboration with Māori.

Tutiana shared that there were mātauranga Māori tools designed for non-Māori organisations to be pro-Tiriti and pro-equity, but that they are not often well utilised.

> There are great tools to support non-Māori organisations, but the outward-facing products are the first thing to be changed, such as giving the organisation a Māori name. However, it is all surface as the mauri (life essence) of the organisation is the core.

To understand if an organisation is pro-Tiriti and pro-equity, the organisation needs to look internally to understand the power distribution, for example, the number of Māori staff within all levels of the organisation (governance, management, lead), who make the decision.

> If a Chief Executive does not support the privilege for Māori to make decisions, then it supports institutional racism. (Tutiana)

Tutiana shared that levers for change included legislation, policy, strategy, equitable funding, equitable distribution of resources, service commission, mātauranga Māori, a braided approach (bringing te ao Māori and Pākehā world together) and enablers such as data, digital information, money, people and practices.

> Let us move from Māori being at the whim of legislation and policies, swimming upstream to Māori being part of the solution and looking at all of these levers in collaboration with Māori, this will move us towards the mitigation of institutional racism.

However, this is only part of the mitigation equation as changing legislation, policy, or strategy does provide change within an organisation, but a new Government can come in and change legislation, or a new Chief Executive can change policy and strategy. Therefore, in parallel to changing the systemic racism that is embedded within non-Māori organisations, understanding how to change people's behaviours and mindsets within organisations is important. Tutiana shared that behaviour can be seen as a cumulation of policies that add up to institutional racism.

Moreover, to change mindsets and therefore behaviours, we need to understand that non-Māori colleagues fit in many camps.

> The main camps non-Māori sit in are, I do not care (do not see that there is institutional racism); sitting on the fence (unsure if there is or is not institutional racism); some want to do something but are paralysed (Pākehā paralysis) so do nothing because they are fearful of doing something but want to do the right thing; some are supportive and may get told off but it becomes part of their learnings. (Tutiana)

The key is to manaaki (support) those allies or the willing and to understand our expectations and role in supporting others, including education for Māori, Pākehā, and other cultures, as we have a different understanding of institutional racism. In terms of educating other cultures, the Asian population is large and growing in Aotearoa, and therefore, they will be in more decision-making areas with the opportunity to influence.

> Māori need to educate the Asian population so that compassion for our people starts now. We need to think laterally, as it is not all about Pākehā (they are still dominant), but other cultures are coming in, so there is a need to educate. (Tutiana)

Māori hold roles to change organisations because the organisations are on a learning journey, and we do it because they don't know how to do it. The problem is balance, as non-Māori also have a role and responsibility to be accountable.

> Let us be clear, roles such as Director Māori within organisations are fundamental to effect change within organisations. However, these roles exist because of institutional racism. (Tutiana)

Getting under the hood is critical to understand what is driving institutional racism from front-facing and back-office organisational systems, which contribute towards behaviours and mindsets. Changing mindsets needs to work alongside addressing the embedded structural racism, such as

legislation, policy, strategy and processes within organisations, so that progress made in changing structural racism is not lost when people (leaders, staff) come and go.

5.2.3 Pūrākau Three: The Crown holds the power and control

A snapshot into the last pūrākau, which focused on power and control where decisions are made for Māori without Māori, even though there are successfully proven Māori-led and owned initiatives across Aotearoa. This pūrākau shares solutions for moving beyond institutional racism by understanding the aspirations and values of iwi and kaupapa Māori providers, creating genuine partnerships. Furthermore, Māori leaders have shown their strength, resistance and resilience to survive in a Pākehā-dominated world through achievements such as the creation of collective approaches that established Māori-led and owned General Practices, Primary Health Organisations and through locally led approaches.

The struggle for power and control is evident throughout the previous two pūrākau, and also in my pūrākau in Chapter One. The power and control have been held on to for so long within Pākehā structures that there is an unwillingness to relinquish this power through decision-making. This pūrākau comes from the kōrero and deliberation of two wānanga that further share examples of Crown power where decisions are made for Māori without Māori, leading to social injustice. Both wānanga discussed solutions such as true partnerships with Māori where governorship, leadership and decision-making are equal between Māori and the Crown, and to do this, valuing te ao Māori and mātauranga Māori is essential. Other solutions included examples of when Māori can lead and self-determine, collective approaches and the positives of the health reform, particularly the locality approach.

The rōpū from wānanga one started with sharing how institutional racism existed as a tool in servicing colonisation; if we were not colonised, there would not be institutional racism. Institutional racism maintains kāwanatanga (government) or colonial power and privilege through the continual battle of power and control of resources that do not address equity. This power leads to social injustice. Part of the solution, as described in pūrākau two, involves changing the behaviours and mindsets of Pākehā and addressing internalised racism, where individuals operate according to the Pākehā (dominant) culture. The other part of the solution is to decolonise through moving towards mana motuhake (autonomy and self-government) and tino rangatiratanga (self-determination and sovereignty).

> Institutional racism starts as personal, my name is Māori, I look Māori, so my experience is personal, and it continues in all shapes, like the way I'm treated at Pak n Save, I had my bag checked and you normalise it. On a professional sense, I look at the world differently, acutely aware and surprised when it happens in your face, but you expect it, it changes the lens in

> which you view life and your interactions. Learn about who you are as Māori, and it creates a lens to social justice. I am much more acutely aware of social justice for our people. (W1)

> Recently, the police were interrogating young Māori males on the street, asking for their information. It seemed to be the new way of getting rid of crime. This is a social injustice towards our people. (W1)

The rōpū from wānanga one had experienced institutional racism through non-Māori (non-Māori or Crown-owned) organisations such as the Ministry of Health, District Health Boards, Primary Health Organisations, general practices and Crown entities that talk about Māori and make decisions about Māori without talking to kaupapa Māori providers. Power and control remain with the non-Māori organisations.

> We as kaupapa Māori providers need to be part of the discussion as we have the answers through being closer (proximity) to the people and understanding the people in their communities. Nothing about us without us. (W1)

The rōpū from wānanga two took this further and discussed a partnership approach with the true essence of a partnership, starting with understanding iwi or kaupapa Māori provider aspirations and values. Once this is understood and there are commonalities between Māori and Crown organisations, this can then move into a relationship and start to form a partnership. This approach takes time, as building trust is essential. Unfortunately, this approach does not occur very often, as it is about what the Crown organisation wants first and foremost.

> Oranga Tamariki wanted a hui with us (kaupapa Māori Mental Health provider), so we invited them down as we don't know who they are. They barged in and started to talk about what was important to them. We said taihoa (hold on), then welcomed them into the whare, then the kōrero was on the table. (W2)

> More and more Crown entities are demanding time with iwi and kaupapa Māori providers to talk about what they want, no consideration of the kawa (Māori protocols) or tikanga or what might be important to us as providers and iwi. (W2)

> Misinformation and mistreatment come from not being a treaty partner. Government organisations need to be good treaty partners. From recruitment to orientation to professional development, etc. If you can't say my Māori name, then I don't want to speak to you, that's not being a treaty partner. (W2)

> It's just about respect. If I treat people right, it will come back to you. I want to be treated as I treat others, with respect. (W2)

The rōpū from wānanga one shared experiences of power and control by non-Māori organisations through a range of examples, with the first example within the justice system, through to a crown entity, a tangata whenua-owned marae clinic and lastly an aero-medical service.

> Management in isolation develops processes in respect to prisoners with mental health challenges, creating a myopic view. Management needs to talk to kaupapa Māori providers and whānau around processes to support our people with the way forward, as we are closer to the community and see what is happening on the ground or what people are experiencing. There needs to be a collective approach to decision-making to include a collective approach to funding. (W1)

The following example shows how non-Māori have the power to shift rules and goalposts to disadvantage kaupapa Māori providers providing services.

> A marae opened a medical centre, a Primary Health Organisation advised it wasn't up to the quality standard and worked with the District Health Board to shut it down. However, when a general practice put in a general practitioner and ran the marae clinic as a philanthropic approach it was accepted by the Primary Health Organisation. The general practitioners are from around the world running the clinic on a marae; their way to include money gained going into the general practice's bank account. The original contract between the general practice and the marae clinic said, 'te reo Māori will be the primary language at the marae clinic', this then changed to suit the general practice way of working to, 'the marae clinic will support the Māori language'. Later, the general practice backed out of the marae clinic. The marae clinic is now a nurse-led clinic being run as a satellite clinic. The District Health Board never looked into this to recognise the marae clinic as a kaupapa Māori provider. (W1)

This experience shows the power and control of the District Health Board and non-Māori organisations (Primary Health Organisation, general practice) exerting their power to control how a medical centre should look and deliver services. Furthermore, here is an example of maldistribution and inadequate funding in the aero-medical space.

> Areas such as Piha or Waiheke Island, where visitors flock to, have service resources and places such as Northland and Tāirāwhiti use cake stalls to run the aero-medical. (W1)

> Air Ruatoria was set up by a kaupapa Māori provider as they saw the need but were

> not getting adequate resources to provide the service. (W1)

The experiences of power and control held by the Crown show the lack of support for tino rangatiratanga. The rōpū from wānanga two shared three experiences where they pushed back on the Crown power and control through a collective of Māori who fought for and achieved the establishment of kaupapa Māori general practices across a locality and subsequently a kaupapa Māori unit and kaupapa Māori ward within the hospital. A few years later, a contingent of the collective of Māori established a kaupapa Māori Primary Health Organisation. Although Māori led the kaupapa Māori organisations, they still faced challenges within the Crown health system. As such, a few years later, the District Health Board disestablished the kaupapa Māori unit within the hospital. The Crown did not see the value of a Māori unit within the hospital and merged the unit with the Māori planning and funding department.

> The District Health Board is white and laundered, but once we had a Māori collective within the District Health Board, ground was made, we got treaty principles in there, and a kaupapa Māori unit and a kaupapa Māori ward were established. When the Māori unit was moved out, it was very difficult to keep people to account. (W2)

> We (collective of Māori) built our own general practice clinics to fix institutional racism, but we still have non-Māori general practitioners and nurses. Māori general practitioners and nurses are difficult to find, and the non-Māori general practitioners and nurses have been shaped by the education system. There is a need for cultural training, recognition and value of mātauranga Māori in the medical training system. More and more non-Māori are coming in as general practitioners, so we have to culturally educate again and again. (W2)

The rōpū from wānanga one discussed the successes of Māori-led and Māori-owned initiatives that, in their view, have worked for Māori. These successes include kura kaupapa, kohanga reo, Māori TV and te Matatini. All these initiatives represent mana motuhake and tino rangatiratanga. The rōpū then moved on to talk about the Whānau Ora delivery model that has tino rangatiratanga embedded within through whānau determining their outcomes. The rōpū agreed that the model is seen as working for our people as it contains social elements within the model and looks at the individual within a whānau from a holistic view. The rōpū further discussed how the Crown system separates services across sectors such as housing and health. However, to address mental wellness for our people, all elements of the social system need to be incorporated, as it is more than just health. Māori designed the Whānau Ora model for Māori, coupled with services delivered locally by Māori.

The rōpū from wānanga two also talked about great collective leadership by Māori, specifically through the pandemic in 2020. The pandemic also showed the flaws of non-Māori leadership,

management and preparedness, including institutional racism, where kaupapa Māori providers and iwi were not trusted to lead in their communities.

> We never forget our communities. COVID is a good example of this. When the vaccines came out, the Ministry of Health said, get vaccines with a voucher at New World. I went to the pickup point, and there was nothing there. Whānau through word of mouth went to a kaupapa Māori provider who gave us the vaccine, kai (food), and information on the process. (W2)

> It was ridiculous at the beginning of COVID-19 as kaupapa Māori providers had to fight to deliver vaccines in the community, and we were not funded, but the District Health Board got funding. Kaupapa Māori providers do it for the people for the community not because of a contract. (W2)

> Iwi and hapū leadership of COVID-19 and emergency supports included marae cooking for the whole community. Civil Defence and others don't recognise the value and complexity of iwi, hapū and kaupapa Māori providers who know their communities and how to support the communities. We were treated as a silent part of the community. (W2)

> Tino rangatiratanga is what is required to meet institutional racism. But mana motuhake is a beginning, through iwi and hapū, enabling the response to emergencies. We need direct access to the resource, not going through others. (W2)

The rōpū from wānanga one discussed the recent changes by the Crown under the health reform, specifically, the establishment of Te Aka Whai Ora. This is a step toward moving beyond colonisation as it is an example of mana motuhake and tino rangatiratanga, albeit within a Crown system.

> This does give us strength that we may move beyond institutional racism over time. (W1)

Furthermore, establishing the Iwi Māori Partnership Boards under the health reform is promising as we need strategic Māori leaders working together to improve health outcomes for Māori. \\

> The devolvement of the leadership structures, Iwi Māori Partnership Boards are a start in health, however, what power will they have with respect to the Crown power. This arrangement needs to be considered in other sectors like education, etc., to provide solutions. Successful strategy, planning and delivery at a local level will move us beyond institutional racism. (W1)

However, there was debate on the power of the Iwi Māori Partnership Boards with respect to the current Kiingitanga (Māori King movement) process, specifically questioning if the Iwi Māori Partnership Boards will dilute the power of the Kiingitanga.

