

The “standard story” of anti-Māori talk in Pae Ora (Healthy Futures) Bill submissions

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ABSTRACT

AIM: To review some common patterns of race talk in a sample of submissions made to the *Pae Ora (Healthy Futures) Bill*. This bill proposed a structural reform of the health system in Aotearoa New Zealand to address long-standing health inequities experienced by Māori, the Indigenous peoples, and other priority populations.

METHOD: In a sample of 3,000 individual submissions made in late 2021, we found 2,536 explicit references to race. Utilising the “standard story” frame of Pākehā/non-Maori race talk, five longer submissions that inferred that the *Pae Ora* bill was “racist” were analysed in detail.

RESULTS: Many “standard story” race discourses were identified in the *Pae Ora* submissions. Three derived discourses included in this paper are: Pākehā as norm (monoculturalism or not seeing Pākehā as a culture), equality and the “Treaty” (equality for all to access healthcare), and one people (we are all New Zealanders). Sources such as the Waitangi Tribunal Wai 2575 Hauora report were drawn on to provide alternative discourses.

CONCLUSION: Identifying Pākehā standard story discourses enables learning about language patterns systems draw on, and the development of tools and procedures to improve equity for Māori and eliminate institutional racism.

The *Pae Ora (Healthy Futures) Bill 2022* was introduced into the New Zealand Parliament by the Honourable Minister of Health Andrew Little on 20 October 2021. This Bill (the *Bill*) proposed a new structure and accountability arrangements for the publicly funded health system in order to protect, promote and improve the health of all New Zealanders.¹ The *Bill* outlined a major restructure of the health system to address inequities in health outcomes experienced by Māori, Pacific peoples and tāngata whaikaha (people with disabilities), and to recognise the Crown’s obligations to Māori under Te Tiriti o Waitangi (the founding document of Aotearoa New Zealand).¹ Te Tiriti outlines the relationship of kāwanatanga (the Crown’s governance over British citizens) and tino rangatiratanga (Māori self-determination) between the Crown and Māori. Implementing Te Tiriti within the health sector would eradicate institutional racism, and achieve health equity for Māori.²

Pae Ora Bill opponents claimed the health reforms were separatist.³ Moana Jackson responds to this “mythtake” of separatism, asserting that “colonisation has always been a separatist process in which the colonising states imposed their own

separate institutions in places that already had their own”.⁴ In this statement, he names what others have also raised—that the reform agenda maintains the dominant colonial settler government health system and is not Te Tiriti compliant.⁵ However, some Māori scholars were hopeful about the potential within the proposed health reforms as a move toward a Te Tiriti-based system⁶ and Tiriti partnership as a means to tackle the inherent racism within the health system.⁷

The bill proposed the establishment of Te Whatu Ora – Health New Zealand (HNZ) as a Crown Agent, to work in partnership with an independent Māori Health Authority (MHA) or Te Aka Whai Ora.¹ MHA, an independent statutory authority, aspires to enhance tino rangatiratanga and strengthen mana motuhake (Māori sovereignty) to address intergenerational Māori health inequities highlighted in Wai 2575 Hauora Report: the Health Services and Outcomes Inquiry.⁸

The intention of the early 2000s health system reforms was to reduce inequalities in health status for Māori. Despite these intentions, health services in Aotearoa New Zealand continue to privilege Pākehā,⁹ are more accessible for Pākehā and offer a differential, usually higher, quality of service to Pākehā.¹⁰ The failure to progress health equity

led to the lodging of Waitangi Tribunal claims by Māori primary health organisations (PHOs) and providers.⁸ The Tribunal Wai 2575 initial report, released in June 2019, found the health system had failed to improve Māori health outcomes and further that institutional racism was a pervasive and core determinant of ill health for Māori.^{8,11} The Minister of Health, in lieu of the Waitangi Tribunal hearings, commissioned a review into the health and disability system.¹² The review contained 86 recommendations to transform the health sector, which informed the *Pae Ora Bill*.

Objectives of the paper

This paper sought to identify evidence that undermines the intent of Pae Ora Bill in establishing MHA and bridging Māori health inequities. To do this, we examined some of the enduring patterns of ways in which Pākehā talk about Māori that were evident in the public submissions to the Pae Ora Bill.

When the health system changes were announced in mid-2022, Riana Manuel, Chief Executive of Te Aka Whai Ora, was hopeful:⁷

I nearly shed a few tears because, in my career, I hadn't ever seen a moment when a Treaty partnership was actually turned into a functional and operating reality. I know we've got a long way to go and these are just the beginnings, but I feel heartened that we may be able to make a difference this time. We may be able to create an enduring partnership.

