POLICY BRIEF

Indigenising our Future: A Call to Action

Takahia te ara hou, ngā tapuwae o ngā tūpuna.
Traverse new beginnings with the courage of our tūpuna.
(Rōpū Kaitiaki Wānanga, Nov 2020)[1]

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1.0 Background

1. *Raranga Tāngata, Oranga Tāngata*[2] is one of six projects in a five-year research programme 'Enhancing Primary Health Care Services to Improve Health in Aotearoa New Zealand' (formally named *Primary Insights: Aotearoa/New Zealand's Primary Health Care Study*) at Te Hikuwai Rangahau Hauora (Health Services Research Centre), Te Herenga Waka–Victoria University of Wellington. The research is authoritatively guided by the professional, clinical and cultural expertise of kaumātua and a Rōpū Kaitiaki[3] who bring a wealth of experience in: mātauranga, tikanga and te reo Māori; iwi/hapū development; hauora Māori; Whānau Ora; health and social services; health promotion; policy development; funding and planning within the health sector; and Māori methodologies. A total of 22 interviews were undertaken with 27 participants for this research, including Iwi health/social service/education providers; District Health Board and Ministry of Health senior management; and nationally prominent Māori primary health care experts. The perspectives of service-users of primary health care will be sought in the next phase of the research.

2.0 Purpose

The autonomy to play out what health looks like for Māori, belongs to Māori.
(Heather Skipworth, CEO IronMāori, Sept 2021)

2. Research participants described the establishment of Te Aka Whai Ora as revolutionary. The solutions enacted by Te Aka Whai Ora must likewise aspire to be revolutionary: reform cannot result in simply more of the same for Māori. As emphasised in this and previous research, a Western paradigm of health cannot be prioritised to address issues

[1] In attendance: Matua Wiremu (Bill) Kaua *(Ngāti Porou)*, Whaea Moe Milne *(Ngāti Hine, Ngāpuhi)*, Gabrielle Baker *(Ngāpuhi, Ngāti Kuri)*, Wheturangi Walsh-Tapiata *(Ngāti Raukawa, Ngā Rauru, Te Ati Awa, Te Atihau-nui-a-Paparangi)* and *Raranga Tāngata, Oranga Tāngata* research team members

[2] The *Raranga Tāngata, Oranga Tāngata* research team has included Kaumātua Bill Kaua, Project Leads Dr Kirsten Smiler *(Te Whānau a Kai, Te Aitanga a Mahaki, Rongowhakaata, Te Whakatōhea)* and Dr Lynne Russell, Key Advisor Dr Amohia Boulton, Researcher Nora Parore, and Research Assistant Elizabeth (Liz) Dewes.

[3] Whaea Moe Milne; Gabrielle Baker; Associate Prof Matire Harwood *(Ngāpuhi)*; Dr Chris Tooley *(Ngāti Kahungunu)*; Wheturangi Walsh-Tapiata; Tracey Wright-Tāwha *(Kāi Tahu)*

it has thus far not only failed to solve, but has made worse (Rolleston et al., 2020). Genuine disruption and transformation of the medically-dominated, general practice-centric, business model of primary health care requires the reclamation of Indigenous knowledge as a pathway to self-determined health and wellbeing solutions for Aotearoa.

3. This Policy Brief summarises the implications of key findings specifically relevant to transformational systems change which have emerged from *Raranga Tāngata, Oranga Tāngata*. The focus is on fully utilising the opportunities for disruption presented by health system reform in Aotearoa by growing our understandings of what is required to truly transform primary health care outcomes for Māori. The current situation of ongoing systemic failure underpinned by institutional racism is discussed. An argument is then made for an intentional and deliberate return to the intent of Kaupapa Māori theory as a disruptive approach to radical change. Essential to this is: the freeing of Indigenous imaginations; an Indigenised State[4] sustained by belief in Indigenous knowledge and solutions; and the development of an Indigenised workforce of disruptive innovators.