> Some high-level professional Māori criticise the Iwi Māori Partnership Boards because the Kiingitanga has the Prime Minister in the room so why have a Partnership Board? (W1)

The rōpū from wānanga two were supportive of the locality approach, another element within the health reform as it is an opportunity for tino rangatiratanga where the localities are designed by Māori and the Iwi Māori Partnership Boards approve the locality plans. However, resources will need to go directly to localities and follow the outcomes of the locality planning. On the other hand, there looks to be too many layers in the newly reformed health system to include Boards (Te Whatu Ora and Te Aka Whai Ora), Chief Executives, Deputy Chief Executives, Wayfinders, Iwi Māori Partnership Board and 80 localities. Will these prove to be barriers to outcomes in the community due to the lack of resource flow to the localities?

> What does tino rangatiratanga look like? It's about leading locally with adequate resource. (W2)

> There was capacity to thrive better under the Health Funding Authority system. Now we have many layers with a cut of the dollar going to every layer, which sucks time and money. Relationships need to go straight to the ground, with money on the frontline. Too many layers. Just have localities straight from hierarchy. (W2)

> Locality planning space is an opportunity, we as iwi and kaupapa Māori providers are already leading locally through whānau-led approaches. Adequate resource needs to follow. (W2)

Through this pūrākau, it is evident that the power and control lie with the Crown, resulting in inequities for Māori. However, there is some hope through the Whānau Ora delivery model, self-determined collective Māori leadership approaches, and elements of the health reform, such as the establishment of Te Aka Whai Ora, Iwi Māori Partnership Boards, and localities where mana motuhake and tino rangatiratanga can be applied. To further embed models described and achieve positive outcomes for Māori, Pākehā need to embrace us as Māori by being valued and equal leaders and as members at the decision-making table. This requires listening, understanding and valuing te ao Māori.

5.2.4 Bringing the pūrākau together

The wealth of knowledge and experience shared by manukura Māori highlighted many commonalities both in the experience of and solutions for institutional racism. The language and examples used may vary, but the context of each pūrākau remains similar. The impact of colonisation has led to institutional racism in the health system through the power and control being held by the Crown, resulting in an imbalance of leadership through to decision-making. Power and control of the Crown are highlighted in the pūrākau through two key issues. The first is the contracting process from the Crown to providers. Issues included the differences in contracting methods between General Practice and kaupapa Māori providers (evergreen versus short-term contracts), resulting in kaupapa Māori providers continually applying for contracts. The competitive tendering environment means that large non-Māori providers have more resources to tender for contracts, and the Crown favours cost efficiencies over health benefits by contracting with large non-Māori providers that cover regional areas, rather than smaller kaupapa Māori providers that cover local areas.

The second issue is how the Crown has embedded institutional racism within legislation, policy, strategy and processes within Crown and non-Māori organisations that subsequently impact the mindsets and behaviours of people operating in those environments, thus further embedding institutional racism. The pūrākau share strategies to address this issue, including power sharing, valuing the voice of Māori, te ao Māori and mātauranga Māori, the creation of partnerships with Māori and changing people's mindsets and behaviours within organisations through working with the willing. Changing people's mindsets and behaviours is an important element to move beyond institutional racism, as a change in a Crown organisation's leadership can shift the focus and priorities with regard to addressing the needs of Māori and/or the government can undo legislation, policy, strategy and process changes that address Māori inequities as decision-making is politically determined rather than based on strong evidence of inequities and need.

The pūrākau also highlight the strength, resistance and resilience of Māori leaders' survival in a Pākehā-dominated world where Māori collectives were established to fight for mana motuhake and tino rangatiratanga through Māori-led general practices, Māori-led services in the community, and Māori-led Primary Health Organisations. The next chapter will discuss further the two issues mentioned and the continual battle of Māori leaders in a Pākehā-dominated world.

5.3 Part Two – A further review of two key issues

5.3.1 Introduction

Collectively, the pūrākau described the impact of colonisation that has led to institutional racism in the health system through the power and control held by the Crown. The Crown's power and control have been highlighted through the two key issues. Firstly, how the Crown has embedded institutional

racism within legislation, policy, strategy and processes within Crown and non-Māori organisations. This subsequently impacts the mindsets and behaviours of people operating in those environments, thus further embedding institutional racism. Secondly, a particular Crown process through the contracting and allocation of resources from the Crown to kaupapa Māori providers has been looked at in depth. This process impacts the delivery of services and the health outcomes for Māori. Part Two presents a further review of two key issues identified within the three pūrākau to highlight the significance of the findings and the impact on Māori. The two key issues were embedded institutional racism, and inequitable contracting and resource allocation by the Crown. I have drawn on the content of the pūrākau and literature to present these findings.

5.3.2 Embedded institutional racism

Racism has a whakapapa, as outlined in Chapter Two, starting with structural to institutional through to interpersonal and on to internalised racism. Institutional racism flows from structural racism, with the racist platform set by the ingrained Western colonial worldview from colonisation. This is then enacted through the government, which normalises Crown and non-Māori organisations to further enact and enforce institutional racism throughout their organisations. An example of this enactment at a Crown and non-Māori organisation level is through the Crown holding the power through decision-making (specific examples are shared further on).

When the Crown holds and controls the power through decision-making, Māori come off second best to non-Māori, as evidenced by the health disparities between Māori and non-Māori in the *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019). The *Tatau Kahukura: Māori Health Chart Book 2024* (Ministry of Health, 2024) also highlights that Māori still have higher rates than non-Māori for some health conditions and chronic diseases such as cancer, ischaemic heart disease, diabetes, asthma, cardiovascular disease and experiencing racial discrimination. Authors named within this thesis highlight the health inequities between Māori and non-Māori. For example, Lawrenson et al. (2017) found that Māori women have the highest incidence of breast cancer in the world. Egan et al. (2020) found that Māori men experience the poorest health statistics in terms of cancer incidence and mortality compared to non-Māori. Cassim et al. (2020) found that there are barriers for Māori to access early prevention and diagnosis of lung cancer within primary healthcare. Scott et al. (in press) found that bowel cancer mortality for Māori men is higher compared to non-Māori.

Furthermore, there is evidence that institutional racism contributes to health inequities between Māori and non-Māori in Aotearoa and is defined as a social determinant of health (Paradies, 2006). Moreover, institutional racism has been linked with the enduring and harmful impacts of colonisation through unequal treatment of discrimination based on race, one that is typically a minority or marginalised, arising from structures or systems (Reid et al., 2019). The decision-making that is

predominantly made by Pākehā in a dominant Western world is embedded in institutions such as the Crown and other non-Māori organisations.

Institutional racism is the differential access to services, goods and opportunities of society by race, Jones (2000) and through monocultural institutions freezing out those cultures that do not belong to the majority (Ministerial Advisory Committee 1988). Furthermore, institutional racism is seen as a tool to service colonisation where the colonial power and privilege are maintained through the battle of power and control, leading to social injustice for Māori. Within the healthcare system, this has been experienced by manukura Māori through the decision-making dominance of Pākehā at the governance tables (or decision-making tables) in many ways.

Governance referred to in this next section is a group of people strategically governing an organisation through a Board or operationally governing a process within an organisation. The experiences of manukura Māori occurred in several ways: Māori voices were not heard, they were not enabled to be heard, or Pākehā misinterpreted their messages. The reasons for this are related to there being only one Māori voice at the governance table, which can often total nine individuals. That is, an inequitable representation of Māori. This Pākehā dominance of numbers means that Pākehā has the voice, leads the process and makes the decisions. This is accentuated when te ao Māori and mātauranga Māori are not valued and/or understood by the Pākehā around the table. This has led to Māori voices being ignored due to the dominance of Pākehā voices around the table, an unwillingness to understand or ignorance of te ao Māori. This is coupled with diversity not being recognised as a strength, as it brings in varying perspectives to the dominant Pākehā view, and the lack of understanding between the differences in equity (providing what each individual needs to reach an equal outcome) and equality (giving everyone the same resources or opportunities). In essence, equity recognises that people may start from a different place and targeted support is required to level the playing field. This argument is backed by Reidy et al. (2025), who identified the policy challenges for achieving equity for Māori as being through homogeneity of the policy makers within the Ministry of Health, Aotearoa, specifically calling out the lack of Māori input at a policy level.

Looking at this through a political economy lens, Reidy et al. (2025) describes the economy as interwoven with politics and where political decision's structure the economy and that power operates through race, class and gender. This is where homogeneity is driven from in terms of individuals or groups that are holding the power (generally the dominant race) which is shaping policy. In an Aotearoa context, Reidy et al. (2025) explored the shifts in power and found that economic and political power are intertwined with racialised and gender inequity, and subordination – the power continues to be influenced by colonisation. Therefore, as described above when Māori are in a position of governance, the Māori voice is dominated by Pākehā voices. For example, in the review of the Primary Healthcare Strategy 2000, Reidy, et al. (2025) found that this approach

resulted in Māori health providers being disadvantaged in the policy design of the general practice capitation model as ethnicity was excluded in the capitation funding formula. This meant that Māori health providers delivering to Māori who generally have a higher burden of disease were not funded adequately for the provision of service, creating an inequity. While there have been changes to the capitation model over time, ethnicity remains excluded from the first contact payment calculations, which constitute the most significant tranche of primary healthcare funding.

Furthermore, this approach of homogeneity or dominant Pākehā decision-making has been evident in the Aotearoa health reforms. Lorgelly and Exeter (2023) critiqued the 1990 health reform from an equity perspective. They found that through the numerous claims heard by the Waitangi Tribunal Health Services and Outcomes Inquiry (WAI2575), from 2016 onwards, the Crown had breached its obligations under Te Tiriti throughout the health sector and in doing so contributed to the pervasive and persistently poor health outcomes of Māori.

Moreover, institutional racism is embedded within the structural racism through the organisation's legislation, policies, strategies and processes. Legislation, policy, strategy and processes within Crown and non-Māori organisations are predominantly created, developed and implemented by Pākehā in isolation within a Western world construct. Humpage (2006) found that Māori inclusion in policy making does not recognise Māori self-determination. Instead, it is premised on Crown principles to include participation as a democracy and as social inclusion. Again, the voice of Māori, mātauranga Māori and te ao Māori are not valued in the decision-making and therefore, equity is not considered. To consider equity in decision-making, Pākehā need to recognise the circumstances of Māori people and recognise the complex needs of Māori. In addition, the mindset of one size fits all or one way is the way, does not work for Māori as Māori require targeted or differing approaches to the non-Māori approach to achieve equitable outcomes for Māori (Scott et al. In press). Valuing equity can disrupt the flow of racism and keep people accountable to achieving outcomes for Māori. Te ao Māori represents a value that can lead strategic thinking and find solutions (W2).

My findings indicate that this Pākehā decision-making is then coupled with the mindsets and behaviours of the people operating within the Crown and non-Māori organisations. People operate according to the legislation, policy, strategy and processes that have been developed (Tutiana). For example, the process of data collection methods may collect outputs (such as the number of individuals who accessed the service), as this is what has been set up by the organisation from a Western perspective. However, a better way that complements output data collection is to also measure outcomes in the form of narratives (what difference did the service make for the individual and/or whānau), which is the method required by Māori to evidence service delivery (Tutiana, W1 & W2). Narratives provide contextual detail that numbers do not; this allows delving into the context which has made a difference to the individual or whānau (Wepa & Wilson, 2019). Data collection

requires both outputs (numbers) and outcomes (narratives together with numerical data) to evidence change for Māori within service delivery, and this is discussed later under inequitable contracting and resource allocation.

Additionally, interpersonal racism comes into effect alongside the dominant Pākehā decision-making (Tutiana). Interpersonal racism is defined by Jones (2000) as prejudice and discrimination, where prejudice is an individual's assumptions about others' abilities, intentions or motives according to their race. Discrimination is an individual's actions towards others based on their race. Both prejudice and discrimination manifest as a lack of respect, suspicion, devaluation, scapegoating and dehumanisation. In other words, devaluing the voice of Māori, mātauranga Māori and te ao Māori in decision-making.

5.3.3 Inequitable contracting and resource allocation

The inequities from the impact of the power and control by the Crown continue to be evident throughout this section. There are challenging and varying processes used by the Crown when contracting for services and allocating resources to non-Māori and kaupapa Māori providers. Manukura Māori have described this process as a form of institutional racism (W1, W2, Tutiana).

The various contracting methods, for example, the evergreen (ongoing) contracts for general practices, and a contract renewal or tender process for kaupapa Māori providers, result in inequities in many ways. Firstly, evergreen contracts continue and are non-contestable regardless of the performance on outcomes for Māori (W1). General practices receive funding for Māori health, yet there are no consequences when the general practice fails to deliver outcomes or health equity for Māori (W1). According to Ashton (2005), the health reforms of the 1990s and subsequent years have led to changes in general practice funding over time. For example, funding was initially provided through government subsidies in the form of fee-for-service and later through a capitation formula. Other subsidies have been introduced along the way. For example, in 2023, a higher rate subsidy was introduced for children up to 17 years and so forth, with general practices retaining the right to set their own fee levels (co-payments) for consultations. The point is, regardless of the changes within the contract, the contracts are still evergreen agreements.