This view was a stark contrast to many of the public submissions to the *Pae Ora Bill* in late 2021. The vast majority were from individuals largely opposed to the *Bill*. Almost all were objecting in principle to the Hauora Māori provisions that included the appointment of a Hauora Māori Advisory Committee and the establishment of MHA. The language used in the submissions prompted the researchers to take a closer look.¹³

Words and language are an essential aspect of social relationships.¹⁴ This paper provides insights into how a section of the New Zealand public reproduce views about Māori and Te Tiriti o Waitangi that echo racist narratives. These narratives have been intentionally cultivated via traditional media and social media.¹⁴ *Pae Ora Bill* submissions highlight the need for greater understanding of entrenched racist views held about Māori that Pākehā draw on when Māori self-

determination is up for discussion. Media narratives about Māori rights often portray Māori through a deficit framework, yet ignore Pākehā privilege, monoculturalism, colour blindness and who benefits from institutional racism.

Methodology

Positionality

Both Māori and Tauīwi (non-Māori) scholars working as anti-racist activists and allies in Aotearoa are involved in the writing of this paper. Our positionality is informed by Te Tiriti o Waitangi as an anti-racist praxis¹⁵ to empower Māori as tangata whenua (Indigenous Peoples) and restore the balance between kāwanatanga and tino rangatiratanga that the Crown disrupted in its own favour.¹⁶

Analysis

Enduring negative patterns in Pākehā talk about Māori, with origins tracing back to early settlement of Aotearoa, have been identified through public documents¹⁷ and media research.^{14,18}

A “standard story” of Pākehā race talk works to justify and legitimise the colonial state while maintaining and reinforcing negative representations of Māori people and culture.¹⁷ Standard story themes that function to uphold racism are frequently used in media, and everyday talk, were identified in many of these themes in the *Pae Ora* submissions.

From a first reading of this sample by hand and using nVivo a number of themes were identified, informed by both discourse and thematic analysis methods. Three of the authors did an initial coding separately and then shared and discussed the codes together. Five substantive submissions (long, repeated by other submitters) that represented the types of talk identified across the sample and that inferred the Pae Ora bill was “racist” were selected for further analysis. The coding phase was deductive and derived from previously identified “standard story” themes.^{14,17} These five submissions were read in detail and coding was discussed and agreed to between the authors. To allow for traceability each submission has an allocated number from one to five.

Results

The anti-Māori views shared by many individual submitters across the submissions were described as “an avalanche of viciousness” towards Māori.¹⁹ The majority of submitters do not identify their

cultural/ethnic identity, and this absence gives a strong indication that they are from the Pākehā majority population group. The Pākehā talk shows a failure to recognise Māori as the Indigenous people of Aotearoa, and a refusal to acknowledge the ongoing impacts of colonisation that have led to the health equity gaps between Māori and Pākehā population groups.⁸ In this paper, we describe three of these themes: Pākehā as the norm; equality and the “Treaty”; and one people.

Pākehā as the norm

This pattern of talk constructs Pākehā as the norm, the natural, the ordinary, the nation, although they are almost never named as Pākehā. Failing to name Pākehā as a cultural/ethnic/race group is problematic in two ways. First, it both hides the power, control and influence of the unidentified majority, making Pākehā dominance invisible while affirming the monocultural New Zealand systems. In this pattern the European/White majority are “we” or “our”, while Māori are marked as outsiders by “you” or “they”, “them” or “theirs”.¹⁴ Secondly, the pattern sets up a sense of cultural lacking expressed as either “I don’t have a culture” or “as I am not named, I am not included”.²⁰

However I really do think we need to stop trying to portray the whole system as having failed just because some struggle to front up. (4)

The quote above is a combination of powerful narratives: Pākehā as the norm and “one people”, which shift attention from the system to individuals by pointing out the system works for the unnamed majority. The health system is not identified culturally as a Pākehā system; rather it is taken for granted that it follows the norms and standards of “New Zealand culture”. Constantly omitting the identity or naming of the dominant group or their culture is a form of ex-nomination that “masks the cultural origins of the state” (p 157).¹⁷

If there is a publicly funded health system, it should operate fairly and justly for all. It is the Crown’s responsibility to ensure this is the case. However, the way this Bill is drafted, our publicly funded health system will be subject to conditions that prioritise race over health. (1)

Any naming of ethnic or cultural groups, such as

Māori, is assumed to disadvantage the un-named majority. The quote above negates the evidence that Māori health inequities are mapped to the intergenerational impacts of colonisation and racism on Māori,^{8,11} and implies that the Crown’s efforts in prioritising Māori health are causing injustices for Pākehā. Māori are viewed as undeserving of access to Crown initiatives wherein submitters assume targeted assistance for Māori indicates less support for Pākehā.

