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Addressing Structural Racism Through Constitutional Transformation and Decolonisation: Insights for the New Zealand Health Sector

Abstract In colonial states and settings, constitutional arrangements are often forged within contexts that serve to maintain structural racism against Indigenous people. In 2013 the New Zealand government initiated national conversations about the constitutional arrangements in Aotearoa. Māori (Indigenous) leadership preceded this, initiating a comprehensive engagement process among Māori in 2010, which resulted in a report by Matike Mai Aotearoa which articulated a collective Māori vision of a written constitution congruent with *te Tiriti o Waitangi* (the founding document of the colonial state of New Zealand) by 2040. This conceptual article explores the Matike Mai Aotearoa report on constitutional transformation as a novel means to address structural racism within the health system as a key domain within the constitutional sphere. Matike Mai suggests alternative conceptual structural formations through its focus on the *kāwanatanga* (governance), the relational and the *tino rangatiratanga* (sovereignty) sphere. This framework is informed by a range of Indigenous ethical values such as *tikanga* (protocol), belonging, and balance that can usefully inform the redesign of the health sector.

We assert that constitutional transformation and decolonization are potentially powerful ethical sources of disruption to whiteness and structural racism. We argue that, to eliminate entrenched health disparities, change processes need to be informed by the Indigenous inspirations expressed in the Matike Mai report.

Keywords Constitutional transformation; Structural racism; Health systems; *te Tiriti o Waitangi*; Indigenous; Decolonization

Introduction

In this paper we engage with a transformation initiative led by Māori in Aotearoa (Matike Mai Aotearoa 2016) as part of national deliberations over our constitutional arrangements to explore its potential to contribute to improved bioethics in the health system of our country. As public health researchers we are acutely aware of the longstanding failures of governance, policy, and practices in our health services, as noted in important recent reports and

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independent research work in the domain (Health and Disability Sector Review 2019; Waitangi Tribunal 2019).

Bioethics, as the discipline responsible for the conduct of medical systems, must be answerable for these massive ethical failures. It is not our intention to address this issue in detail here but rather to work through the potential of Matike Mai to provide an alternative framework for the health system. A move of this magnitude would recast the landscape in such a way that the ethical dimensions around racism and its impacts could be greatly diminished or even eliminated.

Addressing the institutional and historical racism that underpins health system failures one policy or practice at a time might be achievable but it is also likely to be time consuming, complex, and inefficient. We suggest that addressing problems across the entire sector may be fruitful in producing consistency and coherence while ensuring relevant and appropriate ethical prioritizing. At this scale we advance the idea that the governance and the aggregated policies, practices, histories, and power dynamics of the sector have constitutional weight that bears upon ethical questions at the heart of national debates.

Constitutional and governance arrangements have long been utilized by colonizers to entrench their power and control over Indigenous peoples (Yusuf and Chowdhury 2019). The political processes of colonization and assimilation have frequently decimated Indigenous populations through land alienation, social coercion, and warfare (Mowbray 2007). The cumulative intergenerational impacts of this structural racism have compromised Indigenous peoples' sovereignty and contributed to chronic systemic ethnic health inequities (Anderson et al. 2016; Moewaka Barnes and McCreanor 2019).

While constitutions can be a source of structural racism, as has frequently been the case in colonial contexts, they can also be a source of hope and transformation. For instance, within South Africa the constitution was historically the structural mechanism that enabled the oppressive apartheid regime. In 1997 the new rainbow South African constitution became a benchmark for inclusion and social justice (Klug 2010). Their constitution explicitly acknowledges past injustices, commits the nation to racial healing, and embeds affirmative action to redress historic injustices (Constitutional Assembly 1996).

Other nation states have also explicitly protected the interests of Indigenous peoples in their respective constitutions. Roy and Henricksen (2010) identified provisions in the constitutions of Finland, Norway, India, Russia, the Philippines, Bangladesh, and Pakistan that protect

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Indigenous peoples. Likewise, there are Indigenous provisions in the Nepalese and Bolivian constitutions (Busdiecker 2019; Constitutional Assembly 2015).

