RACISM IN THE HEALTH SECTOR IN AOTEAROA –
WHOSE RESPONSIBILITY IS IT?
PROFESSOR PAPAARANGI REID, PROFESSOR DAVID TIPENE-LEACH,
LADY TUREITI MOXON
21 March 9 am

>>PROF TIPENE-LEACH: (Te reo Māori). (Karakia). Kia ora tātou.

>>RINGA HĀPAI: Nau mai haere mai ki te Tiriti-Based Futures 2022. Start off with ngā mihi to Ngāti Whātua Ōrākei, tangata whenua and the people (inaudible) stand today. I mihi the organisers of this wananga who have poured their aroha into this important mahi. I mihi (inaudible) the ADHB have partnered and who I represent today. To our kaiako, esteemed kaiako, Professor David Tipene-Leach, Professor Papaarangi Reid and Lady Tureiti Moxon whose collective experience stands 150 years. Finally to our audience of tauira, students who've tuned in to hear the whakaaro and the kōrero our kaiako are willing to share with us today.

My name is Jo Lambert, I whakapapa to Ngāti Maniapoto and Te Atiawa and I'm a healer. I use that term intentionally because it encompasses my multiple realities as an intergenerational healer within my whānau who bears the associated trauma of being a colonised people, as a tākuta or a doctor who specialised in sexual assault medicine, as a partner, a mama, an aunty, a daughter and a friend and the three tohunga and taonga that I have the honour of chairing today. Have so many realities for them, and the term that most resonates with me is light workers and like Tāne separating Ranginui and Papatūānuku, they bring light to our world with their aroha for our people, their koha of a lifetime of energy and wairua and their kaha, their strength to continue fighting for equity in Māori and indigenous health.

Today I want to raranga, to weave a kete for you, for you and I, to place the pods of effective anti-racism tools, techniques and weapons to carry into our workplaces and our relationships with others.

Today's kaupapa is that each of the panelists will do a not so short kōrero about themselves and their mahi and then later on we'll open it up to questions from the audience.

So first up I have Lady Tureiti Moxon, welcome. You've been described as a transformational servant leader, your work in education, in law, in Te Tiriti and as the managing director of Te Kōhao Health, the eye of the needle(?), as a Māori based provider of health, social employment, whanau ora, education and justice services to a

predominantly Māori-based client base. Thank you for sharing with us your wisdom today, I hand it over to you.

>>LADY MOXON: Kia ora koutou katoa. (Te reo Māori). Thank you for the opportunity to come and just share some of my thoughts with you alongside of Professor Papaarangi Reid and Professor David Tipene-Leach. I guess really the thing that we have to be always mindful of is that on average Māori have the poorest health status of any ethnic group in Aotearoa New Zealand. Māori are more than twice as likely to die of preventable diseases. Māori are twice as likely to face discrimination and health. And we might think about what that discrimination might look like. And it can be in all different kind of ways, it can be societal, structural racism, it can be institutional or systematic racism, it can be interpersonal or personally mediated racism or it can be internalised racism, so there are many different forms that it takes. Some of us don't think we feel that way, or that we do things in that way, but when you're choosing to do something one way over someone else who is different from that person or even different from us, then we often make decisions that come from who we are and from our paradigms.

But Māori unfortunately are more likely to be -- less likely to be referred for diagnostics and so therefore if they ever get to be x-rayed or what not, they don't have the money to pay for that x-ray. And so really, while people may say that we do this to ourselves because we don't look after ourselves etc, the fact of the matter is the system as it is currently geared actually presents barriers for us in respect of that.

So to give you a couple of examples, cardiovascular disease mortality is two and a half times higher. Stroke mortality, twice as high. Heart failure, almost three times as high. Lung failure, especially for our wāhine, three to four times higher. So all types of cancers on average, twice as high. Wāhine Māori register -- I just said that, four times higher than non-Māori for lung cancer, but unfortunately dying at a rate far greater. For our men it's three times higher.

So that's health stats. I also want to bring in here statistics that came before the Waitangi Tribunal in the Wai 2115 and Wai 2941 claims that the Children's Commissioner put forward. In 2019 pēpē Māori zero to three months were five times more likely to be taken into State custody than non-Māori babies. 38% of social work assessments on unborn babies did not find abuse. 53% of social work assessments on zero to 3 month-olds did not find any abuse. It showed abuse had decreased at the peak in 2019. But despite the decrease the removals of unborn pēpē increased from 36 in 2010 to 93 in 2017. And I can tell you, the statistics beyond that in 2020, 2021 are even greater.