This bill imposes, by law, a racially based structure on the whole community. Considerable weight has been given to providing for Māori governance, input and health outcomes, without the same consideration given to all New Zealanders. Health New Zealand (HNZ) has been established with a bias towards Māori. (1)

The text above sees Māori as a race but does not acknowledge or name the cultural basis, or “norms” of the health system under the *New Zealand Health and Disability Act* (2000); therefore its cultural and by extension racist foundations are invisible. The excerpt above (1) was repeated in at least 45 other submissions, indicating a level of organised opposition to *Pae Ora*.

The following text from submission 2 illustrates how effectively the practice of not describing or identifying the Pākehā majoritarian New Zealand culture allows Pākehā culture to appear as the invisible “common sense”.

The Bill runs counter to the underlying ethos of New Zealand culture—equality for all. (2)

A response to the “Pākehā as the norm” pattern of talk is to recognise Pākehā as one culture among many in Aotearoa.²¹ Further, to name the Pākehā group as the majority party in health system changes: the proposed change to the current Pākehā-dominated health system seeks to address the health needs of Māori that are determined by Māori.

Equality and the “Treaty”

The selective usage of the English language term “the Treaty of Waitangi” rather than Te Tiriti o Waitangi (the authoritative document)¹⁶ contributes to establishing settler privilege. In the extract below, Article 3 of the draft English Treaty is interpreted as providing a firm foundation for

demanding strict equality as a Crown obligation in healthcare. This was typical of the ways in which many submitters ignored or denied evidence that the health system privileges Pākehā individuals.¹⁶

The Crown's obligations are to govern for ALL New Zealanders. The importance of citizenship over race was recognised in article 3 of the Treaty of Waitangi in 1840. All New Zealanders were given the rights of British citizenship and protection of the Crown and to ensure equality of citizenship, with no discrimination. However, I have grave concerns that this bill fails to uphold this obligation and will not achieve its stated purpose. (1)

This interpretation differs from the supposedly equivalent translation of mana ōrite (Article 3 in Te Tiriti) that accords Māori the equal rights and privileges of their Pākehā counterparts.¹⁶

Comparable mentions of equality in relation to Article 3 occurred across the submissions, without any reference to Te Tiriti as a whole document that includes Article 1—Kāwanatanga (the Crown governance over own settlers), Article 2—Tino Rangatiratanga (Māori self-determination) and the oral Article 4—Wairuatanga (spirituality).

A response to this “equality and the Treaty” pattern recognises that an equity approach to addressing Māori disparities in health outcomes and access to healthcare is informed by all articles of Te Tiriti o Waitangi. Indeed, the Waitangi Tribunal has put forward “equity” as a Te Tiriti principle to remind the Crown of its obligation to eliminate racism and barriers to care (such as cost and geography) that are more likely to disadvantage Māori.⁸

One people (rights and privileges)

A core feature of this pattern of talk is the importance of treating everyone the same, as one people: the public, taxpayers, New Zealanders.¹⁴ The theme draws on the phrase “he iwi tahi tatou” used by Hobson to acknowledge the signature of each rangatira at Waitangi. This tribal idiom for “we are of one mind about this” has been transformed into a declaration that we will be a unified nation where multiculturalism is tolerated. The “one people” pattern, used in this way, rejects power-sharing models, representing such change as divisive and intolerable.^{14,17}

The concept of ultimate treatment of all

racas as equal subjects as envisaged in the original Treaty seems totally ignored. (5)

Giving priority to one race is abhorrent. This is amplified by saying the Crown and health consumers are twins for the purposes of the legislation. S18 provides “to achieve the best possible health outcomes for whānau, hapū, and Māori in general”. There is no equivalent provision for non-Maori. And who determines best possible? The hospital that gives you second best, pharmac who gives you an unsatisfactory generic? The idea is fine if applicable to all—but what will the costs be? (2)

A large number of comments within submissions highlighted “race”, in this case with the identification of the Māori Health Authority as a named Māori service. This naming divides and disrupts the notion of the all-encompassing New Zealander. Almost without exception, the submitters remain ex-nominated; they fail to name or acknowledge their own race or cultural affiliations. Rather, they are the norm, “the New Zealander”, whose health needs will be less well served by the proposed system:

Health New Zealand (HNZ) has been established with a bias towards Māori. This includes introducing a system where two competing organisations, one whose interests are based on race, are established to co-govern the health system. Each will have its objectives, functions and mechanisms, with only one having an obligation to act in the best interests of all New Zealanders. (1)

NZ [New Zealand] is a small country by world standards and we have limited resources to fund public services such as health and education. We are already at the bottom of the OECD for access to new medicines—how is it that Maori and Pasifika healthcare will be prioritized with all the bureaucracy to manage that, without some diminishment of the service provided to all other New Zealanders? (4)

Further, these submitters may well be assuming that Māori when in positions of authority will act in the same exclusive and monocultural way that

Pākehā have in providing healthcare. Illustrated below is the “very reasonable assertion” that people have different health needs and that health services should be provided on a “needs” basis rather than a “race” basis.