Engagement with Indigenous peoples in constitution making is recognized as a requirement of United Nations human rights bodies such as the Committee on the Elimination of All Forms of Racial Discrimination (Roy and Henriksen 2010). This requirement is echoed in the *Declaration on the Rights of Indigenous Peoples* (United Nations 2007) and the *Indigenous and Tribal Peoples Convention* (International Labour Organization 1989). There however remains a racist, minority voice opposed to the incorporation of Indigenous perspectives in constitutions, in Aotearoa and elsewhere. They are concerned that this is conceding too much power to Indigenous ethnic populations at the expense of the white/settler peoples (O’Sullivan 2008; Salter 2014).

Researcher Standpoint

This conceptual article is written from a critical decolonizing perspective (Denzin, Lincoln, and Smith 2008) as the authors seek to understand where health sector power resides and how social justice and human rights can be maximized and how Matike Mai might guide its transformation. Smith (1997) has argued privilege and lived experiences shape how we see the world. Who we are influences our research questions, what we hear and see, what data we collect, and how it is analysed. By way of whanaungatanga (relationship building) we introduce ourselves so our standpoints are transparent to the reader (Cram, Pipi, and Paipa 2018).

HC is Tangata Tiriti (person of te Tiriti), an activist scholar with expertise in institutional racism, *te Tiriti* application, and critical policy analysis. Her professional background lies in public health.

MB is Māori, with connections to the northern most tribes in Aotearoa. Her professional background draws from working with her people to strengthen Māori health and wellbeing. She has a special interest in Māori mental health and addiction, supported by her doctorate study in Māori experience of mental illness and health services.

TM is a Pākehā senior social scientist with a longstanding interest in the ways in which language shapes and reflects relations between Māori and Pākehā. Health is a current focus of his contributions to research and action for decolonization and social justice.

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Aotearoa New Zealand

The particular history of these islands and particularly the massive disruptions of Indigenous life by Anglocentric colonization (Belich 1986; Moewaka Barnes and McCreanor 2019) means that diverse treaty-making processes lie at the heart of our constitutional development (Orange 2011). *He Whakaputanga o te Rangatiratanga o Nū Tīreni*, (the Declaration of Independence of the United Tribes of New Zealand) was signed by rangatira Māori (chiefs) in 1835 and led to the recognition of Māori as a sovereign independent nation of Aotearoa within the international community (Healy, Huygens, and Murphy 2012; Yensen et al. 1989). It introduced written treaty making to Aotearoa and provided key terms that subsequently appeared in *Te Tiriti*. *He Whakaputanga* remains an important but little-known milestone in the early constitutional history of Aotearoa.

Te Tiriti o Waitangi (the Māori text) was negotiated between the British Crown and *rangatira Māori* representing *hapū* (sub-tribes) in 1840. *Te Tiriti* is recognized as the legitimate foundation for constitutional government in Aotearoa. *Te Tiriti* allowed for two spheres of influence, tino rangatiratanga and kāwanatanga. The tino rangatiratanga sphere reaffirmed Māori sovereignty, an affirmation of nationhood, while the kāwanatanga realm allowed governance of Tauīwi (non-Māori settlers). It was underpinned by a commitment to *ōritetanga* (equity) between Māori and British subjects and diverse verbal explanations of the text along with a guarantee of religious freedom.

The English version—the *Treaty of Waitangi*—is similar in content but it is widely held to mean Māori ceded sovereignty. Under the legal doctrine of *contra proferentem*, the legitimate text is *te Tiriti*, which was the text signed by the great majority of rangatira as well as the Queens' representative, Hobson (Orange 2011). It is useful to think of the Māori text and the English version as two separate documents with different meanings. Under the *Treaty of Waitangi Act 1975*, the New Zealand government and the Waitangi Tribunal—a permanent commission of inquiry to investigate breaches of either text—recognize both documents. The Crown (essentially the New Zealand government) has actively promoted the English version and an array of treaty principles (Hayward 1997). Post 1840, the Crown systematically undermined Māori culture, dispossessed Māori of assets, and marginalized *mātauranga Māori* (Māori knowledge) and constitutional rights (Waitangi Tribunal 2011; Walker 1990).