4. Additional journal articles and technical reports from *Raranga Tāngata, Oranga Tāngata* are forthcoming.

3.0 Current Situation: Systemic Failure

> *… the governing paradigm of providing care in a community setting through clinical experts is a thing that clearly doesn't work for us, the evidence is there. It hasn't worked. Arguably not for the whole community, definitely not for our community.*
>
> *(Helmut Modlik, CEO, Te Rūnanga o Toa Rangatira, Sept 2021)*

5. The medically-dominated, general practice-centric, business-oriented primary health care system was described by research participants as 'programmatic', 'transactional', 'broken', 'flawed', 'deficit-focused', 'reactive' and 'racist'. These views are supported by evidence showing Māori tend to present to general practice primary health care only when acutely unwell, with complex needs (Russell et al., 2013), with this significantly influenced by the composition and delivery of the primary health care system itself (Waitangi Tribunal, 2019).

6. The health system in general was viewed by participants as a place of 'illness and death', where whānau were subjected to racist judgements and assumptions. Whānau held low expectations in terms of health care service provision. Where whānau did advocate for improved care, they were often characterised as agressive or non-complicant; labels which could result in service exclusion. The evidence shows these negative experiences for whānau are not isolated, existing within a health system characterised by decades-long discriminatory interactions with Māori (Graham & Masters-Awatere, 2020).

[4] The term 'State' refers to the broad range of organisations/institutions/structures that serve as instruments of the Crown in respect of the Government of Aotearoa.

Kaupapa Māori Provider[5] Realities

When we use our kupu, we totally understand what that means … And then when you convert it, you know, whakapākehātia, it becomes a completely different definition … the rules change around who has dominion over the words.
(Rōpū Kaitiaki Wānanga, Nov 2020)

7. Research participants emphasised how Kaupapa Māori providers, with their comprehensive infrastructure, governance, data and connectivity systems, have successfully demonstrated their capacity to deliver relational, whānau-centred, Te Ao Māori driven solutions which benefit all. The magnitude of Kaupapa Māori provider expertise was particularly amplified during the COVID-19 pandemic (Boulton et al., 2022; Cassim & Keelan, 2022).

8. Despite this evidenced success, Kaupapa Māori providers continue to be positioned as an 'attachment' or 'add-on' to an unchanged dominant system. In this way they have been constrained within competitive and divisive silos, and accountable to narrow pre-determined State priorities (Boulton et al., 2020). As emphasised by research participants, Kaupapa Māori providers continue to experience: Indigenous knowledge and processes being defined by State agencies; persistent underfunding and a lack of decision-making power; flawed capitation and funding formulas not accurately adjusting for equity issues, including rurality and deprivation; being marginalised as 'different', non-traditional, and unable to meet Western knowledge system 'evidence' standards (Rolleston et al., 2020); and being burdened by disproportionate and excessive compliance and monitoring requirements (Boulton et al., 2020).

Institutional Racism

Equity – I think it's so simple. There should be no discrepancies in equity. But it comes down to that unconscious bias. Which is just the polite way of saying racism.
(Tā Mark Solomon, Chair, Te Pūtahitanga o Te Waipounamu Board, Mar 2021)

9. Research participants identified institutional racism was embedded in the primary health care system in the following ways:
    - Evidence regarding the ineffectiveness of general practice-dominated primary health care for Māori is disregarded.
    - Flawed and inequitable funding incentivises dominant system[6] primary health care providers to seek out the least resource-intensive enrolled populations, whilst whānau with high and complex needs are referred to an already underfunded Kaupapa Māori primary health care sector, or ignored completely (see Senior et al., 2022).
    - Despite equity for Māori always being a stated priority, the State continues to actively support agencies, institutions, and organisations, including health workforce

[5] The term 'Kaupapa Māori' is used broadly to refer to all providers/organisations operating from a Te Ao Māori base, including Whānau Ora providers.
[6]The term 'dominant system' is used instead of the more commonly used 'mainstream'. As it is currently used, the term 'mainstream' sees Kaupapa Māori and Indigenous experience positioned outside of the 'normal'. When Indigenous imaginations are freed, it is entirely possible for Kaupapa Māori to become the 'mainstream'. The term 'dominant system' therefore more accurately reflects the current situation.

training institutions, who repeatedly demonstrate no evidence of having improved equity for Māori.