So between two and three times more babies were removed. So there are issues that we have with legislation and certainly the ex parte orders in section 78 of the Act OT Act 1989, these ex parte orders were just given out like lollies. Judges were just signing them off like nobody's business, not even asking what the reason was. And now we have before the Abuse Commission all the voices, the millions of voices. And when I say millions, there weren't millions before the Commission, but millions of voices that stand behind them who are tangitangi because their children have been taken away from them.

So I think that's probably enough to get things stirred. So no reira, tēnā koutou katoa.

>>RINGA HĀPAI: Kia ora whaea. Next is Professor Papaarangi Reid who is a public health physician and a tumuaki of or head of Te Kupenga Hauora Māori at the Faculty of Health Sciences at the University of Auckland. The words that she has used is that she's had long fights, some uneven battles with some sometimes dirty competitors, that she has a slight leaning to leftism and anti-capitalism and that she loves a good scrap. And I can't think of anyone else that I'd want in my waka to lead us on this journey. So mōrena whaea, I hand it over to you.

>>PROF REID: Tēnā koe Joanna. Tēnā koe David mō to karakia tēnei wā, no reira (te reo Māori). I want to also thank my colleague, Lady Tureiti, for her introduction and in this discussion about racism especially in the health sector, in the health system, she's outlined some really damning statistics and when we really dig into the determinants of health, and previously internationally the determinants of health have been very superficial in terms of how they've been described; important but superficial, you know, housing, education etc, but they're now internationally just starting to pick up on something that we've been discussing quite a lot here in Aotearoa and a heck of a lot over this last few days with this project, and that is racism as a determinant of health.

So how do we get to racism, you know, how do we get here? And we have to understand that racism is central to the colonial project. So colonisation again is something that we should be focused on.

I'm really interested in the Crown has now focused quite a lot on equity and recognise their role in equity. But I think back in the -- some decades ago when Bridget and I wrote the introduction to Hauora IV, we said it's our right to monitor the Crown and actually the purpose of equity and the stats Lady Tureiti highlighted is to monitor the Crown and their role in Treaty responsiveness. But I really hope that we don't think that's

the end, whereas article 3 that focus on equity is really -- shouldn't really be conflated to Te Tiriti compliance. It's only part of the story, it's the monitoring part of the story.

So what do I think is a major problem for the health sector? I think it's wilful ignorance. It's wilful ignorance. They see, we have monitored them, they see, the Crown sees that it has a problem and yet it goes rapidly into denial. It wants to do a little pepeha and it thinks it's done its business, if it's done a little pepeha and we're all good now, we're not racist.

So I think that is a real challenge that we have to get past, the superficial and we have to get past the personal and we have to focus on the institutional and the structural.

So that's the Crown's job, but what's our job as Māori? I think we have to think about what is our theory of change. Gabrielle Baker said that to me once and I think that's -- what is our theory of change? And I want to go back to, you know, what Moana Jackson talks about, that's re-imagining our future, how do we re-imagine the health sector before the reforms come out, otherwise we're going to reproduce a system that is problematic for us, otherwise we're just going to add a little bit of superficial stuff. How do we re-imagine our future for our health system? How do we re-imagine that rangatiratanga is really part of it? What do we imagine the role of kāwanatanga to be, and how do we build into it that ethic of restoration?

So I'm really interested in our discussion over these next few days around how do we change before we -- as we rebuild the system, what is the role for kāwanatanga, what is the role for rangatiratanga and how do we include the ethic of restoration, because we need to get past thinking that equity is the be all and end all, it's the just the monitoring framework. It shouldn't be conflated to Tiriti compliance.

And we are not -- we Māori are not a problem or a project for the Government to fix. We need our own voice, our own space and our own creative imaginings of the future for our mokopuna. So that's how I want to kick off this morning, and yeah, I'll hand it back over to you so you can introduce David.

>>RINGA HÂPAI: Kia ora whaea. Already got a couple of fantastic questions just before we even really sink in. So that's great, my job is going to be easy.