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In the Ngāpuhi claim WAI 1040, the Waitangi Tribunal weighed up the historical evidence and found (2014) that Māori did not cede sovereignty. Within hours of this ruling being released, Crown Minister Finalyson (cited in Bennett and Quilliam 2014) denied the Tribunal's constitutional significance. To date there has been no substantive debate within the health sector of the implications of this ruling.

The processes of colonization and assimilation and relentless breaches of *te Tiriti* have been so substantive that the Indigenous healthcare system (Durie 1998) was supplanted by a Western biomedical system that privileges Pākehā (settler) worldviews and ethical understandings (Dow 1995, 1999; Lange 1999). This enduring bias manifests in the New Zealand health system in the administration and design of policy, practices, services, care, and treatment (Came et al. 2019; H. Came 2014; H. Came et al. 2017).

In Aotearoa there are deep-seated health disparities (Marriott and Sim 2014) that have driven the lodging of multiple claims of systematic discrimination and racism with the Waitangi Tribunal. The Tribunal established an umbrella claim, WAI 2575, to investigate these issues. In their initial report, the tribunal (2019, 170) recommended the Crown "... acknowledge the overall failure of the legislative and policy framework of the New Zealand primary health system to improve Māori health outcomes." The tribunal (2019) also argued that existing entrenched health policies are "non-compliant" in relation to the Crown's treaty responsibilities.

There has been a series of recent reviews of New Zealand's health sector (Government Inquiry into Mental Health and Addiction 2018; Health and Disability Sector Review 2019; Māori Affairs Select Committee 2019; Ministry of Health 2019). They reinforce overwhelming concerns regarding the state of New Zealand's health system and the high numbers of Māori with poor health in the system. In terms of aspirations to health equity and social justice it seems the health system in Aotearoa is unsustainable in its current form and in need of paradigm shift.

Came, O'Sullivan, Kidd, and McCreanor have argued that the system needs to be transformed so Māori tino rangatiratanga (absolute sovereignty) is returned to the heart of a holistic inclusive ethical healthcare system. This system needs to be designed to address the health needs of whānau (extended whānau) including the inequitable impacts of the determinants of health (Commission on the Social Determinants of Health 2007). The authors

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argue that is a matter of some urgency as delays maintain an unethical and deeply flawed system that is continuing to do harm to Māori people, communities, and culture.

In the last decade, two concurrent debates have occurred around constitutional transformation in Aotearoa—one initiated by the New Zealand government (Constitutional Advisory Panel 2013), the other by Māori leaders (Matike Mai Aotearoa 2016). In this article we engage with the landmark Matike Mai Aotearoa (2016) report on constitutional transformation for possible ethical pathways to disrupt institutional racism within the health system.

Matike Mai Aotearoa Report

Māori have been discussing constitutional transformation for decades as a potential pathway for justice. In 2010 it was decided by the National Iwi Chairs Forum (a group of chairs of seventy-three Māori nations from throughout the country) to intensify this *korero* (discussion) and form a working party under the leadership of Margaret Mutu and Moana Jackson. Their brief was to discuss with Māori how to develop a constitution based on tikanga (correct practices), kawa (Māori protocol), *He Whakaputanga o te Rangatiratanga o Niu Tīreni* of 1835 *te Tiriti o Waitangi* 1840, and international human rights instruments. The report outlines the process of engagement which involved Matike Mai Aotearoa in 252 *hui* (gatherings) across Aotearoa. Often the *kōrero* started with the *pātai* (question) “if you could change the way the country is governed tomorrow, what would it look like?” (Potter and Jackson 2018, 2). The report explored Western, Indigenous, and Māori concepts and sites of power and identified a range of values to inform constitutional transformation. These include tikanga (Māori protocol), community, belonging, place, balance, conciliation, and structure that could usefully inform the redesign of the health sector. In addition it included the imperative to incorporate the well-being of Papatuanuku (Earth mother), and the concepts of *mana motuhake* (autonomy), *mātauranga* (traditional knowledges), *kotahi aroha* (peace and mutual respect), and *oranga* (access to quality education, health and wellbeing) within any future constitution.