- State agencies argue a 'limited' Indigenous evidence base as justification for non-action, whilst evidence regarding the limited effectiveness for Indigenous peoples of internationally derived programmes such as the integrated primary mental health and addictions model, is disregarded (see Kopua et al., 2021).
- Successful Indigenous-led and evidenced solutions are disregarded. Whānau Ora; Iwi and Māori provider success in COVID-19 responses; Te Kūwatawata[7]; and Mana Kidz[8] were referred to by participants as examples of successful Indigenous-led innovations.
- Data relevant to both supporting Māori aspirations, and correcting inaccurate assumptions and bias is not prioritised by the State for collection.
- Regulatory bodies holding dominant worldviews are complicit in silencing Māori voices across health workforces.

10. Repeated long-term failure by the primary health care system to respond to significant inequity; higher exposure by Māori to determinants of ill health and disease; and the ongoing under-representation of Māori across the health workforce (Health & Disability System Review, 2020), all support the premise that persistent inequity for Māori has become an accepted and 'normalised' feature of our health landscape in Aotearoa (Boulton et al., 2020; Reid & Robson, 2007).

11. It has been long evidenced that health policy and decision-making processes are not neutral but are heavily influenced by normative cultural expectations which both influence and reinforce dominant paradigms and power settings (Borell et al., 2009; O'Sullivan, 2019). The unchallenged 'universal' paradigm governing the health system is premised upon the delivery of 'universally available' and 'equal' services to all (Reid et al., 2000). The 'universal' paradigm erases the structural roots of health inequity, whilst at the same time endorsing ongoing entrenched institutional and structural racism (Bowleg, 2021; Reid et al., 2000).

12. Adherence to the universal paradigm leads policy-makers, analysts and researchers to view inequity as resulting from a failure on the part of individual Māori to respond to 'universally available' primary health care services. Māori, both individually and collectively, are therefore positioned within policy and research narratives as different from 'ordinary New Zealanders', as 'hard to reach', 'at-risk', and/or 'vulnerable' (Reid et al., 2000). From this lens, Māori within the health system are seen as non-compliant and blameworthy due to poor lifestyle choices and health behaviours (McCreanor & Nairn, 2002; Penney et al., 2011). In addition, concepts such as 'resilience' are conceptualised as individual personality 'traits', as opposed to structurally supported constructs (Boulton & Gifford, 2014; Bowleg, 2021).

[7] A primary and secondary mental health service partnership premised on Mahi a Atua that enables a Māori-resonant and responsive Single Point of Entry (SPoE) to mental health services. See https://www.mahiaatua.com/

[8] Free, nurse-led, school-based programme, led by National Hauora Coalition in partnership with Counties Manukau Health and supported by local providers, which provides comprehensive healthcare for children in the Counties Manukau Health region. https://nhc.maori.nz/matou-mahi/our-programmes/mana-kidz/

13. The normalisation of inequity via the 'universal' paradigm, obscures evidence demonstrating Māori are engaged and proactive in relation to their own health and wellbeing, and that of their whānau (Graham & Masters-Awatere, 2020; Penney et al., 2011). It also removes any possibility of explanations, and more importantly solutions, outside this deficit-lens.