There is no requirement to renew contracts and, therefore, no workforce capacity is required to renew or tender for contracts. In contrast, contracts held by kaupapa Māori providers are contestable as they generally hold terms from one to three years. For kaupapa Māori providers, this results in the utilisation of the workforce capacity to continually apply for contract renewals or compose bids for tenders. When a kaupapa Māori provider is operating on little revenue, this becomes a challenge in finding the capacity to apply for the tenders. Thus, creating an inequity for kaupapa Māori providers as larger non-Māori organisations generally have this capacity to apply for the tenders

(W1, W2). The other key issue is that the tender process creates competition among kaupapa Māori providers. Māori generally operate in a collective nature through kotahitanga (unity), utilising principles that embrace collective responsibility, goals, commitment and vision connected with Māori aspirations (Smith, 1997). Therefore, the competitive process puts kaupapa Māori providers up against each other, which contrasts with their natural collective way of being (W1, W2).

Furthermore, this is compounded by the contracts being established by the Crown or non-Māori organisations in isolation, which has led to the collection of data, such as inputs and outputs, including how many individuals or whānau have utilised the service. This is contrasted with the outcomes that capture the narrative or the story of the difference the service delivery has made to the individual or whānau (W1, W2). Outcomes are important to Māori as they evidence whether the service has made a difference to their wellbeing. For the outcomes to be meaningful, these need to be co-designed with Māori in the community (Tutiana). An example of a Māori outcomes framework that was developed through consultation with Māori communities and whānau is the *Whānau Ora Outcomes Framework* (Te Puni Kōkiri, 2025). Under this framework, outcomes for Māori include whānau that are "self-managing and empowered leaders; whānau are leading healthy lifestyles; whānau are participating fully in society; whānau are confidently participating in te ao Māori; whānau are economically secure and successfully involved in wealth creation; whānau are cohesive, resilient and nurturing; whānau are responsible stewards of their living and natural environments" (Te Puni Kōkiri, 2025, p.1). This framework includes short, medium, and long-term outcomes and recognises the long-term and gradual change required for whānau to achieve their aspirations.

Manukura Māori described how the Crown contracts favour inputs and outputs with little focus on outcomes, which can confine service delivery when the focus is on meeting the inputs and outputs of the contract. Kaupapa Māori providers deliver on outcomes as they know this is where they can make a difference for Māori. However, the consequences of delivering against outcomes when it is not included in the contract are that the Crown does not always recognise the time required to determine and achieve outcomes with whānau and to tell the story of the impact of the service through the outcomes approach (W1, W2). Inputs, outputs and outcomes (narratives) are essential to capture to tell the story of the service delivery and how this has benefited the individual and/or whānau.

Moreover, there is an inequity in resource allocation through the Crown and non-Māori organisations favouring contracts with large non-Māori organisations over directly contracting with small kaupapa Māori providers. This is a cost efficiency gain over a health outcomes approach, that is, it is easier and more cost-efficient to contract with one large organisation versus a few smaller organisations (W1, W2). The large non-Māori organisations tend to span a large region, whereas the kaupapa Māori providers are locally based, with some being iwi-led providers. The difference is that the

kaupapa Māori providers have connections in the localities and deliver from a te ao Māori base (culturally appropriate), resulting in outcomes for Māori communities. The other inequity is that the large non-Māori organisations can choose to subcontract to kaupapa Māori providers. However, in doing this, the non-Māori organisation controls the referral process, resulting in kaupapa Māori providers receiving minimal referrals or complex referrals that require time, but the funding does not support the invested time (W1, W2).

5.4 Conclusion

This chapter has presented the findings through the voices of manukura Māori utilising the method of pūrākau. The findings in Part One are presented as they were discussed through three pūrākau. Pūrākau One is titled, “The inequity in contracting and resource allocation” and is focused on how institutional racism is embedded into the health system through varying contracting and resource allocation processes for services by the Crown. Pūrākau Two, titled, “Looking under the hood” emphasised that institutional racism within non-Māori organisations is embedded through legislation, policy, strategy and processes and alongside this is how people operate and make decisions within organisations. Pūrākau Three, titled, “The Crown holds the power and control” which is focused on power and control where decisions are made for Māori without Māori input. The three pūrākau come together emphasising the impact of colonisation and that it has led to institutional racism in the health system.

Part Two presented a further review of two key issues identified within the three pūrākau to highlight the significance of the findings and the impact on Māori. The two key issues were embedded institutional racism, and the inequitable contracting and resource allocation by the Crown. The Discussion Chapter will bring together these findings along with literature that highlights how to move beyond institutional racism.

6 DISCUSSION

6.1 Introduction

The questions that this research set out to address were how does institutional racism manifest in policy and practice within the primary healthcare sector? And how can the primary healthcare sector move beyond institutional racism at a strategic level? In essence, this research aimed to find solutions for Crown and mainstream organisations in disrupting and eliminating institutional racism at a strategic level within primary healthcare.

This chapter shares how I have embraced kaupapa Māori research and goes on to discuss the key findings from my research through the three pūrākau titled, “Looking under the hood,” which emphasised that institutional racism within mainstream organisations is embedded through legislation, policy, strategy and processes and alongside this is how people operate and make decisions within organisations. Secondly, “The inequity in contracting and resource allocation,” which focused on how institutional racism is embedded into the health system through varying contracting processes by the Crown. Lastly, “The Crown holds the power,” which focused on power and control, where decisions are made for Māori without Māori, despite the existence of successfully proven Māori-led and owned initiatives across Aotearoa. I then move on to discuss moving beyond institutional racism; the strength, resilience and resistance of manukura Māori; and why manukura Māori have to be resilient. To support this discussion, I have incorporated the deeper analysis of the findings from Chapter Five, new literature and relevant information from the literature review in both Chapters Two and Three. Lastly, I discuss the limitations of the research before concluding the chapter.

6.2 Kaupapa Māori research

Linda Smith’s (2021) work discussed decolonising methodologies, which resonated with me as it highlighted that the Western way of knowing has been privileged and, in parallel, dehumanises Māori practices and invalidates Māori knowledge, te reo Māori and culture. Therefore, as a Māori my research is grounded in kaupapa Māori that is by Māori for Māori where Māori voices are privileged and Māori practices such as karakia, whakatau (welcome), mihi (greet), whakapapa, whanaungatanga and sharing kai to connect with each other has guided my research. Kaupapa Māori, as described by Durie et al. (2017), is an inspirational movement that provides the opportunity to use Māori knowledge and approaches to learning and laying the foundation for significant transformations. In addition, Graham Smith (2015) talked about kaupapa Māori being a mechanism for making transformations and called this a transformative praxis. Grounding my research in kaupapa Māori created trust with manukura Māori participants, which has led to their whakaaro and frank discussions on their experiences of institutional racism. Linda Smith (2021) highlighted the

value of research for Māori people through creating a space where whakaaro, inputs and experiences are valued.

I found the kaupapa Māori approach rewarding for both myself as a researcher and the Māori participants, as the wānanga and hui embraced te ao Māori, where Māori could be Māori. The presentation of the findings from the wānanga and hui represents Māori as Māori. Cram (2019) discussed an important element of kaupapa Māori research in that seeking to understand Māori leads to representing Māori as Māori. This approach has provided rich information that tells the pūrākau of not only the experiences of institutional racism and manukura Māori interventions, as I set out to do with my research, it also privileges, values and normalises te ao Māori and mātauranga Māori.

6.3 Key findings

Firstly, the key findings under “Looking under the hood” illustrate how Māori come off second best when the Crown holds and controls the power through decision-making. This is seen at the governance tables (strategically governing an organisation through a Board of Trustees or operationally governing a process). The result of inequitable Māori representation in decision-making is that Māori voices are neither being heard nor enabled to be heard, or their messages are misinterpreted. Furthermore, te ao Māori and mātauranga Māori are not valued, recognised or understood by Pākehā within decision-making. This is more pertinent when there is one Māori within a larger group around the Board table. Moreover, through the Crown power and control in decision-making, institutional racism is embedded within the organisations’ legislation, policy, strategy and processes. This is due to these essential elements of an organisation being predominantly created, developed and implemented by Pākehā in isolation and within a Western world construct. This then contributes to the mindsets and behaviours of the people operating within the Crown and mainstream organisations, as people operate according to these organisational elements. For example, a strategy that does not incorporate equity, can lead to people in the organisation developing policy and processes to not incorporate equity into their thinking.

Secondly, the key findings under “The inequity in contracting and resource allocation” include contestable contracts that create competition among kaupapa Māori providers who then require resources to respond to continual contract renewals and bidding for tenders. This approach goes against the collective nature of Māori where kaupapa Māori providers come together to deliver services across their localities. Furthermore, the contracts are established by the Crown or mainstream organisations in isolation and, therefore, do not consider what is important to Māori. For example, the contracts do not account for outcomes to show the difference the service delivery has made to the individual or whānau wellbeing. In addition, those contracts do not hold the general practice accountable for achieving outcomes for Māori. Moreover, there is an inequity in the resource

allocation through the Crown and mainstream organisations favouring contracting with large mainstream organisations over direct contracts with smaller kaupapa Māori providers. This signals a cost efficiency gain over a health outcomes approach.

Lastly, the key findings under “The Crown holds the power” include how true partnerships between the Crown and Māori are required to effect change for Māori. However, the Crown needs to understand that developing these partnerships takes time, starting with understanding iwi or kaupapa Māori provider aspirations and values, and then looking for commonalities between the Crown and Māori. This then forms a relationship and to progress to a partnership, governorship, leadership, and decision-making become equal between Māori and the Crown and valuing te ao Māori and mātauranga Māori is paramount. Furthermore, mana motuhake and tino rangatiratanga are the ultimate outcome for Māori. There have been glimpses of this approach through the Whānau Ora model delivery, self-determined collective Māori leadership and elements of the Aotearoa health reform of 2022, such as the establishment of Te Aka Whai Ora, Iwi Māori Partnership Boards and localities where mana motuhake and tino rangatiratanga can be applied.

In the following sections, I explore how my research findings can translate into ways to address institutional racism that highlights the strength, resilience and resistance of Māori leaders’ survival in a Pākehā-dominated world. I have titled the next section ‘moving beyond institutional racism’ as it discusses ways that the Crown and other mainstream organisations can disrupt and eliminate institutional racism. The kaupapa Māori methodology supports Māori to move beyond institutional racism, specifically through talking back to power and understanding the past before moving towards transformation.

At a patient level, interpersonal racism can play a part where an individual clinician’s prejudice assumes that the patients’ abilities to make decisions are inadequate. A racial bias, consciously or subconsciously, can influence a person’s interactions and perceptions of other people (Rodriguez-Knutsen, 2023). Burrett et al. (2024) found that a shared decision-making process between the clinician and patient is critical for patients undergoing surgery. Shared decision-making begins with whanaungatanga, which establishes the relationship and connection between the patient and clinician. This shared decision-making then enabled tino rangatiratanga, where the patient was able to self-determine the way forward with the support of the clinician. Whilst this is at a patient level, the essence of the requirements of shared decision-making is the same in relation to governing an organisation or an operational process, in that valuing tikanga, mātauranga Māori, and te ao Māori is important. In doing that, Māori must be at every layer of decision-making such as within governance, executive, manager and lead layers. Also, within every decision phase such as the design, planning and implementation phases. The application of this approach needs to be applied

to decisions such as the development of legislation, strategy, policy, practice and processes within organisations.

6.4 Moving beyond institutional racism

Before moving into the discussion of moving beyond institutional racism, I would like to remind readers that racism is an iniquitous problem where a hierarchy of people based on race exits (Darwin, 1859; Reid & Robson, 2007). In Aotearoa, racism was often enforced by the rule of law, government-sanctioned violence and unjust legislation (Human Rights Commission, 2024). In Aotearoa, since the signing of Te Tiriti in 1840, colonisation has permitted the (mis)appropriation and transfer of power and resources from Māori to newcomers, thereby determining who benefits and is privileged (Reid & Robson, 2007).

Furthermore, Smith's (2017) transformative praxis is essential in relation to moving beyond institutional racism, as you need to understand the problem and then critically reflect, before ending with solutions to move the health system beyond this issue. In this context, the problem is racism as described in Chapter Two and through the experiences of manukura Māori in Chapter Five.

To move beyond institutional racism, all the solutions that are discussed within this chapter need to work in parallel to address the key findings above. Not one solution on its own will move the embedded institutional racism. Institutional racism is a complex issue that is difficult and highly resistant to change (Came et al., 2019b). The literature review in Chapters Two and Three highlights many ways to address institutional racism; however, these have all been done or suggested in isolation from each other. For example, Hobbs et al. (2019) raised the questions of the effectiveness of policies, calling for a revisit of the deep-rooted historical, cultural and systemic issues to address inequities between Māori and non-Māori populations. Talamaivao et al. (202) argued that policy interventions are required to address racism. Came et al. (2019b) found that addressing racism requires both practice and policy interventions, including funding to support the upskilling and strengthening of cultural competencies among individuals. Thackrah et al. (2021) found that focusing on institutional racism within education programmes alone will not address institutional racism, as it stems from organisational procedures and policies. Lorgelly and Exeter (2023) stated that components of the health reform in 2022, such as the establishment of Te Aka Whai Ora (Māori Health Authority), were components that can start to address Te Tiriti obligations of Māori self-determination. However, Russell et al. (2022) stated that Te Aka Whai Ora was revolutionary, but that it should have been coupled with revolutionary solutions through an indigenised workforce that leads the reclamation of Indigenous knowledge as the pathway to self-determined health and wellbeing solutions. Tenbensel et al. (2023) stated that integrated health and social services delivered locally with local Māori and community co-design, is an example of addressing equity for Māori. There are also examples of Māori world view approaches that look to address social service

delivery, such as Whānau Ora through Dame Tariana Turia's policy entrepreneurship (Smith et al., 2019). Came et al. (2019a) found that advisory groups were a mechanism to address institutional racism. However, the advisory groups must be more culturally and politically responsive to Māori and Pasifika members, in that their contributions to the development, design and implementation of policy are captured. In summary, this evidence highlights the complexity of institutional racism and that many factors need to work in parallel to address institutional racism.

Whilst we need the solutions to work in parallel, there is another barrier to be aware of, in that solutions can and are ignored by the government. For example, multiple approaches to institutional racism that failed to make the required change are detailed in Scott et al.'s account of Māori attempts to see the bowel cancer screening age range lowered. According to Scott et al. (2025), advocacy to address bowel cancer for Māori, including Māori voices, mātauranga Māori, and te ao Māori, must be valued by Pākehā decision-makers to achieve better outcomes. The approach that Scott and other Māori cancer leaders took was through advocating for lowering of the bowel screening age from 60 to 50 for Māori and Pasifika peoples. The advocacy was based on evidence of the disproportionate impact of bowel cancer on Māori and Pasifika peoples, including higher mortality rates than non-Māori. To avoid this inequity of practice from the onset, my research found that Māori need to be in the planning and design-making phase of the health initiative in partnership with the Crown. In addition, Scott et al. (in press), engaged with government and used the media to expose the issues and share whānau experiences. Despite the equity modelling that showed non-Māori would benefit more from the bowel screening age at 60 years, the government initially refused to lower the bowel screening age for Māori and Pasifika. The Māori cancer leaders persisted with their advocacy, utilising new equity data that confirmed a further rise in Māori bowel cancer incidence. Since the introduction of the bowel screening programme in 2016, the government supported lowering the bowel screening age in 2022, albeit with limited implementation across Aotearoa. Scott et al. (2025) went on to say that the government's resistance, structural and institutional racism through inaction and the active rejection of evidence-based advice, delayed equitable bowel screening, which has cost Māori lives. My research found that before a screening programme such as this, there needs to be consultation with Māori at the planning and design phase of the initiative to avoid the implementation of the inequitable service.

The government's resistance shows that structural, systemic and institutional racism is embedded in the health system. Structural racism has normalised the historical, cultural and institutional practices that benefit white people. In this context, the government has decided on the bowel screening age to be the same for all populations, regardless of the inequitable impact on Māori. The systemic racism in this example is the way institutions, structures, and policies work together to perpetuate the inequity of bowel screening. This then flows through to institutions that further enable racism through the practices of bowel screening within their institution's structures.

Furthermore, racism gets even more complex when intersectionality is introduced. Crenshaw (1989) claimed that through the intersection of power there are greater levels of discrimination of racism and sexism. There is a tendency to look at one form of oppression or identity to the exclusion of others that people hold which overlooks the complexity. For instance, gender over race. She states that feminists (white) focused on gender to the exclusion of race. While others focused on race to the exclusion of gender. Her conclusion was that this disadvantaged women of colour, including Indigenous women. Huria et al. (2014) found that the Māori nursing workforce struggled within the hospital setting due to the marginalisation of their beliefs, experience and values. Intersectionality was evident through the compounding forms of oppression such as a largely female and Māori workforce. It was apparent that Māori nurses needed to be part of the decision-making governance not only to support the Māori nursing workforce culturally and from a female perspective, but to support the achievement of Māori health outcomes for patients.

Moreover, at a patient level, interpersonal racism can play a part where an individual clinician's prejudice assumes that the patients' abilities to make decisions are inadequate. A racial bias consciously or subconsciously can influence a person's interactions and perceptions of other people (Rodriguez-Knutsen, 2023). Burrett et al. (2024) found that a shared decision-making process that encompasses whanaungatanga and enables tino rangatiratanga, is an important way to reduce the cultural biases and ignorance that tend to underpin interpersonal racism. The same approach as between clinician and patient can be applied when governing an organisation or operational process where tikanga, mātauranga Māori, and te ao Māori is valued through shared understandings, curiosity and cultural humility. Burrett et al's. (2024) evidence supports the discussion on the first solution to move beyond institutional racism.

In summary, racism is a complex and iniquitous issue and understanding and reflecting on it is important before creating the solutions to address the problem. Racism is heightened through the resistance to change by the Crown and mainstream organisations; intersectionality and the cascading effects of racism from structural, systemic, institutional, interpersonal and internalised racism. The discussion below brings in the effects of interpersonal and internalised racism. Significantly, the impact of racism in Aotearoa, specifically institutional racism, contributes to health inequities between Māori and non-Māori, resulting in poorer health outcomes for Māori and undermining equitable service delivery.

Part Two of the Findings Chapter further reviews two key issues of institutional racism, examining how the Crown holds and exercises power through decision-making. Institutional racism is challenging to shift as it is embedded within the healthcare system through the cascading layers of racism. Manukura Māori experienced institutional racism through the decision-making dominance

of Pākehā. Starting with structural racism, where varying processes for contracting of services and the allocation of resources favour mainstream health providers over kaupapa Māori providers. For example, there are evergreen contracts for general practices that are non-contestable, regardless of performance outcomes for Māori. In comparison, kaupapa Māori providers must continually contest for contracts. In addition, there is an inequity in resource allocation, as the Crown and mainstream organisations favour contracts with large mainstream organisations over directly contracting with small kaupapa Māori providers. This is a cost efficiency gain over a health outcomes approach, that is easier and more cost-efficient to contract with one large organisation versus a few smaller organisations. Sumibcay (2024) found that the fundamental cause of health inequities among Māori and other Indigenous peoples is structural racism, through a system of institutions, ideologies and processes working together to generate and perpetuate racial inequities.

The structural racism then flows onto institutional racism through the creation, development and implementation of an organisation's legislation, policies, strategies and processes as they are predominantly created, developed and implemented by Pākehā in isolation within a Western world construct. The voice of Māori, mātauranga Māori and te ao Māori are not valued in the decision-making and therefore, equity is not considered. The Ministerial Advisory Committee (1988) described institutional racism as the most destructive and insidious form of racism and is the outcome of monocultural institutions that ignore and/or freeze out those cultures that do not belong to the majority.

On to interpersonal racism, where the prejudice of Pākehā comes into effect through the assumptions made by the Crown and mainstream organisations about the abilities of Māori to include kaupapa Māori providers. The dominant Pākehā decision-making is evidenced at the governance tables (or decision-making tables) where Māori voices are not heard, they are not enabled to be heard, or Pākehā misinterpret their messages. This is accentuated when mātauranga Māori and te reo Māori are not valued and/or understood by Pākehā. This is coupled with a lack of understanding about the difference between equity and equality. Equity is critical, as it recognises that Māori start from a different place than non-Māori and that different approaches are required to remove inequities for Māori. This is highlighted by Scott et al. (2025), who noted that the same bowel screening age for all, set by the government, had detrimental impacts on Māori. The mindset of 'one size fits all' or 'one way' is not the approach that works for Māori, as Māori require targeted or differing approaches to the mainstream approach to achieve equitable outcomes.

Lastly, this moves on to internalised racism, where the dominant Western world is embraced through the mindsets and behaviours of a colonial Western world, that operates according to the organisation's legislation, policies, strategies and processes. I now move into discussion on how to

move beyond institutional racism. This section of the chapter discusses ways to move beyond institutional racism, through the solutions generated from my findings.

To move beyond institutional racism, Māori must be in every layer of decision-making and within every decision phase. For example, there are layers within organisations, such as governance, executive, manager, lead layers. Māori need to be holding positions within all these levels within an organisation to ensure mātauranga Māori and te ao Māori is recognised and valued. Rawson (2021) found the health sector had an imbalance in representation by Māori in influential, leadership and decision-making positions. My findings found that when manukura Māori are present in the decision-making phases and at all levels, racism in all its forms is less likely to come into play, with Māori voices less likely to be forgotten. This is even stronger when there is more than one Māori present. However, to do this it requires people in positions of power to, (a) accept that they hold an imbalance of power, and (b) be willing to relinquish their power to enable decision-making in partnership between Māori and Crown decision-makers. When manukura Māori are not present, the discussion defaults to the dominant Western way of thinking supporting institutional racism.

Reidy et al. (2025) found that a key enabler for equity is that the workforce needs to equitably reflect the population it is serving, that is, Māori and other groups that are experiencing inequities. This approach enables Māori and other minority groups to be heard within decision-making. Similarly, Torti et al. (2024) found that when clinicians care for patients who have the same cultural background as themselves, there were shared cultural values and a common language, which supported the establishment of patient rapport and trust. The challenges with this approach included the perception of longer appointments and the potential for patients to cross boundaries. However, the positives outweighed the challenges. Furthermore, the challenge with the workforce equitably reflecting the population it is serving is due to systemic barriers such as racism and discrimination, where there is a lack of cultural safety, resulting in Māori struggling to integrate cultural priorities into their workplace (Hunter & Cook, 2020). In my experience as a Chief Executive of Primary Healthcare, other factors include underfunding of kaupapa Māori providers resulting in the Māori workforce seeking employment elsewhere. According to Lorgelly and Exeter (2023), Te Aka Whai Ora had a role in indigenising the healthcare system through growing the Māori workforce. However, Te Aka Whai Ora has now been disestablished, therefore, it is difficult to measure the success of this goal. Moreover, educational programmes for the non-Indigenous workforce have also been implemented to upskill the workforce's cultural competencies (Thackrah et al., 2021). Through my research, I have found that, alongside increasing Māori representation in decision-making, it is equally important to work with non-Māori who understand and acknowledge the inequity that Māori face. I discuss this concept further down in the discussion.

Māori must be at the design, planning and implementation phases of decision-making. To explain this concept, I have chosen policy as an example of a decision-making process. Māori need to be part of policy development to address the root cause of institutional racism, or to ensure a policy does not exacerbate it, this means co-designing the policy with Māori leaders that are both internal and external to the organisation. According to Thackrah et al. (2021) policy generates racial disparities, and Sanzone et al. (2019) found that this is due to the exclusion of Indigenous models of health and healing methods. In Aotearoa, Hunter and Cook (2020) found the same issue, where te ao Māori is excluded from decision-making. Came (2014) found that there are different ways that institutional racism manifests in policy development. For example, through the majoritarian decision-making in relation to setting the policy agenda through the privilege of the biomedical Western evidence over Indigenous knowledge; through the influence of government officials writing and/or reviewing the policy to include variable political and cultural values and competencies; through the flawed consultation process during policy development, as the wrong questions are often asked of the wrong people in the wrong timeframes, and lastly; during the organisational signoff process, Māori and Pasifika content is masked or eliminated. My research found that Māori need to be part of decision-making from the planning stage through to the implementation stage, to ensure the policy addresses the manifestation of institutional racism through Western decision-making practices, the misuse of evidence, the impact of Crown filters and the deficiencies in both consultation and cultural knowledge as outlined by Came (2014). In my experience there are challenges to the consultation approach as the Crown and other non-Māori organisations that may consult have finite resources. Therefore, the organisations look for one size fits all initiatives (discussed further on in this chapter) or the greatest good for the greatest number. Instead of targeting resources to where the need is evidenced through the health statistics.

Furthermore, similar to my research findings, Smith et al. (2019) wrote that it remained clear to Māori leaders and policymakers that new ways or solutions were needed that reflected Māori aspirations, worldviews, and cultural practices. Harmsworth et al. (2016) found that a co-design approach between the Crown and Māori through equal partnerships enabled the embedding of Māori knowledge into policy and practice. The co-design approach is important, particularly when the policy development or review is initiated by the Crown. Blomkamp (2018) critiqued a co-design approach in public policy planning and policymaking, finding it promising for addressing longstanding social challenges. The positives included that the approach generated more innovative ideas; ensured that policies and services matched the needs of people; supported cooperation and trust between different groups; and achieved support for change. Goodwin et al. (2024) found that the framing of co-design needs to be clear and agreed to include a definition, principles and practices. Blomkamp (2018) found that the co-design approach challenged those in a governmental context as the control over the project diminished and the approach required managing and balancing the objectives and interests of diverse people, resulting in extra coordination efforts and

time. Co-design can effect positive change to address outcomes for Māori, as illustrated below by Goodwin et al. (2024). My research findings supported the co-design approach. However, again this needs to occur from the planning stage through to the implementation stage. King (2021) critiqued the co-design process and found that there needs to be a commitment to engage fully with co-design partners. The process needs to include ongoing reflexive, respectful and a reciprocal process of designing, underpinned by tāngata whenua rights.

From the analysis of my findings, an equal partnership between the Crown and Māori is required to set the approach for co-design. Whilst an equal partnership is a requirement of Te Tiriti, successive governments in New Zealand have not prioritised this partnership due to the racist structures, policies, practices, values and norms that exist (Sheridan et al., 2024). The current National-NZ First-ACT coalition government has taken this further through the disestablishment of Te Aka Whai Ora under the Pae Ora Amendment Bill, repealing joint decision-making and co-commissioning of health services (Wilson et al., 2024). In addition to this, is the impact of political ideology where the tenets of neoliberalism, such as individualism and capitalism, create the setting for discriminatory policies that are made as they benefit the majority and marginalise those with high social and health needs by default. Regardless of the government's approach, my research findings have been consistently strong in supporting the right approach to co-design as a mechanism to address institutional racism.

There are limitations to co-design when the parties are not aligned, as co-design can have different meanings for different parties (Goodwin et al., 2024). This is supported by Goodwin et al. (2024), who found four co-design principles essential to achieve effective outcomes for Māori. Firstly, cultural framing that ensures cultural knowledge and cultural ways of being and doing are valued and incorporated. Secondly, equal partnerships are established at the beginning of the co-design process, leading to equal decision-making and resourcing. Thirdly, that Māori are the kaitiaki (guardians) of the cultural knowledge to ensure it is not misappropriated, and it is used for the benefit of Māori communities. Lastly, tino rangatiratanga, where Indigenous-led co-design is enabled. Goodwin et al. (2024) go on to say that a key element of co-design is setting up an equal partnership at the start, which enables the type of co-design approach. For example, a Māori-led or co-led approach where the governance and shared decision-making throughout the project is agreed, this has the potential to move the health system beyond institutional racism.

The role of bureaucracy and bureaucratic practices contributes to siloed decision-making through the creation of hierarchical structures that impede cross-departmental collaboration and communication (Scott & Gong, 2021). According to Egeberg (2002), the bureaucratic structures of central government affect policymaking and decision-making. Structures can be cumbersome and overlook the impact on people. The findings support this sentiment as bureaucracy is made up of a

collective of individuals, who bring their own histories, ideologies, agendas, biases and strengths to their work, which also impacts their contributions to policy. Alornyeku (2011) found that bureaucracy negatively affects the performance of central government as the bureaucratic administrative processes result in a disconnect between the people and the decision-making. Neoliberalism as described by Monbiot and Hutchison (2024) is a deliberate means of changing the nature of power and fostering competition that supports bureaucratic practices through having winners and losers, versus the collective good supporting social outcomes. This structure and disconnect between people and decision-making are problematic for Māori, as they can exclude opportunities for partnerships between the Crown and Māori to incorporate co-design approaches. Therefore, it is essential to reinforce that Māori must be involved in the design, planning and implementation phases of decision-making to move the health system beyond institutional racism.

Alongside bureaucracy, changes in government also impact policymaking, as seen in Aotearoa, where the Labour government introduced a system to address equity for Māori and it was rapidly dismantled after they lost the subsequent election. For example, the Māori Health Authority (Te Aka Whai Ora) was an independent government statutory entity established by Māori under the 2022 health reform for Māori health. It was established to manage Māori health policies, services and outcomes to serve Māori better and give expression to te Tiriti o Waitangi, Ministry of Health (2024). In 2023, the Labour government was overturned by the National-NZ First-ACT coalition government. In 2024, this coalition government disestablished Te Aka Whai Ora under the Pae Ora Amendment Bill, repealing joint decision-making and co-commissioning of health services (Wilson et al, 2024). My findings show that components of the 2022 Aotearoa health reform, such as the establishment of Te Aka Whai Ora (by Māori for Māori health agency), were seen as a step toward moving beyond institutional racism, where elements of mana motuhake (autonomy and self-governance) and tino rangatiratanga (self-determination) were present. According to Came et al. (2024), Te Aka Whai Ora gained significant support from Māori communities. The capacity building at local levels showed potential to advance Māori health and achieve equitable outcomes for all. However, the disestablishment of Te Aka Whai Ora will likely see further entrenchment of the long-standing poor health and social outcomes for Māori. Interestingly, Sheridan et al. (2024) found that some of the functions of Te Aka Whai Ora already existed, complemented by other government entities that have legislative and regulatory powers to perform many of these roles. However, the issue was that the government did not prioritise these functions or roles due to the racist structures, policies, practices, values and norms that existed.

Harmsworth et al. (2016) provided a good example of embedding Māori knowledge into policy and practice. Although this example is in the context of freshwater management in Aotearoa, it strongly reflects Māori rights as exemplified under Te Tiriti. The *National Policy Statement for Freshwater Management 2014* (New Zealand Government, 2014) set the direction for local government. It

references Māori values and refers to Te Tiriti o Waitangi as the underlying foundation of the Crown/iwi/hapū relationship in relation to the management of freshwater resources. This includes the need for collaborative planning and provisions for Māori involvement in planning and decision-making. Under this policy, Māori have sought increased status for decision-making and active participation in collaborative processes and co-governance of natural resources. Harmsworth et al. (2016) shared that there were challenges around integrating different knowledge traditions and value sets as part of governance and management. The Crown, Crown agencies (local councils), and iwi/hapū created collaborative relationships to establish power sharing, resulting in co-governance, co-planning and co-management. Te Tiriti principles, such as relationships, consensus, partnership, trust, and respect were used as a guide for collaboration and decision-making. This process began with the co-establishment of the terms of reference and determining membership, which facilitated an understanding of different perspectives, knowledge systems, values, and issues. Māori have experienced the impacts of institutional racism from Pākehā-developed policies for decades. Smith et al. (2019) described the impact of institutional racism as a significant barrier to Māori wellbeing and that policies that reflect Māori aspirations, world views and cultural practices are needed.

Penehira et al. (2014) discussed the difference between proactive and reactive policy making, in that reactive is where the Crown leads the process and consults with Māori, usually to refine a policy. In contrast, proactive policymaking looks at the long-term change over time and the distribution of power and control between the Crown and Māori. To embed proactive policymaking requires the creation of partnerships between the Crown or mainstream organisations and Māori (iwi, hapū and/or kaupapa Māori providers). However, to do this it requires people in positions of power to, (a) accept that they hold an imbalance of power, and (b) be willing to relinquish their power for a true collaborative partnership to exist. Mooney and Nolan (2006) discussed Paulo Freire's critical social theory that views education as a tool for emancipation from inequality and oppression. The theory looks at the awareness of social injustices (understanding the history, context, ideologies and structures), reflection and action to transform reality, and discussion to raise collective empowerment. The collective empowerment enables oppressed people to challenge social structures, ideologies and identify constraints to advancement. Whilst this is in an education context, where students and teachers become co-learners and co-educators, the approach can be applied in the creation of partnerships between the Crown and Māori. The fundamental requirement is that the Crown must relinquish their power to create true collaborative partnerships. My research findings highlighted a glimpse of this approach in 2021, where the Crown (District Health Boards) looked to commission integrated primary mental health services through a collective approach. Collectives of local iwi, kaupapa Māori and other providers were able to determine the service, who would deliver, and how it was to be delivered. However, the issue was that the Crown maintained control of elements of the contracts, so it did not fully relinquish its power. It only works when the Crown

relinquishes their power to create truly collaborative partnerships. These partnerships are then able to co-design policy to ensure the Māori voice, te ao Māori and mātauranga Māori is valued (Harmsworth et al., 2016) which is generated from my findings analysis.

Another example from my research, is when an organisation is developing a strategy, Māori need to be around the decision-making table, designing the strategy from the onset and holding Pākehā to account to achieve outcomes for Māori. Accountability in this context is a mechanism for addressing institutional racism through measuring whether the strategy is making a difference for Māori. Māori outcome frameworks are a mechanism for measuring if an organisations strategy is making a difference for Māori. An example of a Māori outcome framework, derived by Māori is Accident Compensation Corporation's, *Te Kāpehu Whetu* (Māori outcomes framework), (Te Paetawhiti & Associates, 2025). This is backed by Kidd et al. (2025) who argued that the lack of accountability in the health sector in general is a foundational factor in the lack of progress towards equitable Māori health outcomes. However, as mentioned earlier, one Māori voice at the decision-making table does not always result in a change of behaviours of those working in government or mainstream organisations, as te ao Māori and mātauranga Māori are not always valued through this approach.

Co-planning and co-design through trusted partnerships between the Crown or mainstream organisations and Māori is required. In other words, Pākehā trusting and valuing Māori (Harmsworth et al. 2016). Goodwin et al. (2024) found that co-design can mean different things to varying partners and assessed co-designed research between health services and Māori through applying a kaupapa Māori framework. Whilst this is in a research context, it can be applied in a health system context. The framework assessed six co-design principles, such as hononga (connectedness and trust), mahi tahi (working together), ngā pūkenga (developing skills and sharing expertise), tikanga me ngā kawa (alignment with participants' localised practices or behaviours), tino rangatiratanga (self-determining as a group/community), and ngā hua (equitable outcomes). Goodwin et al. (2024) found that these principles are essential to Māori and that consultation on its own is not co-design. Co-design involves formalising partnerships that then transition into shared governance and decision-making. Authentic co-design is achieved when there is transparency and power sharing with communities, resulting in equitable health outcomes for Māori.

From my professional experience, analysis of the literature and my findings, co-design is an optimal mechanism to share the power in decision-making and achieve equitable health outcomes for Māori. True collaborative partnerships between the Crown and Māori enable co-governance, co-planning, co-management and co-design. Te Tiriti principles include partnership between the Crown and Māori. However, there are Te Tiriti breaches by the Crown as evidenced through the health system failing to meet the needs of Māori (Came, 2014). Many manukura Māori over generations have

attempted to form partnerships with the Crown and in my experience the Crown struggles to relinquish power through these partnerships. An example of a partnership between Crown and Māori that started to move towards a true partnership was in 2022. I was involved in setting up legislation for a new scheme within a Crown organisation. The organisation authentically wanted to establish the legislation to ensure it worked for Māori. A Māori advisory group was established to advise the sub-committee of the Board that had Co-Chairs (Māori and non-Māori), who had governance over the process. In addition, an iwi group that advised the government was also consulted on the legislation for Māori, with a member of this group being part of the Māori advisory group. The Māori advisory group highlighted that advisory roles do not have the same impact as decision-making roles. Through discussions with the Co-Chairs of the sub-committee, the Chair of the Māori advisory group was to become part of the sub-committee. However, the scheme dissolved before this could come into effect. The point is that the Crown organisation's thinking started to understand the value of true partnerships between the Crown and Māori and what they can be. Without true partnerships, there are limitations to co-design when the Crown and other mainstream organisations are unwilling to co-design. Instead, the approach taken is to consult or engage with people to gain their thoughts, but the power is still with the Crown, as they do not always listen or understand what is being shared, and, therefore, the implementation does not encompass what is needed.

In addition to co-design through partnerships, to hold Pākehā to account to achieve Māori outcomes, a form of veto right for Māori is needed to ensure Pākehā do not have the absolute power in decision-making. The application of veto rights for Māori is challenging to find, and the idea of an Indigenous veto was debated during the drafting of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in 1993 with limited effect (Te Aho, 2015). Charters (2024) found that under New Zealand law, Māori do not have veto rights and that within New Zealand's free trade agreements with the European Union and the United Kingdom, Māori do not have a veto right. She also found that Māori participation in limited areas of decision-making was agreed under the UNDRIP. However, this does not equate to a veto right. Māori have been subject to majoritarian decision-making leading to breaches of Māori human rights and rights under Te Tiriti. However, Te Aho argued that the Waitangi Tribunal confirmed that Māori have continuing rights under Te Tiriti to exercise rangatiratanga in the management of their natural resources. My findings supported that a veto right should be agreed upon within the establishment of partnerships between Pākehā and Māori where a decision has the potential to significantly impact Māori negatively. A veto right would support the decision-makers to look for less harmful alternatives that lead to an enhanced cultural and/or social wellbeing (Te Aho, 2015).

Furthermore, whilst decisions that support Māori achievement can be made when Māori are part of the decision-making process, there may not be enough Māori to be at every level of every Crown and mainstream organisation and at every decision-making table. According to the 2023 Census,

the Māori population in Aotearoa makes up 17.8 percent of the total population, which equates to 904,100 people. The median ages for Māori males and females were 25.8 and 27.9 years respectively, compared to the national median ages of 37 and 39 years, thus reflecting a younger Māori population (Statistics New Zealand, 2025). Therefore, other solutions are required to work in parallel when there are not enough Māori within every decision-making process.

In Aotearoa, some Crown and mainstream organisations have identified Māori roles within their senior management teams. For example, Te Whatu Ora (Health New Zealand) has a National Director for Hauora Māori services (Health New Zealand, 2025), and Te Ara Poutama Aotearoa (Department of Corrections) has a Deputy Chief Executive Māori (Department of Corrections, 2025), as do other organisations. Whilst the intent of the organisations is to bring the Māori voice into decision-making, from my experience and from the research findings, these voices can be lone voices around an executive decision-making table. The challenge is to influence the dominant non-Māori, Western way of thinking within decision-making when some executives do not understand or value te ao Māori or mātauranga Māori. In some instances, non-Māori executives do not want to understand or value te ao Māori and mātauranga Māori. These roles are seen by some non-Māori executives as challenging or dividing the Māori race from non-Māori, when the views of Māori are expressed. In some instances, the outcome has been that these roles have been siloed away from the actual power of decision-making due to te ao Māori not being valued. The roles are critical within Crown and other mainstream organisations. However, not as a standalone solution to move beyond institutional racism.

To gain traction on Māori achievement when there are not enough Māori in every organisation, and, therefore, the dominant Western way of thinking resides. These executive Māori roles can be used as a mechanism for change through creating Pākehā allies within organisations. From my experience, Pākehā allies understand the impact of inequities and are willing to effect change through the application of equity approaches. The executive Māori role and its rōpū Māori (Māori group) identify Pākehā allies across the organisation and at all levels to champion the application of equity. Pākehā allies are at differing levels of competency in applying equity approaches, and therefore, the rōpū Māori initially provided support on the application of equity. However, this is not an ongoing process as the Pākehā allies are or become competent to address inequities affecting Māori. Working with Pākehā allies within organisations to change mindsets and behaviours needs to occur in parallel to co-designing legislation, policy, strategy and processes. Came (2015) found that in the pursuit of equity, Crown and mainstream organisations making decisions should focus on equity, changing attitudes and behaviours and strengthening cultural competencies. This parallel process is essential to ensure that the change to institutional racism is not lost or reversed when new people, such as leaders and staff, come and go. The changing of policy through monocultural decision-making is evident in the recent change of government in Aotearoa, where the new National-

NZ First-ACT coalition government reversed Māori rights since coming into parliament in 2023. This government change lacked transparency, as the government rushed the legislation through under urgency (Wilson et al. 2024). This included de-prioritising kaupapa such as te reo Māori and Te Tiriti o Waitangi, which have negative impacts on Māori wellbeing, including the next generation of Māori (Durie, 2024). This approach has dismantled equity, cultural foci, and attitudes and behaviours have taken a dominant, privileged, neo-liberal perspective. This reinforces that it is essential to work with Pākehā allies within organisations to change mindsets and behaviours.

My findings engendered that to change mindsets and behaviours it is important to understand where Pākehā colleagues' mindsets are positioned. For example, those who do not care and do not see institutional racism or inequity (unwilling); those who are unsure if there is or is not institutional racism or inequity (fence-sitters); and those who can see institutional racism or inequity and are supportive of making a change (willing). The next step is to support the willing or allies who generally have been educated or educated themselves on the history of colonisation, equity and the impact on Māori. According to Stephenson (2024), who advocates for a diversity, inclusion and equity approach, allies are members of the dominant group within an organisation that support and advocate for persons who are marginalised, oppressed, or stigmatised. She goes on to say that allies are committed to promoting inclusion, diversity and equity within organisations where the minority groups are excluded or not listened to in decision-making. She also notes that the ally approach can reveal discomfort within the dominant group, which may lead to a fear of backlash or social ostracism of the allies.

Therefore, the dominant group needs to understand the intersection of privilege and oppression. Melaku et al. (2020) described allyship as a strategic mechanism for fighting injustice and promoting equity within organisations. Allies can empower minorities through recognising their own privilege and challenging behaviour that perpetuates bias. This approach works well when there are action plans and targets created to effect change within policy and practice. Working with allies is about recognising the competency level they are at in applying an equity lens across the work they do within the organisation. Some require initial support in the application of equity, as they are willing to effect change, while others do not. Based on my experience and research findings, supporting a Pākehā ally leader in the development or review of an existing policy involves asking a series of questions, such as how will this policy impact Māori? What does this look like for Māori? Who do I need around the table to support me in understanding the impact of this policy? The goal is to work with Māori to understand what matters to them in relation to the policy. I found that this process has been piloted by some manukura Māori, where allies have supported the application of equity in decision-making and influenced the fence-sitters to become allies. There is potential here to create a groundswell of fence-sitters to move to allies, and even those who are unwilling to move, to fence-sitting. In addition to the above, Crown and mainstream organisations need to invest in the

application of pro-Tiriti and pro-equity tools. These tools have been around for many years, for example, the *Health Equity Assessment Tool: A User's Guide* (Ministry of Health, 2008), yet they are mostly not used or invested in. My research findings indicate that the lack of utilisation of these tools by Crown and mainstream organisations, is due to competing priorities, where organisations do not prioritise equity. Therefore, the resources such as staff, time and budget, are not allocated to this initiative. It is contradictory that some Crown and mainstream organisations are investing in rōpū Māori to initially support the application of equity while these tools are available for this purpose.

Kaupapa Māori providers need to be contracted for outcomes through long-term, high-trust contracts. High-trust contracts consolidate health funding into a single contract, rather than multiple contracts from various funders. The approach is based on the importance of mutual trust and good faith in the partnership between the Crown/mainstream and kaupapa Māori providers. It goes beyond the enforcement of legal obligations and emphasises building and maintaining long-term relationships through open communication. This enables kaupapa Māori providers to deliver a range of services that focus on achieving outcomes for Māori. The delivery of the service is determined by the provider based on the need in the community if the results are achieved.

In Australia, Schwartzkoff and Sturgess (2015) found shortcomings in mental health contracting, such as siloed government decision-making that was not linked to strategy. The short-term nature of contracts and insecurity of funding undermined service providers' ability to plan and provide service continuity and workforce stability. The lack of trust in service providers resulted in onerous compliance and reporting requirements that contributed little to achieving the service goals. Failure to utilise the reporting and data requirements gathered, and the inability of service providers to negotiate contracts, to name a few. This analysis has led Australian governments to consider long-term contracts (three years and beyond), outcomes-based contracting (moving from inputs and outputs to focus on outcomes sought and achieved), and high-trust commissioning. High-trust commissioning in Australia's private sector relies on trusted relationships that focus on relational governance over contractual specifics. Whilst this consideration for commissioning change by the Australian governments was formed in 2015, Aotearoa has tested and implemented this change, refer to the two examples below.

In Aotearoa, Manatū Hauora (Ministry of Health) (2023) tested a long-term high-trust contract focused on outcomes with the mainstream National Telehealth service. The national telehealth service was co-designed with the telehealth services sector and the Manatū Hauora. The benefits included a shared purpose, a clear vision, and a culture of learning, with the contract being independent of political cycles. The contract was awarded to a mainstream provider in 2015 and is a 10-year agreement to provide time for the development and execution of a plan. The long-term contract provides a focus on developing best practice for patients versus securing funding and

‘tiptoeing to appease the funder.’ It also supports not having to frequently reapply for funding and ‘proving what you already know how to do,’ directing time away from patients. In addition, it has provided time for the national telehealth service and Manatū Hauora to grow their relationship and work through challenges, enabling the national telehealth service to ‘give things a go’ while operating in a high-trust environment. However, it is noted that in creating this high-trust contract, smaller kaupapa Māori providers were excluded from the telehealth service delivery. It is important to note that the point of this argument is that the Crown can implement high-trust contracts, but that it should not be at the expense of kaupapa Māori providers. Manatū Hauora, 2023, stated that there were disadvantages for small providers to compete against large mainstream providers in this space. High-trust contracts focused on outcomes can be done by the Crown and implemented on a regional or local scale with kaupapa Māori providers.

Curtis et al. (2024) described an example of high trust contracting in Auckland, Aotearoa in 2021 between the Crown and Māori, which was a Māori-led service delivery model during the COVID-19 pandemic. Māori designed and implemented a service to improve the case and contact management of Māori with COVID-19 when the conventional public health system was failing Māori. For example, Māori were more severely impacted by COVID-19 than non-Māori as the age-standardised hospitalisation rate was 2.3 times higher for Māori than New Zealand European or other ethnicity; and Māori aged under 60 years were 3.7 times more likely to die from COVID-19 compared to New Zealand Europeans or other ethnicities. Māori mobile teams were established to respond to the ‘hard to reach’ Māori whānau, shifting from a conventional public health approach of case interviewing to a te ao Māori engagement approach through whanaungatanga and manaaki (caring for people) first. Whilst this approach captured most of the components of a high-trust contract, the limitation is that it was short-term during the COVID-19 pandemic. Schwartzkoff and Sturgess (2015) and my research findings highlighted that an essential component of high trust contracts, is the long-term nature of the contract.

Furthermore, the Māori mobile team and other Māori external experts proposed to the Crown (District Health Boards) that a Māori Regional Coordination Hub (MRCH) be established, a proposal that was accepted. Māori leaders designed the MRCH to save Māori lives, and the model reached a highly vulnerable population, addressing the clinical, public health and social needs. The key difference between the Māori-designed (MRCH) model and the conventional public health response was that the MRCH model was focused on Māori, with the service designed to meet the needs of Māori best. The Māori community's expertise was valued and incorporated into the model, rather than the focus being on the health professional. This innovative model went on to inform the development of the national triage tool for COVID-19 and service delivery approaches across Aotearoa. The model required the Crown to be willing to share power with Māori, enabling innovation. Whilst this model was short-term during the COVID-19 pandemic, Curtis et al. (2024) go

on to say that this successful model can be applied elsewhere in a range of clinical and social settings to improve the way in which government health and social services meet the needs of Māori. This is a good example of moving beyond institutional racism, through the government trusting Māori to deliver a Māori-designed health service, which achieved positive outcomes for Māori. The high-trust contract approach, coupled with contracting for outcomes where the whānau or individuals determine the outcomes to be achieved based on what is important to them or is valued by Māori, is a step towards moving beyond institutional racism.

Lastly, the well-known Māori whakataukī (proverb), Ehara taku toa I te toa takitahi engari he toa takatini (my strength is not mine alone but belongs to the many), talks to the natural collective nature of Māori. My research found that collectivism needs to be recognised and embraced by the Crown and other mainstream organisations that are making funding decisions. This can be achieved through the removal of competitive tendering, which puts kaupapa Māori providers against each other. However, this approach goes against the political ideology of neoliberalism, such as individualism and capitalism, which requires competition (Monbiot and Hutchinson, 2024). In my experience, the competitive approach creates the setting for discriminatory practices as they benefit the majority and marginalise those with high social and health needs by default. Strategic and collective commissioning is required to deliver services across localities. This approach is where kaupapa Māori providers come together from across regions to self-determine how the service is to be delivered locally by a collective of kaupapa Māori providers and others, where relevant.

The review of the 2022 health reforms in Aotearoa, Tenbensel et al. (2023) found that the development of localities would be led by local Iwi-Māori Partnership Boards that involve local communities in planning through more integrated local services. These changes were incorporated in the Pae Ora (Healthy Futures) Act 2022. Noting that the Act went under review, and in 2025, changes were made under the Pae Ora Amendment Bill. These changes included the disestablishment of Te Aka Whai Ora, repealing joint decision-making and co-commissioning of health services (Wilson et al, 2024). My research found that manukura Māori have been collectively delivering locality approaches for decades and that the recognition of this approach is a step towards moving beyond institutional racism. The locality approach is important for Māori as it supports tino rangatiratanga, enabling access to resources through direct contracts into collectives at a local level. Tino rangatiratanga in this context is about Māori collectively determining the localities and designing the locality plans to support the collective contracts and funding to follow the outcomes of the locality plan.

An example of a collective model is the Whānau Ora collective, discussed in Chapter Three, which exemplifies a self-determining approach by kaupapa Māori and iwi providers, delivering an outcomes-based approach to whānau. There have been recent changes to the Whānau Ora model,

and according to Te Puni Kōkiri (2025), four new commissioning agencies have been commissioned to deliver Whānau Ora beyond July 2025 to strengthen the existing foundations through a widespread public service delivery model that has a greater reach to more whānau. The late Dame Tariana Turia (cited in Baker, 2025), founder of Whānau Ora stated, “My concern was always about how we could make sure Whānau Ora was driven by whānau first and foremost, not by governments, ministers, political parties, departments, providers, commissioning agencies but by whānau (Baker, 2025, p. 6).” In essence, Whānau Ora is about recognising the mana and capability of whānau and that it is whānau-led. Whānau Ora has not been without its challenges. At a political level, the leader of the New Zealand First Party in 2012 argued that the whānau innovation, integration and engagement fund used taxpayers’ money to fund family reunions and continues to be a critique of the Whānau Ora model today. This then opened Whānau Ora up to enhanced levels of government scrutiny through government-initiated reviews that are heightened in the media. The scrutiny places additional pressure and costs on Whānau Ora leaders to demonstrate their value. Whānau Ora leaders showed their resilience throughout the ongoing reviews, through commissioning their own evaluation to combat constant criticisms (Smith et al., 2019). My research findings highlight structural racism through the Crown holding on to power and control and the constant changing of goalposts by the Crown; the government scrutiny is an example of this structural racism.

6.5 Strength, resilience and resistance of manukura Māori

The manukura Māori shared examples of their strength, resilience and resistance towards the isolated Crown decision-making, racism and discrimination. An example of this is through the formation of kaupapa Māori collectives where kaupapa Māori providers (iwi-led and/or non-iwi-led) came together across a region and work together to deliver health and social services. A lead provider will contract with the Crown then disseminate the contracts across the region based on what Māori determine is required within each region. Another collective approach is through the kaupapa Māori Primary Health Organisations, which lead the delivery of general practices alongside other kaupapa Māori-led primary care services to local communities. These general practices and other services delivered across the region are governed and led by Māori. Smith (2017) discussed the struggle of colonisation through an educational lens. However, the struggles are similar within a health system context. For example, we know from Chapter Two that Māori experience significant social and health inequities due to the historical and ongoing impact of colonisation (Tenbensel et al., 2023). Kaupapa Māori providers have sought to self-determine how health services are delivered, where te ao Māori and mātauranga Māori are valued, embraced, and prioritised. Whilst this kaupapa Māori service delivery is within a Crown system, it is a form of resilience, resistance and transformation. Smith (2017) discussed the importance of valuing and practising the collaborative power residing in the collective. The kaupapa Māori providers have led a collective

approach for decades. Not only does it come naturally, but it has also supported the survival of kaupapa Māori providers.

Another example is the delivery of services locally by kaupapa Māori providers who are immersed in their rohe. Localities is a term used within the Aotearoa Health Reform. However, kaupapa Māori providers have been delivering in this way for decades. Kaupapa Māori providers are familiar with their rohe, including the issues within the health system, who to partner with to address these issues, what services are available, and how to access them. In 2023, Te Whatu Ora (Health New Zealand), established under the health reform, embraced the concept of localities, where the decision-making is in the hands of communities and whānau through the development of locality plans (Te Whatu Ora, 2023). Māori have led the development of the locality plans across Aotearoa.

Furthermore, to achieve mana motuhake and tino rangatiratanga, manukura Māori and kaupapa Māori providers have partnered with the Crown through Māori governorship, leadership and decision-making to achieve outcomes for Māori. However, this only works when the partnership is equal between Māori and the Crown and in doing so valuing te ao Māori and mātauranga Māori. Some successful examples from the literature review and research findings include the Māori-designed Whānau Ora health service. Tino rangatiratanga is embedded within the model not only through Māori developing and delivering the service, but through whānau determining their outcomes. The Whānau Ora model was evaluated in 2016, highlighting that the Commissiong Agencies were seen as networked and connected to their communities, closer to whānau and better informed about their needs (Te Puni Kōkiri, 2025). Another example is during the COVID-19 pandemic where the collective leadership by Māori across Aotearoa was evident. A Māori-led service delivery model based in Auckland was one successful example, which Curtis et al. (2024) claimed improved the case and contract management of Māori. Whilst Te Aka Whai Ora was short-lived, it was established to address Te Tiriti obligations of tino rangatiratanga. This was through the establishment of Iwi Māori Partnership Boards and locality approaches that mana motuhake and tino rangatiratanga can be applied (Lorgelly and Exeter, 2023). External to the health system, my research findings highlighted the successes of Māori-led and Māori-owned initiatives such as Kura Kaupapa, Kohanga Reo, Māori TV and te Matatini. All these initiatives represent mana motuhake and tino rangatiratanga.

6.5.1 Why should manukura Māori have to be resilient and resistant?

Māori encountered racism at their first contact with Europeans. Since signing Te Tiriti in 1840, tangata whenua have endured colonisation, racism and white supremacy that was often enforced by the rule of law, government-sanctioned violence and unjust legislation (Human Rights Commission, 2024). Colonisation has permitted the (mis)appropriation and the transfer of power and resources from Māori to newcomers. The systems created by the newcomers, based on new

values, enable this determination of resource allocation, resulting in who benefits and is privileged. This process resulted in Māori becoming marginalised, reclassified and scrutinised as ‘outsiders’ (Reid & Robson, 2007).

Racism comes in many forms and has a whakapapa as described in Chapter Two and above. In summary, systemic racism creates a particular environment and is ingrained in the environment that we live and function within, which, in an Aotearoa context, is a Pākehā worldview. Structural racism is where the dominant race holds the power and control to make decisions for all people through their worldview. This flows on to institutional racism where there is differential access to the services, goods and opportunities of society by race. Then flowing on to interpersonal racism that allows or even expects people to behave in racist ways, and internalised racism that embraces the dominant culture where individuals operate according to those values. Institutional racism is where the health structures reside and is dominated by the Crown or Pākehā decision-making. Through the manukura Māori determination, kaupapa Māori providers continue to survive, regardless of the embedded racism within the health system.

The strategic, proactive, and sometimes reactive approaches taken by Māori have been necessary for survival in the Pākehā-dominated world, where generally decisions are made for Māori without Māori. Kaupapa Māori providers are disadvantaged due to the shifting of goalposts or changing of the rules by the Crown and the need to continually adjust to survive. Smith (2017) stated that colonisation remains present as it is resilient through the continual changing into new forms. Māori need to be prepared to resist these continually shifting forces.

As evidenced in Chapter Five’s pūrākau and according to Penehira et al. (2014), in response to colonisation and the ongoing dominant Pākehā system, manukura Māori and kaupapa Māori providers have been resilient and resistant through sustaining our status as tangata whenua and our Māori ways of being. Māori have drawn from their whanonga pono in developing strategies to resist Crown policies. According to Penehira et al. (2014), resilience has been recognised as a significant contributing factor to the health and wellbeing of Māori people.

> “Resilience may be defined as the means by which Indigenous people make use of individual and community strengths to protect themselves against adverse health outcomes.” (Penehira et al. 2014, p. 97).

The findings emphasised that survival through a resilience and resistance approach can impact manukura Māori through exhaustion. However, as mentioned earlier in the chapter, manukura Māori have a collective approach to their work, which sustains the continual resilience and resistance approach.

Indigenous peoples have criticised resilience as it may assume an acceptance of Indigenous positioning as disadvantaged and place the responsibility for coping on Indigenous shoulders. However, in contrast to this, resilience has also been defined as the collective fight-back that exposes the inequitable distribution of power and opposes these forces that have a negative impact on Indigenous lives, economically, politically and socially (Penehira et al., 2014). Furthermore, through colonisation, Aotearoa has seen the decline of the Māori population, increased health issues, language dispossession and educational failure. However, through Māori resilience and resistance there has been a resurgence of the Māori population to include a demand for self-determination, the resurrection of the Māori language and cultural achievement. Penehira et al. (2014) goes on to say that acts of resistance are construed through our pursuit of coming up with effective responses to Crown oppression and our self-determining rights to live as Māori.

6.6 Limitations

My research incorporates the diversity of participants across various iwi, hapū and service providers. It highlights the similarities and differences of experiences that exist depending on their health delivery and personal experiences within a primary healthcare perspective. Therefore, further research needs to be undertaken within Crown agencies and entities that impact healthcare and secondary healthcare to bring together a complete picture of institutional racism into the broader healthcare system in Aotearoa. Nonetheless, this research focused on experiences of institutional racism within primary healthcare at a service delivery level and how to move beyond institutional racism. This incorporates a wider context than primary healthcare, as Crown agencies, entities or secondary healthcare can adapt the solutions. Furthermore, participants also shared experiences of institutional racism within the education and justice sectors. Whilst the experiences were similar to the experiences within primary healthcare, this research focused on the healthcare sector. There is an opportunity to unpack institutional racism through further research into other sectors such as education and justice.

6.7 Conclusion

This chapter has utilised literature and the wisdom of manukura Māori to describe the issues and solutions to move beyond institutional racism. It has captured the strengths, resilience and resistance of manukura Māori within the health system and questioned why Māori need to battle for equitable health outcomes. The Conclusion Chapter brings together the research journey to include a concluding statement, the learnings from my research, key points, and ending with the celebration of the strengths and innovation of the manukura Māori.

7 CONCLUSION

7.1 Introduction

This thesis highlights that for decades manukura Māori have worked within a dominant Western colonial health system continually adjusting to meet the ever-changing rules set by the Crown. Manukura Māori continue to pursue mana motuhake and tino rangatiratanga in the design and delivery of healthcare. In doing this, manukura Māori and kaupapa Māori providers have partnered with the Crown through Māori governorship, leadership and decision-making to achieve outcomes for Māori. In this pursuit, manukura Māori have held true to their te ao Māori, mātauranga Māori, tikanga and te reo Māori, regardless of the embedded racism within the health system. This has been evident in the collective approach to healthcare design and delivery within their rohe (locality), and through the self-determined healthcare models such as Whānau Ora. These strategic, proactive, and sometimes reactive approaches taken by Māori have been necessary for survival in the Pākehā-dominated world and to achieve equitable outcomes for Māori. The solutions to move beyond institutional racism posed by the manukura Māori need to occur in parallel, as not one solution on its own will move institutional racism.

Prior to taking on this research I had observed, experienced and been part of teams that have tackled elements of institutional racism within primary healthcare. However, I wanted to showcase the real struggles for Māori within a Western-dominated health system through hearing and elevating the voices of manukura Māori experiences of institutional racism and to understand their perspectives on how to move beyond institutional racism. I have been able to attain this goal through ensuring that the manukura Māori voices were at the forefront of the research by conducting the study through wānanga and hui with Māori and for Māori. Therefore, my research was conducted using a standalone kaupapa Māori methodology. This methodology embodied tikanga to include valuing whakapapa and whanaungatanga to establish relationships and create the free-flowing kōrero and tautohetohe through wānanga.

7.2 Revisiting the research

Institutional racism is a complex and iniquitous problem that is difficult and highly resistant to change. Understanding and reflecting on the problem is important before understanding the solutions to address the problem. Racism is heightened through the resistance to change by the Crown and other mainstream organisations; the cascading effects of structural, systemic, institutional, interpersonal and internalised forms of racism; intersectionality that compounds racism; neoliberalism to include individualist and capitalist agendas; moving goalposts by the Crown; to the mindsets and behaviours that enact racism. Therefore, there is no simple solution or one solution that can move the primary care and the health system beyond institutional racism. A collective of solutions and people committed to disrupting and eliminating institutional racism is required.

This thesis started by introducing the concept of race and the evolution to racism. It then went on to describe racism in general and the different forms of racism, such as structural, systemic, institutional, interpersonal and internalised, therefore highlighting the relationships and interconnections of racism. It also highlights that institutional racism contributes to health inequities between Māori and non-Māori in Aotearoa and is defined as a social determinant of health.

The systematic review of literature set out to understand how institutional racism manifested in policy and practice within the primary healthcare sector; and how the primary healthcare sector can move beyond institutional racism at a strategic level. This literature review coupled with the research from manukura Māori describing their experiences of institutional racism and solutions to move beyond institutional racism has provided insights for Crown and non-Māori organisations to disrupt and eliminate institutional racism at a strategic level within primary healthcare.

The key findings included, that Māori come off second best when the Crown holds and controls the power through decision-making. This is seen at the governance tables with inequitable Māori representation in decision-making resulting in the Māori voice not being heard or enabled to be heard, or the messages being misinterpreted. Furthermore, te ao Māori and mātauranga Māori is not valued, recognised or understood by Pākehā within decision-making leadership. Moreover, through the Crown power and control in decision-making, institutional racism is embedded within the organisations legislation, policy, strategy and processes. This is due to these essential elements being predominately created, developed and implemented by Pākehā in isolation and within a Western world construct. This then contributes to the mindsets and behaviours of the people operating within the Crown and non-Māori organisations, as people operate according to these elements. In addition, the contracting process by the Crown or non-Māori organisations creates competition among kaupapa Māori providers going against the collective nature of Māori. The contracts do not account for outcomes to show the difference the service delivery has made to the individual or whānau wellbeing. There is also an inequity in the resource allocation through the Crown and non-Māori organisations favouring to contract with large non-Māori organisations over direct contracts with smaller kaupapa Māori providers. Lastly, true partnerships between the Crown and Māori are required to effect change for Māori. It is important to note that, mana motuhake and tino rangatiratanga are the ultimate outcome for Māori. There have been glimpses of this approach through the Whānau Ora model delivery, self-determined collective Māori leadership and elements of the Aotearoa health reform of 2022, such as the establishment of Te Aka Whai Ora, Iwi Māori Partnership Boards and localities, that mana motuhake and tino rangatiratanga can be applied.

7.3 Key points in the thesis

Moving beyond institutional racism requires the Crown to accept that it holds an imbalance of power, and that it needs to be willing to relinquish its power to achieve equitable outcomes for Māori. The establishment of true collaborative partnerships between the Crown and other non-Māori organisations with Māori is essential. These partnerships must enable shared decision-making through co-governance, co-planning, co-management and co-design of legislation, polices, strategies, processes and services, to name a few. In doing this, partnerships value mātauranga Māori, te ao Māori, te reo Māori and tikanga. Alongside partnerships, there are Crown and non-Māori organisations themselves that have embedded racist structures, processes and practices. Through key Māori roles within these organisations, there is an opportunity to change the mindsets and behaviours of the people operating within them through allyship. Allyship supports Pākehā leaders to apply an equity lens to their work, considering the impacts of their decisions on Māori. The discussion also shared that mana motuhake and tino rangatiratanga are crucial to meet the needs of Māori, and Māori-led innovative initiatives have evidenced this success. The approaches mentioned above will move the health system beyond institutional racism and elements important to Māori, such as long-term outcomes-focused high-trust contracting, and where locality and collective approaches can be enabled.

Furthermore, manukura Māori need to be enabled within the healthcare system to achieve mana motuhake and tino rangatiratanga. To do this the Crown and other non-Māori organisations need to take heed of the key findings and the solutions posed by the manukura Māori, which are supported by the literature. After taking heed of the findings and solutions, the Crown and other non-Māori organisations need to then implement these solutions consistently across the regions of Aotearoa throughout all Crown and other non-Māori organisations; noting that implementing one solution in isolation will not move the embedded institutional racism within organisations. There will be challenges to implementation, because the Crown and other non-Māori organisations need to accept that they hold an imbalance of power, and then be willing to relinquish the power through the approaches mentioned above. This is essential to achieving equitable outcomes for Māori, who over decades have experienced the poorest health statistics as compared to non-Māori. This is evidenced through the health disparities between Māori and non-Māori in the *Wai 2575 Māori Health Trends Report* (Ministry of Health, 2019) and more recently in the *Tatau Kahukura: Māori Health Chart Book 2024* (Ministry of Health, 2024) for health conditions and chronic diseases such as cancer, ischaemic heart disease, diabetes, asthma, cardiovascular disease and experiencing racial discrimination.

It is important to note that institutional racism contributes to health inequities between Māori and non-Māori in Aotearoa and is defined as a social determinant of health (Paradies, 2006). Furthermore, institutional racism has been linked with the enduring and harmful impacts of

colonisation through unequal treatment and discrimination based on race, one that is typically a minority or marginalised, arising from structures or systems (Reid et al., 2019). The decision-making that Pākehā predominantly make in a dominant Western world is embedded in institutions such as the Crown and other non-Māori organisations. To that end, the Crown and other non-Māori organisations can monitor and measure the implementation of the solutions through a change in health statistics for Māori as compared to non-Māori.

7.4 Institutional racism can end!

Firstly, I am acknowledging and celebrating the strength and innovation of the manukura Māori who have contributed to this thesis, who have survived and continued to deliver health services within an institutionally racist system in Aotearoa. The resilience and resistance practices of Māori have enabled not only survival, but a move beyond institutional racism through drawing on the Māori way of being, our whakapapa, our whenua (land), our kotahitanga (unity and collectivism), our wairuatanga (spirituality) and our mātauranga Māori. Manukura Māori stand in their own mana with their continual pursuit of mana motuhake and tino rangatiratanga. For decades, manukura Māori have fought to self-determine the way health services are delivered and determine health outcomes that make a difference for Māori, albeit in the constraints of a Crown environment.

Secondly, the Crown and non-Māori organisations' current practice must change to move primary healthcare and the health system beyond institutional racism, as manukura Māori should not have to battle for equitable health outcomes. The ultimate challenge for the Crown and non-Māori organisations is to trust and value the Māori voice, mātauranga Māori and te ao Māori. It is evident throughout this research that Māori have the solutions to improve health and wellbeing for Māori in Aotearoa. To do this, the Crown needs to share the power and control of decision-making with Māori authentically. This can be done through true partnerships between the Crown and Māori. Through the inclusion of Māori at all levels of the organisation to include the planning, design and implementation of legislation, policy, strategy, and processes; enabling the Crown to be held to account for equitable Māori health outcomes. In addition, to embrace mana motuhake (autonomy and self-government) and tino rangatiratanga (self-determination and sovereignty) through the support of Māori collective and localised approaches; and to commission through outcomes-focused (derived by Māori) high trust contracts. Manukura Māori should not have to battle the primary healthcare and health system to achieve equitable outcomes for Māori. However, manukura Māori will continue to self-determine the way health services are delivered through collective and locality approaches, as Māori communities cannot wait for the Crown and other non-Māori organisations to implement the solutions identified in this thesis.

“Tangohia mai te taura I tāku kakī, kia waiata ai i ki tāku waiata”

Take this rope from my neck so I can sing my song

Have the strength to speak up, and the truth will not be silenced.

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9 APPENDICIES

Appendix 1 Participant invitation

Rau rangatira mā tēnā koutou tēnā koutou tēnā koutou katoa

“Moving beyond Institutional Racism”

I would like to invite you to a wānanga to **share your aspirations on moving beyond institutional racism at a service delivery level in relation to the delivery of health services in the primary healthcare sector**. I am currently completing my Doctorate of Health Science focusing on moving beyond institutional racism within the primary healthcare sector. The wānanga will be focused on your experiences of delivering health services. The final thesis will be shared with the attendees upon completion.

The **research aims** to answer the following questions:
1. How has institutional racism manifested in policy and practice at a strategic level within the primary healthcare sector?
2. How can the primary healthcare sector move beyond institutional racism at a strategic level?

In essence the wānanga will highlight how to move beyond institutional racism in the primary healthcare sector.

Your expertise would be very much welcomed at this wānanga! Kai and drinks will be provided and as an appreciation of your tautoko a $50 voucher will be provided. Below are the details of the wānanga and attached is a Consent Form and Information Sheet for those wishing to **participate in changing the primary healthcare sectors systems to enable better outcomes for Māori**.

I am an independent researcher and this research will not benefit me professionally. My day to day role is the Tumu Pae Ora (Chief Māori and Equity Officer) for Accident Compensation Corporation. Confidentiality will be upheld through the confidentiality agreement.

Wānanga details:
Date: 2nd March 2023
Time: 2pm to 5pm
Venue: *Removed to protect participant confidentiality*
Contact: Michelle Murray, 021 302 531 or MichelleMurray740@gmail.com.

Mauri ora

Michelle Murray
Doctorate Student

Appendix 2 Participant information sheet

Participant Information Sheet – Māori Leaders

Date information sheet produced
10/01/2023

Project Title
Moving beyond institutional racism within the primary healthcare sector.

What is the purpose of this research?
This research aims to understand how the primary healthcare sector can move beyond institutional racism at a strategic level. To meet this aim, a kaupapa Māori methodology will be used. Firstly, two wānanga with Māori leaders in the health sector will be held to understand how the primary healthcare sector can move beyond institutional racism. The participants will share their aspirations and experiences of moving beyond institutional racism. Data will be collected through listening to the kōrero at the wānanga and a thematic analysis will be used to interpret the findings. The benefits of the research to the participants, researcher and the wider community includes solutions for Crown entities/agencies to move beyond institutional racism at a strategic level within the primary healthcare. Secondly, a desk top review will be conducted on key strategic health documents to ascertain their alignment to te Tiriti o Waitangi obligations.

The findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?
The criteria for inclusion in the wānanga are Māori leaders that have recently and/or currently work for primary health providers and have had service delivery interactions with health providers such as District Health Boards, Ministry of Health, etc. Therefore, you have been identified as a potential participant.

How do I agree to participate in this research?
If you agree to participate in this research you will need to email me on michellemurray740@gmail.com (my email is on the invitation) your acceptance and attach the completed Consent Form which is attached to the email invitation.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

I will hold a wānanga at either a marae or on a health provider premise, where you as the participant will attend to share your aspirations of moving beyond institutional racism within the health sector that you have worked in. After the wānanga I will present on the findings at a hui to gain further input if required. The intent is to move beyond institutional racism within the health sector therefore, the participants will benefit from this application with respect to improving access, experience and outcomes of care for our communities. The data collected at the wānanga will be used only for the purposes for which it has been collected and that is to complete the research on moving beyond institutional racism within the primary healthcare sector.

What are the discomforts and risks?
I intend to manage the wānanga in a culturally, mana enhancing manner. However, participants may feel some discomfort or distress when telling their stories of racism. Therefore, I will continually check in with the participants to see how they are feeling and support through debriefing.

Confidentiality of the participants input will be upheld through the confidentiality agreement. Participants that are delivering contracts, no questions or discussions will occur that are based on commercially sensitive information.

How will these discomforts and risks be alleviated?
To alleviate these discomforts, I will check with participants to see if they would like a debrief after the wānanga and my supervisors will be available to support any debriefing. All organisations have access to workplace support such as EAP and I will recommend this as an option if required. In addition, AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet. You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?
The benefits of the research to the participants, researcher and the wider community includes solutions for Crown entities/agencies to move beyond institutional racism at a strategic level within the primary healthcare sector. The research will also look to empower you as the participant, to be part of the change within Crown entities and be validating for participants.
I, as the researcher, will also gain a Doctorate of Health Science qualification on the completion of this research.

How will my privacy be protected?
The participants will have their identity held confidentiality to protect their privacy, with no participant identifiable information in the research findings. The contact details of the participants and research findings will be collected and stored by me. In addition, confidentiality will be upheld through a confidentiality agreement.

What are the costs of participating in this research?

The costs associated with the research is your time and travel to the venue (to be confirmed). The wānanga will likely take three hours. Food, drink and a $50 voucher will be provided as koha for your time.

What opportunity do I have to consider this invitation?
On receipt of the invitation, you will have three weeks to consider the invitation.

Will I receive feedback on the results of this research?
A summary of the research findings will be provided.

What do I do if I have concerns about this research?
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr Jacquie Kidd, email address Jacquie.Kidd@aut.co.nz.
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?
Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:
Michelle Murray, email contact michelle.murray740@gmail.com

Project Supervisor Contact Details:
Dr Jacquie Kidd, email Jacquie.kidd@aut.co.nzand Dr Heather Came, email Heather.Came@aut.co.nz.

Approved by the Auckland University of Technology Ethics Committee on 2 December 2022, AUTEC Reference number 22/207.

Appendix 3 Participant consent form in person

Consent Form

Project title: *Moving beyond institutional racism within the primary healthcare sector*
Project Supervisor: *Dr Jacquie Kidd (primary) and Dr Heather Came*
Researcher: *Michelle Murray*

¡ I have read and understood the information provided about this research project in the Information Sheet dated 10/01/2023.

¡ I have had an opportunity to ask questions and to have them answered.

¡ I understand that notes will be taken during the wānanga and that they will also be audio-taped and transcribed.

¡ I understand that the consent forms will be manually stored in a lockable filing cabinet on AUT premises by the primary Project Supervisor and shredded after six years.

¡ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

¡ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

¡ I understand my data will not be identifiable.

¡ I understand that electronic data will be downloaded to a password protected Pen drive and stored in the applicant's locked filing cabinet on AUT premises and then the data will be deleted once the research findings have been produced.

¡ I agree to take part in this research.

¡ I wish to receive a summary of the research findings (please tick one): Yes¡ No¡

Participant's signature: . .....……

Participant's name: .....……

Participant's Contact Details (if appropriate):

……..
……..
……..

……..

Date: …….

Approved by the Auckland University of Technology Ethics Committee on 2 December 2022, AUTEC Reference number 22/207

Note: The Participant should retain a copy of this form

Appendix 4 Participant consent form oral

Oral Consent Protocol

Project title: *Moving beyond institutional racism within the primary healthcare sector*
Project Supervisor: *Dr Jacquie Kidd (primary) and Dr Heather Came*
Researcher: *Michelle Murray*

The participant joins the videoconference

¡ Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated and they will be asked the following:

¡ Have you read and understood the information provided about this research project in the Information Sheet dated 10/01/2023?

¡ Do you have any questions about the research?

¡ Do you understand that notes will be taken during the wānanga and that the in wānanga will also be audio-recorded and transcribed?

¡ I understand that the consent forms will be manually stored in a lockable filing cabinet on AUT premises by the primary Project Supervisor and shredded after six years.

¡ Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?

¡ Do you understand that if you withdraw from the study then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used? However, once the findings have been produced, removal of your data may not be possible.

¡ I understand my data will not be identifiable.

¡ I understand that electronic data will be downloaded to a password protected Pen drive and stored in the applicant's locked filing cabinet on AUT premises and then the data will be deleted once the research findings have been produced.

¡ Do you agree to take part in this research?

¡ Do you wish to receive a summary of the research findings? Yes¡ No¡
¡ Do you want me to send you a copy of the audio recording for this consent? Yes¡ No¡
¡ Please confirm you name and contact details

Participant's name: .....

Participant's Contact Details (if appropriate):
……..

……..
……..
……..

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 2 December 2022, AUTEC Reference number 22/207.

Note: The Participant should retain a copy of this form

Appendix 5 Agenda

Agenda

Pōwhiri and/or Mihi/Whakatau (welcome)

Karakia Timatanga (opening prayer)

Whakawhanaungatanga (introductions)

Whakatā (break) – Kai/Kapu tī

Purpose of the wānanga – introducing the kaupapa (topic)

Wānanga through an open discussion of stories and experiences of institutional racism

Solutions for moving beyond institutional racism

Karakia Whakamutunga (closing prayer)

Appendix 6 Auckland University of Technology Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

2 December 2022
Jacquie Kidd
Faculty of Health and Environmental Sciences

Dear Jacquie

Re Ethics Application: **22/207 The dynamics of institutional racism within the primary healthcare sector**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 2 December 2025.

Non-Standard Conditions of Approval

1. Amendment of the information Sheet as follows:
   a. Inclusion in the 'Invitation' section the role that the researcher has at ACC.
   b. Include advice that the wananga will be outside of work time, perhaps give them an indication of when this might be.
2. Update the invitation email with the researcher's role.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be reviewed by AUTEC before commencing your study but send through the finalised documents for file.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee
Cc: Michelle.Murray@acc.co.nz; Heather Came-Friar