These values turn on the acknowledgement and inclusion of considerations around the importance of culture, identity, equity, and structure, in a manner that should work for all New Zealanders. While space is given to the failure of the Crown and settler peoples to embrace these relational values, Matike Mai carries the vision that:

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a constitution for good, just, and participatory government for and by all peoples is consistent with those values and benefits everyone in the changing demographics of this country where all New Zealanders can prosper and celebrate our heritage ... We also set a longer-term aim of encouraging all New Zealanders to seek a more inclusive understanding of the relationships that are meant to be constitutionally acknowledged through Te Tiriti (17).

The indicative constitutional models presented in Matike Mai are focused on three spheres of influence (Matike Mai Aotearoa, 2016:9). These were the rangatiratanga sphere where Māori make decisions for Māori, the kāwanatanga sphere where the Crown makes decisions for its people, and the relationship sphere where they will work together as equals where the *te Tiriti* relationship will operate (see figure 1). The relationship sphere is where a conciliatory and consensual democracy would be required.

[Figure 1 Matike Mai spheres of influence -insert here]

Tino Rangatiratanga Sphere

Māori have emphasized the importance of tino rangatiratanga—self-determination and sovereignty—for generations (Awatere 1984; Durie 1989; Mutu 2018a). This sovereignty is underpinned by tikanga (correct cultural protocols) that have guided the regulation of behaviours and ordered political and constitutional decision-making. Māori have always exerted authority and agency independent of Crown rule and in response to settler misadventure or aggression (Walker 1990).

The term rangatiratanga was coined in the early nineteenth century, as a neologism derived from rangatira (chief), with the addition of tanga (the matter of). It came to mean chieftainship and sovereignty, as included in *He Wakaputanga* and *te Tiriti*. Matike Mai (2016, 8) maintains that the essence of tino rangatiratanga is “the right for Māori to make decisions for Māori.”

Power or mana, is about autonomy, with the right of Māori to be, to live, to prosper, to occupy whenua (land), and to be a sovereign nation (Szasz cited in M. Jackson 1994). Further, Jackson (1992, 6–7) equates sovereignty with inherent mana.

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It was impossible for any iwi (tribe) to give away its sovereignty to another. The sovereign mana or rangatiratanga of an iwi was handed down from the ancestors to be nurtured by the living for the generations yet to be. It could not be granted to the descendants of a different ancestor, nor subordinated to the will of another.

These understandings are crucial to consideration of the meaning and implications of *te Tiriti* and *He Wakaputanga* and along with other key tenets of tikanga Māori have been deeply inscribed into Matike Mai through the foundational input of Māori communities. Together these principles guide the conceptualization of the need for acknowledgement and enactment of the tino rangatiratanga sphere as called for by the report. A programme of advancing and expanding the tino rangatiratanga sphere is inherent to the vision of Matike Mai to the transformation of the constitutional arrangements of the country to a state in which they can deliver social justice and the aspirations of Māori hapū and iwi.

Breaches of *te Tiriti* in the form of active policies of colonization and assimilation have been vehicles through which vast and diverse harms have been visited upon Māori. These processes have simultaneously enacted advantages for the Crown and settlers that have produced and maintained ethnic inequities. To eliminate these disparities requires the restoration of mana and rangatiratanga.

Kāwanatanga Sphere

Through *te Tiriti* the Crown was granted kāwanatanga (governorship)—another settler neologism (adding ‘tanga’ to a transliteration of ‘governor’)—over their (settler) people (Healy, Huygens, and Murphy 2012). It was predicated on the immediate and pressing need for authority over unruly Pākehā and on hapū continuing to be free to exercise authority (Matike Mai Aotearoa 2016, 40). This granting of kāwanatanga was consistent with tikanga and a whakapapa (genealogical) ethic where there is an expectation that people will manage their affairs in a way that is consistent with agreed norms.