4.0 Returning to Radically Disruptive and Transformative Kaupapa Māori

Equity is not the end goal. It's not the ceiling, it's a starting point. We are fighting to be at the same starting line.
(Dr Chris Tooley, CE, Te Puna Ora o Mataatua, Mar 2021)

Investing in Māori kaupapa services - we fully support that. Providing that it is kaupapa … a true investment in kaupapa is what we'd be supporting; that is measured by true kaupapa measures ... back to the hauora, the whole ora.
(Kerri Nuku, Kaiwhakahaere, New Zealand Nurses Organisation, Sept 2021)

14. The urgent need for transformative change which addresses the relationship between persistent inequity in health outcomes and institutional racism is well-established (Boulton et al., 2020; Reid et al., 2000; Waitangi Tribunal, 2019). Transformative outcomes for Māori will not occur if the wider context of primary health care remains fundamentally unchanged (Rolleston et al., 2020; Russell et al., 2013).

15. As emphasised by research participants, the starting point for primary health care reform cannot be the existing universal, medically-dominated, general practice-centric, business model of primary health care which has thus far failed to delivered equitable outcomes for Māori. Also stressed by participants was that dominant system primary health care providers and health workforce training institutions cannot keep demanding more and more resources to achieve outcomes it has now been charged with for over 20 years.

16. Research participants referred to the concept of 'disruptive innovation', an approach which explicitly challenges the status quo in order to effect some form of 'radical change' (Afolabi, 2013). Indigenous knowledge is internationally recognised as a 'disruptive approach' (Mapara, 2021). In Aotearoa, our own version of Indigenous knowledge as a 'radically disruptive'[9] transformative theory is Kaupapa Māori.

17. Kaupapa Māori theory unequivocally activates:
    - self-determination and autonomy;
    - the validity and legitimacy of cultural aspirations and identity;
    - a shared and collective vision;
    - critical analysis of Western knowledge bases and power structures; and
    - a focus on the collective as opposed to the individual (Smith, 2015).

    Integral to Kaupapa Māori theory is its focuses on critically interrogating, exposing, and challenging assumptions of structural power and privilege, making explicit how they continue to act to obscure institutional racism and inequity (Smith, 2017).

[9] https://www.unitec.ac.nz/about-us/the-radically-disruptive-progression-of-kaupapa-m-ori-in-early-childhood-education

18. Although there is a focus on structural change, it is the everyday decisions and actions of whānau which, despite the presence of continued resistance, collectively combine to create transformative change (Smith, 2017). Examples of how Kaupapa Māori theory provides the basis for disruptive innovation is evident across a range of movements, such as Te Kōhanga Reo, Kura Kaupapa Māori and Mahi a Atua. Those referred to by research participants include Whānau Ora, IronMāori[10], and Te Kūwatawata.

19. 'Kaupapa Māori' is an accepted part of health sector vocabulary today. However, it can be argued that as the power of definition over what constitutes 'Kaupapa Māori' has been increasingly claimed by the State, Kaupapa Māori has moved further and further away from its original intent as a radically disruptive and transformative praxis (Coombes, 2017; Smith, 2017). It has been suggested that the willingness of the dominant group to embrace 'Kaupapa Māori' shows the extent to which Kaupapa Māori is understood solely as a 'cultural add-on', devoid of any real threat to dominant systems and existing power arrangements (Hoskins, 2017).

Freeing Indigenous Imaginations

> *Freeing our own mind is integral … belief in one's own purpose; belief in power of mātauranga Māori to support oranga … free ourselves from mental slavery, none but ourselves can free our minds …*
> *(Materoa Mar, Upoko Whakarae : Te Tihi o Ruahine Whanau Ora Alliance, Oct 2021)*

20. Research participants emphasised the vital importance of 'freeing our own minds'. Kaupapa Māori theory emphasises the key to transformation lies within ourselves; a 'freeing-up of the Indigenous imagination stifled by colonisation' (Smith, 2017, p. 72), and a belief in our own ability to reflect and act in order to transform (Smith, 2003). This mind-set liberation enables a 'collective envisioning of new possibilities' unrestrained by deficit-focused, narrow, restrictive, Crown-defined aspirations for Māori (Coombes, 2017, p. 40). These new possibilities extend well beyond State objectives of 'inclusion' and 'participation' within the existing add-on, two-option 'mainstream' and 'Kaupapa Māori' system.

21. Research participants emphasised how a transformed primary health care system would see the entire narrative shifted to the possibility of seeing Indigenous knowledge leading out the entire system for the benefit of all. When Indigenous knowledge is prioritised across the entire system, as opposed to being confined to the 3% of services designated as 'Kaupapa Māori', profoundly different solutions are possible. The establishment of Te Aka Whai Ora, and even addressing inequity, simply becomes the starting point.

22. Kaupapa Māori providers and innovators have always been ahead of their time, demonstrating what is possible when Māori futures are collectively imagined (Murchie, 1984). As was stressed by research participants, Kaupapa Māori providers are agile, flexible, and innovative; experts in combining mātauranga Māori and whānau-centred

[10] Established to tackle growing issues of ill health amongst Māori, IronMāori is the provider of the largest Half and Quarter triathlon in New Zealand. http://ironmaori.com

innovations with new technology, sophisticated data collection and research, and effectively utilising scarce resources to improve access and outcomes for whānau.

Freeing Indigenous Imagination: He Aha Te Tikanga o Te Ora?

He aha te tikanga o te ora?
He aha te tikanga o te oranga?
(Rōpū Kaitiaki Wānanga, Nov 2020)

23. Innovation which resides within Indigenous knowledge has always led the way in understanding wellbeing for all in Aotearoa (Durie, 1998). The starting point for a transformed health system must be what keeps whānau well. As is identified by participants in this and previous research, it is the explicit articulation of Whānau Ora, the uniquely Indigenous paradigm recognising that the wellbeing of individuals is intricately connected to the wellbeing of the collective (Taskforce on Whanau-Centred Initiatives, 2009) which has had the most significant impact on the wellbeing landscape for Māori over the past decade (Boulton, Levy, & Cvitanovic, 2020). As identified by research participants, wellbeing is not transactional; it is best understood as a 'change' conversation.

24. Participants in this research identified a markedly different starting point for health and wellbeing than that which is currently offered by the primary health system: *'He aha te tikanga o te ora'*? 'Ora' encompasses the capacity to:
    - engage with the world as Māori, and be safe to do so;
    - ensure tamariki and mokopuna can survive in this world;
    - connect and live intergenerationally;
    - effect tikanga; and
    - effect collective wellbeing.

25. When these capacity statements are utilised as a framework, pathways to health and wellbeing, and the measures used to assess progress, are very different to those within the existing medically-dominated, illness-focused paradigm. As is integral to Whānau Ora, the findings of this research emphasise the centrality of connected communities, and explicitly encompassing the wider determinants of wellbeing in order to provide appropriate responses to 'health' issues. Participants stressed addressing the social determinants of health is fundamental to the 'health' response.

26. Similarly, the entire narrative of what a 'health' service looks like changes. As referred to by research participants, culturally-embedded concepts and processes, such as whanaungatanga, manaakitanga, and kaitiakitanga, form the foundation of relationships with whānau, thus influencing every aspect of service design and delivery (McMeeking et al., 2020; Te One & Clifford, 2021). 'Services' become organised around enduring community structures where whānau live, work and play – marae, sports clubs, shearing sheds, and hui. As has been evidenced by Whānau Ora, the nature of relationships across the system are also altered, as providers, organisations and groups are supported to explicitly focus on wellness (Smith et al., 2019).

An Indigenised State

… systems change that starts from Indigenous knowing …
(Rōpū Kaitiaki Wānanga, Nov 2020)

27. Indigenous disruption and innovation which has occurred in Aotearoa has happened *despite* the system, not because of it. Previous research shows how the primary health care system is deliberately configured to maintain existing clinical hierarchies of power and resource-capture (Middleton et al., 2018).

28. Tino rangatiratanga and mana motuhake in health encompasses the power to not only self-determine what constitutes wellbeing for Māori, but also ways in which it is achieved. Aspirations to Indigenise the State move well beyond limited goals of Indigenous 'participation' or 'input', which relegate Indigenous worldviews to the margins. As was identified by research participants, moving beyond State-led and defined practices of 'consultation' and 'co-design' to true partnerships requires a paradigm shift underpinned by the genuine transfer of power, decision-making and resources to Māori.

29. Research participants were clear the State must move beyond its fear of losing control, to genuinely understanding how addressing equity, via active partnership-focused governance, management, and operational arrangements, will generate significant gains not just for Māori, but the whole of Aotearoa. Furthermore, the establishment of Te Aka Whai Ora plays a significant role in the journey towards constitutional change, providing a unique opportunity to tangibly demonstrate the possibilities for transformative change when genuine power-sharing occurs, resources are devolved, and relationships are re-set.

30. When the State is itself Indigenised, Māori move beyond being forever positioned reactively, always having to respond, engage, and explain. Instead, the focus shifts to being aspirationally driven and critically conscious in order to actively engage with the deeper structural issues of institutional racism responsible for holding inequity in place (Smith, 2003).

31. Integral in the movement to critical consciousness is the process of Indigenising: a reassertion of self-determination and a reclaiming of Indigenous ways of knowing, doing, and being (Jones et al., 2019; Kopua et al., 2021). An Indigenised State rejects deficit-based, individualistic paradigms, as complex issues are responded to with intersectional, creative strategies rooted in Indigenous knowledge (Opara, 2021).

32. An Indigenised State will see Indigenous worldviews and knowledge positioned centrally, and fundamental power structures and relationships dictating policy and decision-making across the health system transformed. The way in which the health system operates and interacts with Māori is dismantled, moving away from the dominant illness-focused medical paradigm, characterised by low trust, multiple contract models, to a commissioning for outcomes approach which is flexible, agile, and purposefully focused on growth and future development.

33. As stressed by research participants, advances made by Whānau Ora Commissioning Agencies and providers over the past decade, particularly in relation to operationalising the role and value of a Māori-led commissioning model able to invest in responsive, agile and flexible Māori-led solutions, provides both an extensive evidence base and a repository of expertise to inform transformative innovation in Aotearoa. The centrality of Whānau Ora providers to the national COVID-19 response has been widely reported (Cram, 2020; Whānau Ora Commissioning Agency, 2022).

34. Participants emphasised the fundamental importance of creating optimal conditions for genuine relationship re-sets. This includes tikanga informed, 'rangatira ki te rangatira', relationships across the health sector. The importance of Te Aka Whai Ora not simply replicating the status quo and going beyond existing Crown-defined mechanisms and structures which have tended to exclude the mana which endures outside Iwi-Crown relationships, specifically within hapū who are more closely connected to communities on the ground, is stressed.

35. Alongside this, is Tāngata Tiriti[11] being responsible for their own learning regarding how to activate Te Tiriti-led partnerships, including knowing when to step aside in favour of genuine devolution to Māori communities.[12] Te Aka Whai Ora must have the capacity to reach across the determinants generating inequity, for example, housing, justice, and education. Key State agencies, including Te Whatu Ora and the Ministry of Health, must all have a vested interest in the success of Te Aka Whai Ora.

Critical Consciousness: Going Beyond the 'Competency' Approach

> *There's a fundamental question about how much resource the health system takes and how much outcome it delivers. We have to be critical.*
> *(Dr Rawiri Jansen, Director, National Hauora Coalition, Mar 2021)*

36. Kaupapa Māori theory emphasises the centrality of critical consciousness and praxis to transformation. Understanding and taking action to address structural variables via reflective self-assessments of power, privilege, and bias, by health practitioners, healthcare organisations, and the wider systems in which those individuals and organisations exist, is essential (Curtis et al., 2019).