The purpose of such an authority can only be to give priority access to publicly funded health services to a section of society based on race rather than on health needs. Although there may be different health needs attributable to race, an effective focus on health needs would easily be able to deal with those differences without reference to race at all from a priority perspective. More generally I cannot support any kind of race based prioritisation or discrimination, whether negative or positive in a free and democratic society as this country has previously fought to become and remain. (3)

These critiques of the proposed Māori Health Authority illustrate the tyranny of the majority. They do not acknowledge the irrefutable evidence that health services, while serving the needs of the Pākehā majority, have systematically failed to provide adequate healthcare for Māori peoples.²²

An honest response by Pākehā to the “one people” theme is to understand their place in Aotearoa in relation to Te Tiriti o Waitangi; to acknowledge the tino rangatiratanga (self-determination) of tangata whenua as sovereign peoples; and to recognise the damage caused by colonisation. This response requires a shift from the colonial mindset that presumes the right to govern over Indigenous peoples and accepts a “sharing the sovereign” position.²³ This examination should make explicit the power and privilege that Pākehā people hold within Aotearoa society and actively work to dismantle this hegemonic position.²⁴

Discussion and conclusion

The health system transformation aims to improve health outcomes for Māori to a standard that is defined by Māori. It also aims to increase Māori life expectancy to at the very least the same levels currently experienced by Pākehā (European) New Zealanders, leaving no one behind and ensuring we all flourish together.²⁵ Put simply, improving outcomes for Māori (levelling the floor) will increase the benefits for all (lift the ceiling).

Addressing racism is the challenge that will determine the success of proposed health reforms, according to Māori public health medicine specialist Dr Elana Curtis:²⁶

Racism in how our systems operate, in how our health professionals engage with Māori patients and their whānau, and the management decisions they make, is an important determinant of health that must be addressed. If it isn't directly named and addressed, this racism will continue regardless of how many health authorities or health entities we create. We will need this detail sorted if we are to have the vision realised with these new health reforms.

Our findings demonstrate the need to examine language and every day talk as an essential strategy in the anti-racism toolkit. They draw on the large body of work examining and revealing racist discourse within Aotearoa and a long history of negative patterns of talk by Pākehā settlers about Māori.^{14,27} A “standard story” of Pākehā race talk uncovers the unexamined benefits and advantages accrued by Pākehā settlers through colonisation, and the power and privilege that Pākehā consequently hold within Aotearoa.²⁸

The *Pae Ora* submissions reveal that “standard story” patterns of talk continue to be used to defend the colonial construct of the state of New Zealand where the dominant group is both the norm and culturally unmarked as a people. Several submissions utilised the “one people” pattern to argue that the proposed reforms were creating a race-based health system that favoured Māori to the disadvantage of other New Zealanders. There are other patterns of talk (e.g., Māori privilege and rights) that we hope to explore in future analyses.¹⁴

Thirty-four years after the release of the first government report into racism in the public service, the Ministry of Health has committed to an anti-racism kaupapa “Ao mai te ra” through Whakamaua: Māori health action plan 2020–2025.²⁹ “Ao mai te ra”, translated as the dawn has come, is in reference to “Puao-te-ata-tu”, a new dawn.²⁵

To respond to and address racism as part of the vision to achieve *Pae Ora*—healthy futures for all New Zealanders—the Ministry of Health released the *Position Statement and Working Definitions for Racism and Anti-racism in Aotearoa* in August 2022.³⁰ Our findings demonstrate the

types of race-based talk that both sustains opposition to and hinders implementation of health equity initiatives for Māori and all living in Aotearoa. Identifying these patterns will enable Te Whatu Ora – Health New Zealand to partner with Te Aka Whai Ora – Māori Health Authority to design and utilise anti-racism tools that challenge and change the “standard story” narratives making Pākehā power and privilege visible.

Footnote

Generally, in this paper we are referring to Pākehā as the non-Māori European/White majority of settlers in Aotearoa. Pākehā are the group with whom Māori understood they were working with and who have betrayed them since the signing of Te Tiriti o Waitangi. *Tauīwi*, rather than Pākehā, is the more inclusive term used to encompass all non-Māori peoples who have settled in Aotearoa.

COMPETING INTERESTS

The funders had no roles in study design and collection, analysis, and interpretation of data.

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