In 1852, without consultation or Māori representation, the Crown declared, under the Constitution Act, unitary parliamentary sovereignty through a house of representatives elected by the male settler land-owning cohort. This was in itself a fundamental breach of *te Tiriti* and illegitimately expanded the limited scope of kāwanatanga allowed in that document. Matike Mai calls for exploration and agreement around:

the relationship between rangatiratanga and kāwanatanga and how the authority granted to the Crown in Te Tiriti might actually be reconciled in ways that are consistent with [decolonisation] (p37-8)

The concept of spheres of influence (see figure 1) reflects the value of balance of obligations that binds Māori and the Crown together through the notion of “jurisdictional choice”:

That is, the right for [Māori] to exercise their rangatiratanga and kāwanatanga in different ways subject only to their respective tikanga and laws and the need to honour the authority of the other. (86)

Historically we argue that the Crown has unilaterally usurped tino rangatiratanga and imposed Crown sovereignty in its place and that the intent of Matike Mai is to work toward restoring that balance in a staged orderly process. Clearly there is a long way to go and there is much difficult and demanding work to be done by all parties to breathe life into the relational sphere that is envisaged as the key location of transformation.

Relational Sphere

Matike Mai describes the relational sphere as a joint deliberative body, but there is a sense in which it involves the entire society. It is a sphere where joint decisions would be made in a way that respected and upheld the mana (esteem or authority) of all concerned (49). The importance of fair representation within the relational sphere was emphasized, with reassurance sought that Māori would not be subordinated in this sphere (77). It was envisioned that Māori and Pākehā would choose their own representation in this sphere. When consensus could not be achieved there would be a *tikanga*-based resolution framework to resolve the impasse.

Results

Inaction in the face of need is one of the ways racism manifests, and we see this as widespread in the health sector (H. Came, McCreanor, et al. 2019), requiring a planned approach to disrupt and eliminate it (H. Came and McCreanor 2015). The United Nations Committee on the Elimination of All Forms of Discrimination (CERD 2017) has recommended the New Zealand government urgently develop a national action plan to end racial discrimination. Likewise, they recommended that the constitutional review out of which Matike Mai has sprung be advanced to address the systemic issues affecting Māori.

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In the 1980s, with the release of a series of reports on institutional racism in the public sector (Jackson 1988; Ministerial Advisory Committee on a Māori Perspective for the Department of Social Welfare 1988) many were optimistic that racism could be minimized if not eradicated. O’Sullivan (2007) has argued convincingly that the seemingly progressive bicultural work in response to these reports did not transform government departments but were window dressing rather than a substantive power sharing. Decades on, the evidence confirms institutional racism remains entrenched within the public sector (MacDonald 2019; Waitangi Tribunal 2019). What was missing was a vision or framework aside from the hegemonic, racist forms entrenched through colonization that could inspire, guide, and inform transformation toward decolonization and sustainable social relations. Mutu (2018b, 6) makes a compelling argument “after 178 years of struggle against our oppressors, it is clear that *only* constitutional transformation will free us from suffocating colonisation”. She maintains having *te Tiriti*-based constitutional arrangements could provide the foundation for *te Tiriti* compliant legislation, policy, and practice. The ethical imperatives of the social contract that *te Tiriti* represents is more likely to be upheld if the necessary constitutional foundation is in place.

Kāwanatanga

In the broad domain of health, as identified by WAI 2575 (Waitangi Tribunal (2019), the Crown needs to be reconfigured and realigned so it addresses issues of *kāwanatanga*—that is the governance of wayward behaviour of Pākehā. Here we are referring to a deeply entrenched praxis that includes (though not exhaustively) inaction in the face of ethnic inequities (H. Came, McCreanor, et al. 2019), collusion with structural racism (H. Came 2014; H. Came et al. 2017), and dishonouring *te Tiriti* (Waitangi Tribunal 2019). The Crown needs to take full responsibility to implement the WAI 2575 recommendations in dialogue with Māori (H. Came, O’Sullivan, et al. 2020). In this context, this entails acknowledgement of Māori as a treaty partner, as well as acknowledging the *tino rangatiratanga* of Māori within the Crown. Matike Mai suggests that in the *kāwanatanga* sphere this calls for reflection, debate, and transformation of the role of the Crown and the settler population to the point where they can respectfully enter the relational sphere to negotiate the reorganization of the health sector with their *te Tiriti* partner.

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Huygens (2011) has argued that for honourable *kāwanatanga* to be achieved, Pākehā need to engage in ideological, emotional, cultural, and constitutional work. She maintains Pākehā have to i) revisit and unlearn colonial history, ii) respond emotionally to the injustices of colonization, iii) undertake collective cultural work, and iv) work toward mutually agreed relationships with Māori.

WAI 2575 requires all health legislation and policy to be *te Tiriti* compliant. We take this to mean policy will transparently aligned to the articles of *te Tiriti* (the Māori text) (H. Came, O'Sullivan, et al. 2020). Transparency is critical to a politically competent public sector, as is a planned response to implementing *te Tiriti*, ending institutional and other forms of racism, and improving Māori outcomes. *Te Tiriti* compliance has a strong emphasis on accountability that enables Māori to enact their right to monitor the Crown's progress (Reid and Robson 2007). The preamble to *te Tiriti* makes it clear the Crown, in proffering the agreement, takes on responsibilities for protection of Indigenous rights. Non-performance in relation to Māori outcomes is an unacceptable breach of *te Tiriti*. Gaps between policy rhetoric, and practice are also a breach.

Came, O'Sullivan, and McCreanor (2020) have developed a tool for assessing *te Tiriti* compliance—Critical Tiriti Analysis (CTA). *Te Tiriti* compliance in relation to policy is inclusive of how policy is developed, the content of policy, and how it is implemented and evaluated. Pivotal to the CTA approach is Māori making the final determination. To achieve *te Tiriti* compliance, existing quality assurance systems (Ministry of Health 2003) would need to be reconfigured to incorporate *te Tiriti*. Likewise, structural racism within the administration and delivery of the health service would be recorded on risk registers and be reduced, minimized, and/or eliminated. Such endeavours would be part of tiered, monitored *te Tiriti* compliance plans across the health sector negotiated with Māori.

A resourced, tiered, sector-wide anti-racism strategy would also be developed with measurable and achievable indicators to track progress. Components of the plan would address racism in human resource practices, leadership and governance, service delivery, policy development, implementation and evaluation, contracting processes, and investment decisions. Racism and inequities would be mapped and then systematically eliminated by a workforce and leadership proficient in anti-racism praxis.

Training curricula would be strengthened in relation to political competencies such as anti-racism (H. Came and da Silva 2011). This would occur for current students and also be rolled

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out for the existing health, policy, and management workforce. Transformative educational programmes would be required that reflect on power, white privilege, and racism (Borell, Moewaka Barnes, and McCreanor 2017). Structural analysis (H. Came, Warbrick, et al. 2019), reflective practice (Margaret and Came 2019), and systems change (Griffith et al. 2007) must be part of this revitalized core curricula. Came and Griffith (2017) have identified several core elements of anti-racism praxis. These include i) engagement in reflexive relational praxis, ii) utilization of structural power analysis, iii) uptake of socio-political education, iv) engagement with monitoring and evaluation, and v) systems change approaches.

Te Tiriti education in the wider public sector also needs to be repositioned from a one-off training to an ongoing professional development requirement, with salient competencies attached. It is a lifelong learning process for currency in this field to be maintained and strengthened. Came and Tudor (2016) identify four elements to strengthen professional practice: to i) learn the history of the whenua (land) on which one practices, ii) nurture good cultural manners, iii) actively support the continuation and restoration of Māori authority and control, and iii) prioritize work that advances Māori aspirations.

To achieve constitutional transformation, Pākehā need to actively engage in decolonization. Tuhiwai Smith (2012, 98) has defined decolonization as the "... long-term process involving the bureaucratic, cultural, linguistic and psychological divesting of colonial power." Ramsden (1994, 3) was steadfast that "... it is not normal for any group in control to relinquish power and resources to the less powerful simply on the grounds of goodwill or a sense of moral obligation." Matike Mai in its recognition of the *kāwanatanga* sphere provides an inclusive vision in which the benefits of its transformative approach are delivered to the entire society through the enactment of safe, collaborative, and sustainable social relations for all.

Relational

The relational space described by Matike Mai is predicated on a high trust relationship between Māori and the Crown. It will require a substantive commitment to *whanaungatanga* (active relationship building) and both parties having the necessary core political and cultural competencies. Crown representatives would need to be proficient in engagement with the earlier articulated values of *tikanga*, belonging, balance, *mana motuhake*, *kotahi aroha*, and *oranga*. Māori involvement in these processes will need to be resourced.

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Both the mana (power and status) of the Crown and Māori would need to be acknowledged structurally and interpersonally and this would be moderated by adherence to tikanga. Partners would relate to one another in a way that is tika (right and just) and pono (truthful). Negotiations would be entered into from a place of good will and a commitment to rangimarie (peace) and staying in relationship when things became challenging. To achieve this new environment for the health sector, staff would need to be recruited with these new sets of competencies and existing staff upskilled to meet these requirements through professional development programmes. University health, policy, and management curricula would need to be refreshed and tertiary teachers up-skilled to prepare the future workforce. The planned revision of the New Zealand history curriculum at all levels of schooling (Ministry of Education 2019) will help by making sure that citizens enter professional health training with a grounding in the harms and changes wrought by colonization, racism, and deregulated capitalist economics.

The Crown would need to surrender their attachment to being the senior/dominant partner in the sector. The perpetual cycle of restructuring in the health sector would need to cease so high staff turnover could be contained and long-term relationships established. In order to govern effectively, power needs to be shared. It would be useful to recognize that if something works for Māori, it is likely to lift the collective health status of everyone (Durie 1999; Hunter 2019). Māori health providers across Aotearoa have a long history of not only delivering effective services to Māori communities but also non-Māori (Bramley et al. 2005; Pipi et al. 2001). Health would no longer be siloed, and matapaki (discussions) would occur across government agencies to advance Māori aspirations with whānau at the centre. The negotiation sphere would be one where te reo me ona tikanga (Māori language and protocol) would be ordinary. Kaumatua and kuia would have substantive rather than ritualistic roles. Matapaki and decisions might take place in Te Reo. New decision-making processes would need to be imagined which centre Māori voice and process.

Tino Rangatiratanga

There is little doubt the tino rangatiratanga sphere of influence challenged the Crown's hegemony (Pryor 2007), and indeed Matike Mai is a contemporary high-profile example of such resistance. Acknowledging the tino rangatiratanga sphere involves shifting the paradigm of authority from the Crown to Māori control and decision-making processes. For generations

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Māori have fought to retain sovereignty (Awatere 1984; L.T. Smith 2012; Walker 1990). Early Māori strategies such as Kotahitanga (a Māori parliament) (Cox 1993) and Kingitanga (Māori king movement) were examples of sovereign movements contesting the Crown's unitary sovereignty (Ballara 1996; Keane 2012). Over time, in part enabled by Waitangi settlement processes (Mutu 2018a) and sustained activism (Harris 2004), some Māori have regained control over some resources and matters that impact on Māori lives.

At Toitu Hauora: Māori Health Leadership Summit held in 2019, Sir Mason Durie (2019) argued the point for a new system more attuned to Māori in order to deliver better health outcomes for Māori. Durie's point was for a new health system that would be defined by the norms of *te ao Māori* that would favour Māori decision-making at all levels and would foster an integrated approach that saw a range of Kaupapa Māori organizations work towards the same goals and values to recognize the *te Tiriti o Waitangi*. This new system would be the responsibility of a new Māori health and well-being authority—Te Rūnanga Whakapiki Mauri (Durie 2019).

In the health sector, the elimination of racism and achievement of *te Tiriti* compliance through the *kāwanatanga* sphere would go a long way to clear the way for *tino rangatiratanga* to flourish. In such an environment, Māori knowledge, experience, and strategic thinking would be trusted and not filtered through personally-mediated, institutional, and cultural racism. Māori ways of thinking, designing, and doing would be ordinary. In this domain, *Te Reo me ōna tikanga Māori* would be practiced. The sector would be configured in a way that reflects *mātauranga Māori* and *te Ao Māori* rather than being dominated by Western understandings of health and disease.

The Waitangi Tribunal (2014) in WAI 1040 rejected the long-standing Crown belief that Māori ceded sovereignty through signing *te Tiriti*. In WAI 2575 (Waitangi Tribunal 2019), the health sector has been called to action to address inequities and *te Tiriti* breaches through the *tino rangatiratanga* sphere of influence. WAI 2575 claimants argued:

The only Treaty-compliant solution, in their estimation, was to transfer Māori health systems and services completely to Māori, along with the necessary funding and technical support, so that Māori would design, operate, govern, control, and administer those systems and services. (Waitangi Tribunal 2019, 13)

Māori want to govern themselves, to have the authority to make their own decisions, and to give expression to the values and the matters that are important to Māori.

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To achieve this, governance and decision-making health policies/structures and mechanisms would need to be installed so that tino rangatiratanga can grow—so that Māori can increasingly make decisions for Māori. H. Came et al. (2020) have argued that achievement of constitutional transformation requires the *Treaty of Waitangi Act 1975* to be realigned with international law and requires recognition of only *te Tiriti o Waitangi*—the Māori text. This change would have a cascading impact across public sector legislation, policy, and practice. Within a *te Tiriti*-compliant public sector, collaboration would occur across Crown agencies to ensure all Māori have access to the prerequisites of health (WHO 1986) and no longer live in circumstances which put *whānau* at risk (Came et al. 2016). In addition, intergenerational trauma and the legacies of colonization would be recognised as drivers of inequities (H. Came, Herbert, et al. 2019; Chin et al. 2018; Kingi et al. 2017; Pihama et al. 2014). Māori providers would flourish in a tino rangatiratanga sphere, offering Māori diverse strategies for health promotion as well as a choice of cultural and clinically safe health providers. Services would be agile enough to respond to diverse and complex Māori realities as decolonization progressed (Eggleton, Stewart, and Kask 2018; Herd 2006). Holistic health policy development, implementation, evaluation, contracting, monitoring, and relationship management would all reflect tikanga Māori and the values of Matike Mai. Māori would be leading decision-making about the design, function, and configuration of health services. The performance of the health sector would be measured by indicators consistent with Māori aspirations (Durie et al. 2002). Māori providers would have at least 55% of Vote health monies and underfunding of Māori health would be a thing of the past. New funding formulae would be developed that took into consideration, amongst other factors, *te Tiriti o Waitangi*, burden of disease, the right to health, and the intergenerational legacy of colonization.

Conclusion

The current systems, including those of bioethics practice that are in place to respond to Māori health issues, are fragmented and often inconsistent with Māori approaches to building and sustaining good health and well-being. Matike Mai offers an alternative vision that would acknowledge both tino rangatiratanga and kāwanatanga spheres linked by relational spaces of negotiation and transformation. Such a shift would add vast new resources in the form of tikanga or values to the ethical dimensions of the health sector that would ensure alignment

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and engagement with Māori needs, approaches, and aspirations. In addition, systemic racism and discrimination would be eliminated, allowing kaupapa Māori / mana motuhake praxis to take hold so that health disparities would disappear and health equity, wellness, and thriving would emerge. Benefits for all peoples of Aotearoa would be realized through all sectors being able to reach their potential and through significant reductions in health spending, minimizing the social gradient, and promoting the emergence of an equitable, ethical, sustainable social order.

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