37. Without this critical consciousness, the same systems of dominance continue to be reproduced across all aspects of our problem-solving and decision-making processes, meaning structural change able to genuinely impact and transform health inequity is impossible (Jones et al., 2019). The explicit naming of institutional racism across all levels is key to its elimination (Curtis et al., 2019). Researchers cannot continue to simply highlight inequities for Māori, whilst simultaneously upholding the status quo which is perpetuating existing unequal power and social relations.

38. The evidence suggests that the movement to critical consciousness will not occur via the existing competency-based approach favoured by policy-makers, regulatory bodies and

[11] Those who belong to this land by right of te Tiriti o Waitangi/the Treaty of Waitangi (includes everyone who cannot whakapapa to a Māori ancestor) https://nwo.org.nz/resources/who-are-tangata-tiriti/
[12] See '17 Habits of a Valued Treaty Partner' https://www.flyinggeesepro.nz

health workforce training institutions in Aotearoa. This approach sees 'cultural competency' positioned as a 'skill' able to be fully achieved through a static process of knowledge and skill acquisition (Baker & Levy, 2013).

39. Competency-based approaches leave the overarching paradigm, with its deeply entrenched bias towards Western knowledge and its power structures, out of focus and unchanged. Because of this, competency-based approaches cannot provide what is required for genuinely transformative change. The reliance on this 'competency' approach is why, despite decades of 'cultural competency' programmes, and despite individuals and organisations having genuine insight and motivation, long lasting transformative outcomes for Māori have not resulted (Jones et al., 2019).

40. When analysis becomes removed from action, 'Kaupapa Māori is in danger of losing its radical potential' (Smith, 2012, p. 12). Authentic paradigm shifts founded upon critical consciousness are a long-term and often difficult process of active critical self-reflection about one's own contribution to institutional racism. That is, how as part of institutions, individuals are producing, reproducing, maintaining, and benefiting from intersectional systems of oppression (Curtis et al., 2019; Kopua et al., 2021; Opara, 2021). Unsurprisingly, this process of critical self-reflection is often experienced by both Indigenous and non-Indigenous people, as confronting and challenging, significantly more so than that of the technical competency acquisition approach (Baker & Levy, 2013).

41. Aotearoa was well ahead of its time with the introduction of critically-based cultural safety in the early 1990s (Hunter et al., 2021). Recognised as a key approach to eliminating institutional racism in the health system (Health & Disability System Review, 2020), cultural safety has further evolved to explicitly focus on: critical consciousness as opposed to narrow conceptualisations of cultural competency; application within systemic and organisational contexts in addition to the individual provider-whānau interface; power relationships and inequities within health care interactions that reflect historical and social dynamics; and alignment across all training and practice environments, systems, structures, and policies, as opposed to limited to formal training curricula (Curtis et al., 2019).

An Indigenised Workforce: Creating Communities of Disruptive Innovators

> *For our existing workforce, there will need to be a different approach. Our system is straining, and we keep pushing more of the same type of workforce out for quite a different approach. How we get there, will the reforms give us an opportunity? I hope so.*
> *(Hayden Wano, CE, Tui Ora, Sept 2021)*

42. The status quo, characterised by highly medicalised, professional silos, will not result in transformative outcomes for Māori. Systemic transformation across the primary health care system requires a more expansive view of what constitutes the 'health' workforce: we must move beyond ineffective system and service configurations, and outdated scopes of practice (Goodyear-Smith & Ashton, 2019; Health & Disability System Review, 2020).

43. As identified by research participants, integral to this is facilitating a shift away from clinicians seeing themselves as 'interventionists'. The concept of 'de-centering' professional interventions which position whānau solely as dependent recipients of assistance (see Bracken & Thomas, 2017), in favour of generating authentic opportunities for individuals and whānau to drive their own journey forwards is a cornerstone principle of Whānau Ora (Smith et al., 2019).