So next on our esteemed panel is Professor David Tipene-Leach who is the professor of Māori and indigenous research at the Eastern Institute of Technology. He's a public health physician, a GP, and my personal connection, chair of Te Ohu Rata o Aotearoa, the Māori Medical Practitioners Association and his primary interest is in how to attain equitable health incomes, and this includes working with cultural competence or the

term that he used earlier, cultural incompetence, cultural safety, institutional racism and social determinants of health. And on the topic of raranga, I love one of his many projects which is Te Wahakura, which is the flax bassinet that is an outcome of one of the research projects that he's been driving for the last many, many years, for decades in fact, and I love that that is a really practical application for our people and I wish that I'd got one for my pēpē, maybe my moko. Kia ora.

>>PROF TIPENE-LEACH: Kia ora Joanna, (te reo Māori). It's always easy to be last because I can hear what everyone else has said then you can try and sort of add to it. I think what I wanted to talk about was I think Papaarangi's right, it's not all about equity but it's great place to start.

So I want to start there, and I want to talk about access, because I think that -- we are talking about racism, we are talking about racism in healthcare and in some ways if you're looking for a framework it's about access. So you know, at one level it's about access to personal care and the fact that your person who you're sitting in the room with, or who's doing your operation, or who is responsible for your bit of personal healthcare doesn't understand you, mispronounces your name, doesn't understand your relationship with your whānau, doesn't enable you to have the things that make you feel best placed in the service place where you're at, so it's about personal service and the other term it's about cultural incompetence, it's about a group of practitioners who don't understand this particular group of people and today we're talking about Māori people, and cultural incompetence at the personal level.

If you go up one level it's about institutional stuff, it's about you with a kidney problem, for instance, and Māori have, you know, Māori people are two-thirds of people with end stage renal failure in this country, but we get 10% of transplant as first treatment. So two-thirds of those with the problem, but 10% of those with the best form of treatment, because everyone else is stuck on the second best form of treatment, and what's that all about? It's about institutional racism, how is it modulated?

There are certain things that happen, in particular BMI is the one that I'm always picking on. There is no evidence whatsoever that a BMI of 35 is a cut-off point, is the right cut-off point for stopping you having a transplant, but it's what happens in this country. In other words a level of institutional racism.

Then, of course, if you were living in poverty and over-crowded housing, and you had a low income and you were exposed to not good working conditions, in other words

you don't have the benefit of good social determinants of health, then of course you are literally on the back foot from the beginning.

Then the last part of this is at our bigger than societal level, and it gets into actually equity, it's not all about equity, but it's about colonisation and it's about Māori people and the way that we live, breathe, think and eat; basically they're not the right way of doing things in New Zealand. So the fact that we are strangers in our own country, noisy strangers, and thank God, you know, we make up nearly 16 to 18% of the population depending on the age group, but we are still strangers in our own land.

So it's about levels of access and each of those levels of access are determinants of health and each of them are implicitly racist. So heoi anō from me, I'm David Tipene-Leach, I'm from Pōrangahau in Hawke's Bay and, yeah, I love being in here with these two great women. Kia ora Jo, back to you.

>>RINGA HÂPAI: Kia ora, wow, okay. So I've listened -- let's do some raranga and then some excellent questions so I don't need to ask any of mine. Whaea Moxon, you talk about internalised racism and I then link that to -- and the children taken or children in custody and I link that to disconnect and connect and it's not just Māori who are disconnected from their cultures, I think a lot of tauiwi are disconnected from their own culture, and that that is -- so that's an issue that I would like to see thought about, is that disconnect for both peoples that live in this land.

Then Whaea Reid, monitoring and accountability and wilful ignorance and a theory of change. Some of the questions are picking up on that already. And matua, access and being strangers in our own country really resonates with me and that comes back to that connection and disconnection from everything.

So I might go to a couple of questions first up, and I think Professor Reid this came up when you had your kōrero and it says -- it's from an anonymous attendee, "what are your whakaaro on how we move from monitoring to a place of holding the state accountable and creating change?"

>>PROF REID: Kia ora. First of all I don't think we move from monitoring, monitoring is an essential part of the whole issue. But the accountability is a really important framework. You'd hope that shame would be enough to motivate people to be accountable. You'd think shame would be enough, but obviously it's not. So what are the issues playing in that.

And one is that it's permitted. Because as soon as we try and negotiate for an intervention, there's a pushback. There's a pushback by white supremacy in our community. The example was when we negotiated for an earlier age of vaccination for

Māori in the delta outbreak, starting Māori at a younger age instead of just starting with all 65+, to start Māori and Pacific earlier, there was a pushback from especially the right wing, white supremacists who said that's Māori privilege, we shouldn't do all this race-based rubbish, and that affects Government policy because they want to stay in the middle and in charge.

So how it's permitted, how it's allowed to go on is this wilful ignorance that is driven by factions of white supremacy that are able to swing voters and therefore Government action. So how do we get accountability? Can we change white supremacists and white privilege? That's pretty difficult. How do we move to the fact that people actually want to and want to believe that we should love our people, that we should love Māori. And they don't have to love all our behaviours or all our whatever, but to basically love us, not -- so it's moving not just from in the health sector not just knowing and understanding what the patient needs, the patient in front of me needs, but to feel it's okay to assume because I don't know about their whānau, I don't even think about it, I'm not trained to work with it, and so -- and to actually feel that's okay, to be that ignorant. And worse than that, I don't know how to ask and how to create the space to engage about it.

So that's picking up on David's work in cultural safety; cultural safety is demanding that the system becomes accountable, not just for the Government accountability for the statistics Lady Tureiti mentioned, but David as health practitioners, how do we become accountable by making this space to change our practice and to stop being ignorant and to not assume but to make the space to know how to ask, to know how to engage, to find out those underlying issues and to try and put them right.

So I think accountability's there at all levels, accountability of the Crown. But also accountability for us as practitioners.

>>RINGA HÂPAI: Ngā mihi whaea.

>>PROF REID: I don't know if Lady Tureiti wanted to add anything to it, or David, because I did sort of pick up on what they were saying.

>>LADY MOXON: Yes, I think you're absolutely right and I absolutely agree with what you've just articulated, because I think that it's in the articulation that we come to realise what it is we're doing, and you know, we sometimes think that what we're doing is for the best of the person in front of us when we're working with them or dealing with them.

But in actual fact what we are doing is bringing forward our own bias, our own way of looking at the world to put this person into a pigeon hole that says this person over here is more deserving than this person over here. And, you know, there is a foundation

principle within medicine which is to do no harm. And yet here we are at the brunt really of a huge amount of harm that has happened to us. And yet we've been told in all kinds of ways, at school, you know, wherever we are, that it's our own fault, that we are less deserving, and that we're not as good as everybody else.

But in actual fact, we're much better than everybody else and as I taught my babies when they were little, and they went through Kohanga Reo and they complained to me, "why did you put us into that thing, why did you do this?" And they moaned at me, because they felt inferior to their classmates because they learned how to speak te reo, to tuatahi, the first language and they complained because they weren't as good enough like their mates. I said "one day, one day you'll come back and you will thank me for this." And I tell you what, every single one of them has, because they have within them their own cultural belief that they are important people, that they have an important contribution to make to our world and who we are and stand tall as a Māori, as a Ngāti Kahungungu, Ngāti Pāhaurewa and Kai Tahu person and they know this and they believe in it, and their babies and our mokopuna to come will believe in that too.

So that's what I think and I think, you know, we're all in this together. Kia ora Professor Tipene.

>>PROF TIPENE-LEACH: And the likelihood is that those kids that you're talking about will be healthy, and will be well and will progress, and you know, it's not because people in the health system did anything fabulous for them, it's because all of the things that you just said, (te reo Māori) and that's what health's all about.

You know, I'm just reflecting back on when we're talking about moving from monitoring to the next stage. I was reflecting on how we have railed against racism over the years and, you know, when Papaarangi and I both had black hair we used to go on protest marches. You know, we would protest and you'd get arrested and there would be confrontation with other people and with Police, and what have you and by the time we had two or three grey hairs we would be encouraging people to go to workshops about bias and cultural safety and thinking things through carefully and trying to think about justice.

And now, and I reflect about what I said with cultural safety to the College of General Practice last year and what I saw when I was swatting for today and Matire Harwood's article in the New Zealand Medical Journal, was that we are now all trying to talk in a non-threatening fashion in order to bring people on board to what is so blatantly obvious.

I mean, you know, sick people cost money. And if we as a group of people didn't have the health problems that we had, there would be another billion dollars to play with at some other end, and why isn't that just so obvious? Why do we have to behave ourselves so much now? When we were young we were disgracefully, poorly behaved protesting racism. These days we are disgracefully well behaved. I mean we go to court, we don't protest these days about racism in health we go to court. How well behaved is that?

>>RINGA HÂPAI: I wish I was there with you when you were protesting. One day. