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Hauora Māori: Aspirations of Māori health practitioners for a culturally relevant health system

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Abstract

Healthcare in Aotearoa New Zealand privileges the Western worldview. Consequently, institutional racism is a health system attribute demonstrated by prolonged health inequities, including life expectancy, between Māori and non-Māori. The Crown has breached Te Tiriti o Waitangi, an enduring agreement between Māori and the Crown, by failing to design and deliver health services adequately for Māori, and failing to provide opportunities for Māori sovereignty. Māori experts have articulated the need to surpass equity and achieve Māori aspirations. This qualitative kaupapa Māori research explored Indigenous aspirations for health system transformation, specifically in an environment free of racism. Three online wānanga with Māori health practitioners highlighted the difficulty of describing aspirations when mamae (hurt) continues to be felt in the existing system. By capturing these experiences, we mapped differences between the current system and Māori aspirations for Hauora Māori—a construct where whānau healthcare and support for wellbeing is indistinguishable from everyday life. The biggest barriers identified in moving towards this approach are Crown resistance to prioritising Māori aspirations for hauora, and the expectation that aspirations should fit within current structures. To achieve hauora Māori, we need changes to funding allocations, prioritising hapū-based commissioning, and improved monitoring and accountability.

Key words

Rangatiratanga; primary health; Tiriti o Waitangi; oranga; racism; wairua; whānau; hauora; Māori

Introduction

Te Tiriti o Waitangi (Te Tiriti), signed in 1840, is an agreement between the British Crown and Māori to live in unity in Aotearoa New Zealand (Aotearoa). Te Tiriti represents the continuation of Māori sovereignty that was recognised internationally in He Whakaputanga, the Declaration of Independence asserted by hapū (sub-tribes) in 1835. It grants the Crown the right to govern their subjects in Aotearoa, affirms Māori sovereignty over Māori lands and taonga (valued possessions), accords Maori the rights and privileges of British subjects, and affirms religious freedom (Waitangi Tribunal, 2016). However, Māori were almost immediately subjected to the violence of British colonisation, with its attendant decimation of the Indigenous population, land confiscation, depletion of economic resources, and forcible alienation from language and culture.

The subsequent fabric of life in Aotearoa has been carefully constructed to privilege the Western worldview, so unsurprisingly, institutional racism is a longstanding feature of the current health system and a major driver of Māori health inequities (Waitangi Tribunal, 2019). This is evidenced by generations of disparities in preventable and non-preventable diseases, co-morbidities, and lower life expectancy for Māori than non-Māori (Harris et al., 2018). Māori die almost eight years earlier than non-Māori (Statistics New Zealand, 2015).

The Waitangi Tribunal, established under the Treaty of Waitangi Act in 1975, provides an opportunity for legal investigation of Crown breaches of Te Tiriti. The Tribunal makes recommendations to resolve any breaches. In December 2017, an inquiry commenced into allegations of breaches pertaining to the health system. In 2019, Phase One of WAI 2575, the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal, 2019), identified that the Crown had breached Te Tiriti o Waitangi by failing to design and deliver health services that addressed known inequities and by failing to provide opportunities for Māori sovereignty in policy and public health. Following the release of the WAI 2575 Phase One report, the government at the time commenced significant health reforms.

Previous attempts to address inequities experienced by Māori have been hindered by a lack of targeted policies designed to contribute to their reduction (Cumming, 2022). Many iwi (tribe) and hapū-based Māori health services have been developed by and for communities to support whānau Māori (Māori families) to navigate the Western system and, in some instances, provide an alternative. Despite knowing what whānau want and need, these Māori health providers, services and staff are constrained by structures that continue to invalidate their cultural realities (Wilson et al., 2022) and ignore their priorities of holistic Indigenous approaches to health and wellbeing (Reid et al., 2019).

Indigenous approaches prioritise health and wellbeing aspirations through strengthening self-determination, identity and connection with the environment (Wilson et al., 2021). It is also vital that these Indigenous realities are supported in critiquing and deconstructing the status quo of Western structures. Indigenising approaches refer to the integrated weaving of Indigenous power and influence, meeting the rights of Indigenous peoples to self-determination and equity (Ahuriri-Driscoll et al., 2021; Russell et al., 2022).

The Māori Expert Reference Group within the Health and Disability System Review (Health and Disability System Review, 2020) articulated the need for a health system that transcends the notion of equity as an end-point to achieve Māori aspirations of hauora (holistic, culturally

grounded wellbeing). A key step towards this is the recognition of tino rangatiratanga (absolute authority) within health legislation. The Pae Ora (Healthy Futures) Act 2022 legislated a new structure for the health and disability system in Aotearoa. These health reforms included the establishment of Te Aka Whai Ora (the Māori health authority) and represented a collective hope that the health system in Aotearoa could finally support Indigenisation and hauora in ways that are prioritised by Māori.

The research detailed in this paper started at the outset of these reforms, and forms part of a larger project investigating anti-racism praxis in health. While the larger project focused on racism and anti-racism, our intent in this study was to centre Indigenous aspirations for health system transformation, specifically in an environment free of racism. Our research took place towards the end of the COVID-19 lockdowns in 2020, a time that demanded and saw the disruption of existing processes, enabling innovation to flourish.

Method

The overall aim of the wider study was to examine ways to disrupt racism and reduce health inequities. The approach was co-led and co-designed in a model based on the tricameral domains of Matike Mai (Matike Mai Aotearoa, 2016) incorporating the political and cultural aims of kaupapa Māori research in an arm conducted by Māori researchers (Pihama, 2017; Walker et al., 2006), Western change theories conducted by all ethnicities and led by Tauiwi (Griffith et al., 2007; Stroh, 2015), and an integrated 'third space' where ideologies come together in an act of creation.

The focus of this paper is a small study conducted within the Māori or rangatiratanga sphere of the Matike Mai model. It reports on a qualitative kaupapa Māori study designed by Māori researchers to delve deeply into Māori hauora aspirations situated within te ao Māori (the Māori world) culture and ideologies without the need to explain or justify to others.

We utilised a wānanga method for data collection. In this context, the practice of wānanga is a verb referring to a group dialogue or conversation regarding particular matters or issues relevant to the collective. As a methodology, wānanga is an increasingly common practice in varying research contexts to encourage, elicit and support kōrero (discussion), which continues Māori knowledge-making (Mahuika & Mahuika, 2020). During the wānanga, we engaged in whakawhiti kōrero (idea negotiation), a collective process of analysing and critiquing ideas with the intent of actively negotiating a consensus (Elder & Kersten, 2015).

Seventeen health professional participants, making a collective 'whānau', attended one of the three wānanga. Whānau were purposively recruited through the professional networks of the research team to ensure varied and rich data, with a range of expertise, experience and disciplines reflected. These included nursing, public health, medicine and allied health. All whānau members were actively involved in mahi (work) that improves equitable health outcomes for Māori, including anti-racism, decolonisation and Indigenisation. Three wānanga were held over a 16-day period in October 2021, each taking approximately 90 minutes. Ideally, wānanga should take place kanohi-ki-te-kanohi (face-to-face) (Mahuika & Mahuika, 2020). However, due to COVID-19 restrictions and the nature of the work of health professionals, these wānanga were held online. No whānau member attended more than one wānanga. The first wānanga had the most whānau members (n = 8), the second had seven, and

the last wānanga had the least (n = 2). The wānanga were facilitated by JK. ZT and HR attended all three wānanga as researchers and contributed clarifying questions to participants at times.

The wānanga were opened with karakia (blessing) followed by whanaungatanga, a process of identifying and nurturing connections among the whānau to create a safe space for whakawhiti kōrero. An overview of the study was provided, and although we had a schedule of open-ended high-level questions, only the first prompt was required. This was, "what is your vision of the health system if the health system wasn't racist? What would it be like? What would you hear, see and feel?"

Data analysis

The wānanga were recorded and transcribed by a member of the research team. Following transcription, the qualitative data were coded and organised into themes by JK, ZT and HR, drawing on the inductive thematic analysis procedure described by Braun and Clarke (Braun & Clarke, 2012). The initial five themes were presented to the participants in a subsequent hui (gathering) and were refined into three key themes. These are detailed in the next section.

It was notable that, although each wānanga started afresh with the same open-ended questions, the kōrero in each was unique. In Wananga One, we were privileged to be supported by two kuia participants who each brought decades of struggle and mātauranga to share. Their kōrero led the whānau through an in-depth discussion of structural and institutional racism, along with much laughter and the fierceness of wāhine toa (warriors) who have fought many battles. Wānanga two was immeasurably enriched by a māreikura (wise and esteemed friend) participant who is steeped in the world of wairua, tūpuna and ātua. She shifted the kōrero into the spiritual realms just through her presence, gifting us some gems of wisdom. In wānanga three, the smallest of the series, the focus was shaped by two clinical expert participants who shared their stories of work at the 'coal face' of healthcare with unwell and struggling whānau. These different foci are transparent within our findings section, as we have identified the quotes according to wānanga one, two or three (W1, W2 or W3). Generating overall themes which may have been discussed in only one wānanga is a political choice. In doing so, we argue for the whānau right to be heard and resist the notion that 'valid' data analysis must be wholly representative. However, we also record here that nothing in the other wānanga contradicted or brought into question the themes that were generated primarily by one group, and in fact, the kōrero built on each other's content even without it being specifically shared.

Ethics approval was granted for this research by the Auckland University of Technology Ethics Committee (21/187). Consent from participants was recorded.

Findings

The wānanga kōrero generated three themes. While whānau were asked, "what is your vision of the health system?" it was also important for each wānanga to kōrero about the current situation of a health sector that is steeped in racism and barriers for kaimahi me tūroro Māori (Māori workers and patients).

In presenting the themes, we have therefore grouped them according to a continuum that moves the narrative from current experiences, through to *mapping the differences* and ultimately to *hauora Māori*.

Current experiences

The stories told by the whānau about what they are currently experiencing have been organised into subthemes of racism, anti-racism and cultural safety. It is important to note that participants did not discuss kawa whakaruruhau, which includes Māori practises alongside Tauiwi in the safeguarding and uplifting of Māori patients and staff (Papps & Ramsden, 1996). Instead, they utilised the term cultural safety as a means of discussing Pākehā organisational and individual practises.

Racism

The time spent discussing racism was relatively short in each wānanga, with most of the kōrero occurring in the larger Wānanga One. Participants acknowledged racism as a significant problem, but also said, "I want them [Pākehā organisations] to bloody call the racism, not us" (W1), noting that addressing racism takes time and resources away from the proactive work of Māori health practitioners.

> *Racism is not our bloody problem to solve. We need to be really clear about what we want and how we're going to do that … they [Pākehā] need to do some work and not drag us in to fix up stuff. (W1)*

Whānau noted the enmeshed, illogical nature of calling out racism within an institution where, "when staff complain of racism … you end up with the racist actually determining whether it's a racist complaint or not" (W1).

Differences were identified in the ways racism is experienced and responded to between Māori and non-Māori, including the emotional urgency experienced by Māori when responding to health inequities and the attendant loss of quality and length of life.

> *We talk about racism [but] we deal with it from a very emotional point of view. And that emotional point of view stems out of the fact that we value ourselves, our whānau, our whenua, and our hapū. … if you're talking to a group of people who don't value that, who don't come from that philosophical underpinning, then they have a different way of dealing with it. (W1)*

One kuia warned against being too forgiving and timid when we address racism, saying that "as Māori, we aroha ki te tangata [love the people], aroha ki te tangata, and we keep being aroha at our own demise" (W1). This kōrero was picked up by the rest of the whānau as the cost of enduring racism was described. This quote exemplifies the results of a racist health sector:

> *[Māori] would rather die at home with their mauri intact than risk being engaged with healthcare. They want to have control over their dignity and their mana [status and authority]. (W1)*

Antiracism

The whānau did not generally perceive anti-racism work as something they wanted to engage with, either out of a sense of frustration or because actively working to address racism has the paradoxical effect of continuing to centre both the racism and the perpetrators.

> *The ngāngara [monster] that is the Western system … is just so inherently what it is. That's the nature of it. That's the mauri [essence or life force] of it.*

I just don't know if we could ever actually decolonise it or get it to a point where it is anti-racist. (W2)

The ongoing resourcing of "teaching our Pākehā colleagues to be less racist" (W1) was viewed sceptically as misallocated funding that would be better spent on Māori workforce development.

I went to this wānanga around what could we do for workforce development around antiracism. … the end solution that we got to was that everyone needed this antiracism training. So it was like the re-centering of white people and the things that they needed to be less racist. I'm like, no, we shouldn't be resourcing this. (W1)

They proposed, instead, that the Māori workforce should be strengthened and the wider whānau empowered to have their say about the health sector.

Instead of doing training for Pākehā, maybe we should focus on training our own people to be able to resist and constructively confront situations, rather than withdrawing into themselves? Feeling stink, you know, having their own mana diminished by experiencing racism. How do we empower them to be able to respond constructively to it? (W1)

Once the whānau is strong … then they get to a place where they don't ask for permission to do things. They don't ask, they don't. They don't put up with bullshit. (W2)

Whānau also noted that where institutions appeared to be making an effort to be anti-racist, they often did so by appropriating and then misusing Māori reo and tikanga (language and customs).

And I said [to Human Resources], hang on, sorry, we're not going to use a Māori process now just because you're in trouble. You want to use our peaceful process now, but when they [the kaimahi] go to mahi [work], they're being bullied and harassed. They're not being treated with respect, and their mana intact. … I told them to bugger off … because, basically, we're using our own people and these white systems to then just step on their mana again. (W1)

When whānau viewed anti-racism work from their Māori perspective, they focused on their strengths and chose where to direct their focus.

We have to focus on what we want and what works for us, and just put our energy on that. There's so much put into arguing with the system, trying to fight with the bureaucracy. That's never going to change because that power system is ancient. It's imported. It's at the essence of colonisation. (W1)

We've got it [challenging the status quo] in our histories, in our whakapapa. We've got the blueprint, we've got the kōrero there. (W1)

> *We've got to start talking about not tolerating the stuff that's been not in our best interests for all these years. Institutions maintain the status quo, maintain the whole racist aspect. (W1)*

A part of the strengths-based focus in wānanga one was illustrated in this story about spending years as an anti-racism educator:

> *We have spent a lot of time and resource trying to teach Pākehā about wairua [spirituality], and some of them just don't get it. Now I tell them to just leave. They're not meant to know because maybe they're dangerous. It's not for everyone to know, and it's not our job to move them into knowing. Just let them leave. (W1)*

Cultural safety

Cultural safety has long been viewed by the healthcare sector as a way of addressing racism and inequities, with some version of cultural safety or cultural competence present in all health professional competency requirements. Cultural safety was viewed by the whānau as ideally "…the norm, and if you don't have that then you can't work in the sector. You're dangerous" (W1).

However, the whānau identified that cultural safety is often low on the priority list for organisations, who place it well below other types of safety. They particularly discussed this in relation to the cultural safety of Māori working in the sector.

> *Organisations say, 'we have to think of kaimahi and patient safety first'. I say, well if you are continually culturally unsafe, you're going to continually keep the kaimahi unsafe. But those are the kind of arguments they keep putting up. (W1)*

> *I think the other thing is around how do we make cultural safety for our workforce? Because they are dealing within this biomedical paradigm. How do we make that mandatory, and if you're not willing to engage, you're in the wrong profession? Because we battle that a lot within [my organisation], around getting people to become compliant. And we need some kaha [strength] behind that from a government legislative perspective. (W2)*

Mapping the differences

This theme incorporates the areas where te ao Māori and the Western health sector interconnect or impact each other. Subthemes include Te Tiriti o Waitangi, disconnected whānau and turning towards the future.

Te Tiriti o Waitangi

Te Tiriti o Waitangi sets out the agreement between hapū and the Crown in terms of governance practices, Māori authority, equity and spiritual freedom. In the wānanga, whānau primarily discussed the failure of the health sector to uphold Te Tiriti.

> *The time we've been born into has been to challenge an enactment of Te Tiriti o Waitangi and the articles. We're not even doing the basics around that.*

Partnering means co-constructing resources held by Māori so that we can design and develop ways that work for us. (W2)

The Tiriti is the thing that we should put at the front for the Māori issue, the Aotearoa kōrero. And the other one is around hapū and iwi. We keep addressing it as though it's just one whole lump thing. (W2)

The government gives authority to iwi [groups as partners with them]. Umm could people go back and read the Treaty please, and see who the relationship's with? It's with hapū. It's actually with hapū. … If [the govt] manage to call them 'communities', they become a really nice public health package. (W1)

In order to meet the conditions of Te Tiriti, whānau identified Māori leadership, equitable representation at governance and management levels, a fully culturally competent workforce, and a workforce that included at least 50% Māori. For example, a participant in wānanga three said that "we need … good staircases to leadership for Māori across all the different health disciplines. We need more Māori in leadership and decision-making" (W3).

One of the most basic things is just everybody employ more Māori. Because we've got the whānau with the skills out there, and we've failed dismally at having more Māori wherever we are. (W2)

A small, nimble health system that has built into it mana motuhake [self-determination], Tiriti rights, just a normal thing like business as usual. Two critical masses: competent, skilled, capable Māori and another of non-Māori with competence, skills and capability to work in this new health space. (W2)

Whānau noted, however, that there are still institutional behaviours and attitudes to overcome before this can be fully realised.

We need 50% of Māori in all those positions of power – but sometimes I've been in rooms that have 50%, and all the Māori are quiet because it's just too uncomfortable. … There are consequences for speaking out. (W3)

Measurement and accountability were also viewed as essential components of a Tiriti compliant health sector. However, participants described a system that does not know how to measure or even understand health services working in a Māori way. They recounted stories of a sector that discounts relationships and misunderstands the relative importance of senior management roles.

Our practice has to be measured on relationships and how we build relationships with people, and how successful those are. Rather than just how many people we're seeing today, and then tune out. How many tasks do I do? We've got to change that. Tip that upside-down. (W3)

Start tying their [management] performance indicators and their own promotion and their salaries to actually delivering on some of the things that their policies purport to say. I think you've got to have that whole assistive approach. (W1)

> *That caseworker is more important than the CEO. That Mama that's locked up in the caravan with their tamariki [children] is more important than the chair of the DHB or the chair of some new health authority. Let's bring back the mana to our workers that are on the ground. (W1)*

However, the biggest barriers expressed by whānau remained around Pākehā and Crown resistance to prioritising Māori aspirations for hauora, or who attempt to reshape those aspirations into a form that meets current Crown expectations.

> *Pākehā have a problem with giving up power, and the power is entrenched in their thinking after having a Pākehā-ized ascendancy over everything else. So we're actually talking about a different way of decision-making as well. (W1)*

Disconnected whānau

One of the primary concerns for the whānau was how to gather in and include Māori who have been disconnected from their iwi and hapū structures through intergenerational colonisation and assimilation practices.

> *I was thinking about the hauora of our population as [being] only as good as our most vulnerable or our sickest person. And so many of our whānau don't have our tikanga, they don't have our reo. They are living in a korowai [cloak] of shame, actually. They're disconnected from their whakapapa [genealogy]. And how is it that we can tautoko [support] them to be engaged in wairuatanga or te taiao [the environment], or relationships with our tīpuna [ancestors] that we have and we know keep us well. But there's such a divorce of that. That's kind of where I was going about intergenerational trauma and mamae [hurt] and how present that is in our people, in their wairua and their tinana, their whānau. And how would the new way, how would the new way look if we were going to whakamana [uplift, empower] those whānau. (W2)*

> *What about all the people that aren't involved in iwi development? And there's bloody hundreds of them in our town. They're not connected. Where does their voice come into this? … How do we really give genuine authority to those whānau? (W1)*

This concern also extended to those kaimahi who are working in isolated organisations, far from their home bases.

> *I work well away from my hau kāinga [home base]. But how do we generate a hapū sense for our Māori colleagues within those spaces? … It can get quite isolated within the differing areas that you work, and then your responsibilities rest on your shoulders to be answerable, and to be yes for everything. And so, how do we connect and create those environments that generate a lot of support and nourishment? (W1)*

Turning towards the future

The current health reforms in Aotearoa are significant, although they were not universally viewed as positive by the whānau. Indeed, most of the wānanga involved kōrero about the potential benefits tempered with a sense of mistrust about what might eventually emerge.

So we're getting excited and thinking we have some authority and resource finally. But actually, I think we need to remain incredibly sceptical. Because people are now starting to talk about lift and shift, and I'm going, what the…? So we're just going to lift all the bureaucrats out of the DHBs and the Ministry of Health and dump them down into the new entity. So while we've got some new entities and there's some potential for real partnership, I think it could go sadly awry. (W1)

I'm really interested to see what happens in the health reforms going forward, because I'm excited about the potential that the Māori Health Authority has. But I would hate to see if we just mimic the same stuff that we currently have. If we have Māori providers providing Western mainstream services that just do the same thing, and we don't end up any better. … For me, that's not good enough. (W2)

Given that the Māori Health Authority sits within that Western structure already, we already know that there's going to be limitations and… I feel aroha for the whānau that are leading it and inspired by them at the same time. … From the inside, we've talked about trying. Is that ever going to be enough? Is it ever going to be enough to change that ngāngara? I don't know. (W2)

Unless we free that [funding] up in health reforms we get stuck with retrofitting stuff within a system that doesn't allow us to build anything new. We just try and make it not as bad as it is. (W3)

In contrast to their scepticism about what might be achieved within a Western frame, the whānau expressed their confidence in the future because of the new generation coming through. This generation has often been steeped in te reo Māori me ōna tikanga (language and culture) through attending kura kaupapa (Māori language schools) and kapahaka (Māori cultural performing groups).

We are having some amazing nurses, the new generation of Māori are coming through stronger. A lot stronger than what we've been in the past. And they are coming through kura kaupapa, which is really beautiful. (W2)

There's a new generation. This new generation I see in Māori nurses is people being really strong in who they are, and quite prepared to take on a system that's not working for them or their whānau. And I think that's great. Because I've been trying to bridge worlds for so long that it's nice that people are quite heavy to come in and just say, "no, this isn't good enough." It's quite a change. (W3)

I don't know how many generations of our kapahaka kids we got now. … But once the new generation comes through, I don't even think our new authorities understand that. Our DHBs have no idea. Because they're sitting around talking policy and all this sort of stuff. (W1)

Hauora Māori

When asked to describe their vision of the health system, the whānau at each of the three wānanga discussed hauora Māori as a system of wellness. While hauora and oranga are terms that are frequently used together to describe holistic wellbeing and health, in this theme, we use hauora Māori to describe the overarching system whānau aspire to, and oranga as whānau, hapū and individual wellbeing. This kōrero generated the overlapping and interdependent subthemes of wairua, mana whānau, and oranga (respectively, spiritual connection, self-determination and pride through whānau; and wellbeing).

Wairua

Expertise in different focal areas emerged within each of the wānanga. In terms of wairua, one māreikura described wairua for the whānau in wānanga two, sparking an in-depth kōrero; "wairua is our first being, and the tinana [body] is like a sock, and the mauri [life essence] is the glue that keeps it all together" (W2). Whānau spoke of the everyday presence of wairua for Māori in terms of how to approach hauora, "…because wairuatanga is our health system. We got tohu [signs]. We get dreams." (W2).

> *We're dealing with wairua problems in physical ways in their health system all the time. (W2)*

> *...wairua does permeate everything in our daily interactions with every element, or with each other, with environment wherever we are……We've ignored it a lot. (W2)*

> *Maybe all of us hanging out and doing this antiracism work is them upstairs? I'm really interested in the wairua, not the wairua of racism, but in the bigger aspects of how wairua is informing ourselves, how we work, how would we work… (W2)*

Whānau consensus in this wānanga was that wairuatanga is intrinsic to hauora Māori.

> *If wairuatanga is something philosophically underpinning all of our things, then we need to ensure that it's well and truly entrenched in any discussion around a reformed health system. A reformed health system should be surrounded by and embedded in wairuatanga. (W2)*

Similarly, the other wānanga commented on the importance of mauri, or the essential quality and vitality in hauora Māori that is intrinsically connected to wairua through "a focus on the mana, the tapu, the mauri of the people" (the status, the sacredness and the life essence) (W3).

Mana whānau

Mana is the enduring spiritual force of a person (or object) which can be enriched or diminished through experiences. Interactions and experiences whānau have when seeking help for health concerns can alter a person's mana. Whānau articulated that "illness and death are not calamities. But it's actually the degree to which you can you have your dignity, your mana. A mana that is expressed and enhanced" (W2).

An essential part of enhancing mana in any setting, including hauora Māori, is providing space for Māori to be Māori, allowing and offering authentic opportunities for choice. Whānau described choice and decision-making as essential in hauora Māori, from the political to hapū and whānau levels.

Bring it back to tino rangatiratanga. Having confidence to say, my own mana motuhake, my iwi's mana motuhake. We just want to build our own reliance in our own mana around the way that we determine our own destination. (W1)

We need authority and resource to do our own thing. And to do that, it can be in partnership with whoever we want, but it's our choices, our decisions. (W1)

Similarly, access to services would also be a choice, rather than relying on entry criteria, referral based processes, and constraints on the availability of services as seen in the existing system.

The health system would fit in with whānau, so whānau don't have to contort themselves into different shapes to fit in with the health system. The system would bend and adapt and adjust and respond to whatever whānau wanted – including where they want to receive the service, how they want it, who they want to receive it from. (W3)

...we make ourselves strong, make whānau strong, and then they can choose to go in and out as they need, rather than at the whim of whether or not they'll get the access, the level of access, what they're offered, all those sorts of things. (W2)

The notion of strength was frequently included in the descriptions of hauora; strength in responses, in decisions, and in knowing what is required for whānau wellbeing. This strength was often aligned with wairuatanga, whakapapa and te taiao (spiritual, ancestral and geographical connections). That is, knowing where you come from, who you connect to, and your role within whānau. The feeling among the whānau was that this hauora Māori system would support and strengthen future generations to realise their potential.

That's something ... is looking at papakāinga [original home base]. And I believe as well that we should be including that in this story, or this kaupapa of health. That whenua [land] should be a big part of that. Whenua, whakapapa. Because I believe that there is a lot of healing in that. (W1)

Āhuru ki te ūkaipō [all the real homes that nurture you], deliberately and directly focusing on your ūkaipō [source of sustenance]. Whether that is your whānau, your physical location, your hapū, your ancestral lands, etc. And bringing everything back there, so it's driven from that space. (W2)

Implicit in the notion of whanaungatanga, or connectedness, is respect for the roles individuals and groups play in the hapū network, which is a collective, non-hierarchical structure. A hauora Māori approach would also operate within this context.

Everyone has a responsibility, a place and a role. You're not always the boss, sometimes you're the one in the kitchen. (W2)

Oranga

The defining kōrero in this subtheme was moving away from the Western construct of a health system that focuses on diagnosis and treatment, "it's about curing disease" (W3). Whānau described the need to fundamentally shift to a "hauora system or a system of wellbeing for our

people" (W2). Oranga or wellbeing is so much more than physical, so a hauora Māori system would "look a lot more holistic than what we've currently got." (W3).

The whānau vision of a hauora Māori system drew strongly from mātauranga Māori (inherent, traditional Māori knowledge) that has been handed down through the generations. They explained that the hapū and whānau processes of self-care and keeping each other healthy are a part of the same system as being sick and receiving help and treatment. Whānau described this as a wellness approach that doesn't require entry into a 'system' because oranga occurs naturally within hapū and communities. Underpinning this approach is whanaungatanga and reciprocity, noting that wellness includes a responsibility to care for others. Oranga is about nourishing and being nourished.

> *The health system that we call it today resides within whānau. Whānau. That we don't need to go outside anywhere else to reclaim and reignite the healing that we already have through our tūpuna and ourselves. So, I would be seeing my own whānau doing the healing, my own whānau supporting each other. Whether it's rongoā [hauora Māori treatments] or any other kind of treatment or support. And I would feel comfortable and happy and nurtured because that's my whānau looking after me. And that's sort of our inherent responsibility to each other, and I'd feel empowered about them. (W2)*

> *If we could flip that and it was just something that existed and resided amongst us, it wouldn't even be a health system. It would be just us, being. (W2)*

> *It would be the dream that I could just go and see my whānau, or they can come to me, and they can support me with the knowledge that we have that's right for us. And whatever the outcome is, it feels like it would be more palatable. (W2)*

> *If the health system actually supported hauora, and it was just normal to access mirimiri [massage], rongoā, just connection with other people, then it wouldn't be such a big drama going to get help if something was wrong. … Because you're already part of something that's promoting your wellness, when something's not right, you know where to go and that you can trust it. (W3)*

> *I suppose I'm encouraging us to not be fearful of what we have to offer. I think we've got some amazing tikanga and knowledge. And it might be your auntie down the road who just says, "eh you fullas, why don't you do such and such?" (W1)*

These discussions have offered insight into the effects of racism, efforts to integrate Māori and Western health expectations, and what hauora Māori involves from a te ao Māori perspective. We conclude our findings section by circling back to a quote from a kuia who participated in the first wānanga. This whakaaro, or thought, was treated within this wānanga as the primary one that framed the aspirations whānau held for the future outcome of hauora Māori.

My dream is that every child born to a whānau Māori are honoured and recognised for the potential that they bring to achieve the dreams of their ancestors (W1)

Discussion

The findings from this qualitative kaupapa Māori study have described the health sector aspirations of 17 Māori health professionals during a time of high-level health reforms in Aotearoa. In the almost three years since these wānanga have been held, there have been significant changes to the sector.

A Māori Health Authority

In 2022, the governance of the health system changed to include a partnership between Te Aka Whai Ora, the Māori Health Authority and Te Whatu Ora, Health New Zealand. On the landing page of their now defunct website, Te Aka Whai Ora stated their aim to create a 'more equitable system' that would 'uplift the health and wellbeing of not only whānau Māori, but of all New Zealanders'. However, Rae et al. (2022) noted that although the legislative foundation of the partnership was framed as being responsive to Māori health inequities, it stopped well short of meeting the Māori sovereignty and equity requirements of Te Tiriti as it also granted the Crown the ability to opt out of their obligations. This contradiction between aims, aspirations and reality was reflected in our findings, where the participants expressed their hopes for shared power despite their own knowledge of the Crown's unwillingness to relinquish decision-making and resources. Similarly, Gabrielle Baker (2024) wrote that the dream for Te Aka Whai ora was "always something truly independent, away from government control", but in the end, that was not what the Crown delivered with this restructure. Nonetheless, she considered that it was "a step forward".

A new National-led coalition government was elected at the end of 2023, and they promptly acted on the reversal of Māori rights that they had signalled throughout the election campaign. These reversals included the cessation of work on the UN Declaration on the Rights of Indigenous Peoples, dismantling Te Aka Whai Ora, rolling back the official use of te reo Māori, reversing smokefree legislation, threatening established Māori wards on local councils, reducing or eliminating the ability of Oranga Tamariki or the courts to take whakapapa into account when making welfare decisions, and greatly diminishing the opportunity for Māori to be heard on environmental protections (Durie, 2024; Woods, 2024). As we draft this paper, Te Aka Whai Ora has nine more days of existence, although its functions were halted some months ago.

In response to this "very aggressive anti-Māori campaign" (Jones, cited in Woods, 2024), Māori and allies have unified in protest, with calls of 'Toitū te Tiriti' (honour the Tiriti) (https://toitutetiriti.co.nz). However, there is also a strong advocacy movement that looks beyond merely reacting to racism, instead focusing on the strengths of te ao Māori living and governing (Durie, 2024; Meyer, 2024). Against this backdrop, our findings of imagining a health system beyond racism have become a part of the fabric of resistance as well as a view of a thriving future.

Primary healthcare

The features of the hauora Māori system envisaged by whānau partially align with some of the existing initiatives in primary and community care, predominantly those that Māori health providers offer. However, Aotearoa has a rich literature that examines racism and other diverse problems with current existing primary healthcare service delivery in Aotearoa (Eggleton et al., 2022; Eggleton et al., 2019; Savage et al., 2020; Sheridan et al., 2024; Sheridan et al., 2023; Smith et al., 2021; Waitangi Tribunal, 2019). Examples of the problems include: cost barriers in accessing care; limited consultation times that focus on an uncomplicated physical presentation from an individual; siloed care, rather than holistic or complex approaches; disregard for cultural practices or considerations, including such basics as the correct pronunciation of names; and empowerment of the predominantly Western models of service through inequitable and inadequately monitored resourcing and contracting. Furthermore, inequitable funding models have had a demonstrable impact on the sustainability of Māori primary healthcare providers, particularly those that serve high-needs and/or rural populations (Eggleton et al., 2022; Eggleton et al., 2019; National Hauora Coalition, 2016).

The conversation around making significant changes to primary and community care is largely shaped by the financial implications for general practices that operate as businesses (Gauld et al., 2019), and is further influenced by the recent growth of corporate practice ownership (Sheridan et al., 2024; Sheridan et al., 2023). Addressing equity in health service delivery requires time, expertise, and, ultimately, resources that negatively impact the running costs of a business. Attempts to improve equity and business efficiencies have repeatedly seen the importing of overseas models including, but not limited to, Healthcare Home, Health Improvement Practitioners, and Physician Associates (Collaborative Aotearoa, date unknown; Oberzil, 2023; Te Pou, 2023). Once implemented, many of these models require further adaptation, particularly through the inclusion of whanaungatanga, a focus on strengthening relationships (Collaborative Aotearoa, date unknown) and training for the Aotearoa context (Oberzil, 2023; Te Pou, 2023). Workforce challenges, including recruitment, have impacted the ability of some of these models to make the anticipated improvements to health outcomes (Te Hiringa Mahara New Zealand Mental Health and Wellbeing Commission, 2022). However, there are no fiscal or accreditation consequences for primary healthcare services that receive funding for Māori health but fail to deliver health equity (Waitangi Tribunal, 2019). This lack of accountability in the health sector is a key underpinning factor in the lack of progress towards equitable Māori health outcomes.

Repeated recommendations for the resourcing of Indigenous primary healthcare approaches have been met with resistance at government and health sector levels (Eggleton et al., 2019). Despite the barriers, Māori providers have developed and implemented community-based services that are grounded in mātauranga Māori and tikanga based healthcare (Office of the Auditor-General, 2015; Savage et al., 2020; Sheridan et al., 2024; Te Puni Kokiri, 2015; Waitangi Tribunal, 2019). The findings from this paper are largely consistent with such Māori initiatives but extend the vision further into rangatiratanga and te ao Māori.

Hauora Māori

Findings from this study describe a way of delivering whānau healthcare that is indistinguishable from everyday life within te ao Māori. The whānau described ways of accessing healthcare that "wouldn't be such a big drama going to get help if something was

wrong ... because you're already part of something that's promoting your wellness" (W1). Further, they described a sector that has whānau and hapū embedded into business as usual.

Participants described a wairua-led wellness system that seamlessly moves between different domains, for example: self-care such as karakia, mirimiri, healthy kai (food) and relationships; medically focused self-care activities such as calling on tohunga (experts), participating in screening programmes, utilising rongoā, and seeking expert advice about possible vulnerabilities; and actively seeking diagnosis and treatment for identifiable symptoms. Being wairua led means that health activities are grounded in tikanga, whānau needs and with attention to, for example, the environment and the maramataka (lunar phases) (Warbrick et al., 2023; Wilson et al., 2021). This represents the extension of complex, culturally specific health literacy that whānau Māori already apply to their health decisions but that is rarely recognised or accommodated by Western health providers (Kidd et al., 2018).

The concepts described in our findings are not new. They have been a feature of research findings for decades, where mana motuhake through whānau centred care, whanaungatanga, geographic proximity and by-Māori-for-Māori, community-based service provision have been called for (Baker et al., 2015; Carlson et al., 2016; Cassim et al., 2020; Slater et al., 2013; Wilson et al., 2022; Wilson et al., 2021). The COVID-19 pandemic show-cased the efficacy of embedded healthcare in Māori communities when whanaungatanga and existing relationships meant that primary care nurses could establish new ways of working with whānau Māori in short timeframes and under trying conditions. These relationships meant the nurses and therefore the health service were already known to be trustworthy, "a safe pair of hands who had the trust of the community"(Davis et al., 2021, p. 87). However, alongside such success stories, the pandemic also shed further light on the structural barriers that were maintained by government-designed emergency funding models that overlooked and/or disadvantaged Māori providers, monocultural public health messaging, and a vaccine rollout that perpetuated inequities (Waitangi Tribunal, 2021; Waitoki & McLachlan, 2022).

In their recent research into primary health equity in Aotearoa, Sheridan et al. (Sheridan et al., 2024; Sheridan et al., 2023) argue that a significant cultural reform of the health sector is needed, one that adheres to the articles of Te Tiriti o Waitangi and prioritises equity. However, our findings suggest that such a transformational reform is unlikely to ever occur within Crown structures, and that instead the vision of a wairua-led, fully embedded hauora Māori service for whānau requires hapū mana motuhake; hapū based control of service configuration, delivery, resourcing, and monitoring.

Accordingly, we make three calls towards the achievement of hauora Māori: 1) immediate equitable funding for existing Māori primary and community care providers; 2) monitoring and fiscal accountability for Western practices to deliver equitable services and outcomes for Māori; and 3) reallocation of Crown contracting and resources to regional hapū-centred commissioning agencies.

Conclusion

Our whānau hope for a place of healing and promotion of wellbeing that is, for most, far from the reality of what is available today. Significant changes will need to take place within multiple layers of our primary and community care system to achieve hauora Māori, including the

realignment of service configuration, delivery, resourcing, and monitoring to align with hapū mana motuhake. However, many Māori primary and community health services provide services that are progressing towards our whānau aspirations. That is, they are meeting people in their own environment, their home/marae/community setting, focusing on wairua connections, whānau and whanaungatanga, and ensuring a whole of life, wellness perspective.

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