44. Research participants recognised significant advances have been made in relation to growing the Māori clinical and professional health workforces. However, from a Kaupapa Māori theory perspective which asserts recognition, affirmation, and validation of Māori worldviews, Māori health workforce development cannot simply focus on the acquisition of technical skills; it forms a central element of a wider liberation movement built on Indigenous methods and mechanisms of critique, measurement, and judgement (Baker & Levy, 2013).

45. The dominant deficit, medically-focused paradigm cannot be the assumed starting point for Indigenous health workforce development. Participants in this research questioned why institutions and training paradigms who have demonstrably failed Māori for decades, are essentially being rewarded with more resources to continue to fail? If overall system transformation is the aspiration, simply adding more Māori health professionals trained within a paradigm which steadfastly resists Indigenous worldviews and solutions is not the answer.

46. Integral to Kaupapa Māori theory is the creation of 'change agents'; those focused on the development of 'radical pedagogy', and critical approaches to transformative change (Smith, 2003). Health workforce development must be understood within a wider context of creating communities of change agents and disruptive innovators: those whose Indigenous imaginations have been freed to consider the possibilities and creative solutions which extend well beyond existing paradigms of narrow, constrained, and siloed thinking.

47. As is fundamental to Kaupapa Māori theory and recognised across key movements for change in Aotearoa (e.g., Whānau Ora; Te Kōhanga Reo; Kura Kaupapa Māori; Mahi a Atua; IronMāori), 'change agents' do not only exist within professional workforces, but across flax-root communities and whānau (Kopua et al., 2021). Anyone has the potential to become critically conscientised and critically engaged in their belief and capacity to not only resist, but to act transformatively via every day, individual and collective actions (Smith, 2003). This was clearly demonstrated in Kaupapa Māori COVID-19 responses which visibly showed the immense value of the Indigenous community workforce (Boulton et al., 2022; Whānau Ora Commissioning Agency, 2021)

48. These communities of disruptive innovators lie at the heart of paradigm and system transformation, entrenching Indigenous worldviews not only within their own practice, but across whānau, communities, organisations, training institutions, regulatory frameworks, and professional bodies.

49. Acknowledging ongoing resistance to examining racism and privilege, it has been argued that medical training institutions must dismantle colonial curricular, system, structures, policies, and practices (Jones et al., 2019). Consistent with Kaupapa Māori theory, this occurs alongside a process of Indigenising: reclaiming Indigenous ways of knowing, doing, and being. Similar processes are of relevance to other health professions, as well as accreditation bodies, and policy and legislation development (Jones et al., 2019).

Conclusion

50. Participants in this research described the establishment of Te Aka Whai Ora as revolutionary. The solutions enacted by Te Aka Whai Ora must likewise be revolutionary: reform cannot result in simply more of the same, albeit with brown faces. As emphasised in this and previous research, a Western paradigm of health cannot be prioritised to address problems it has thus far not only failed to solve but has in reality made worse (Rolleston et al, 2020). That persistent inequity remains a key driver for health system reform some 20 years after the development of the Primary Health Care Strategy (Ministry of Health, 2001) illustrates the extent to which the existing system and its underpinning paradigm has failed Māori.

51. The assumed starting point in reform therefore must be what keeps whānau well - the exact opposite of the illness-focused primary health care system. As emphasised by participants, Indigenous aspirations for 'ora' go far beyond the individual, extending to the collective, including both the living and those yet to be born, the mokopuna of mokopuna, and beyond. Realising these aspirations requires an intentional and deliberate return to the radical and transformative intent of Kaupapa Māori theory: the freeing of Indigenous imaginations; an Indigenised State sustained by belief in Indigenous knowledge and solutions; and the development of an Indigenised workforce of disruptive innovators.

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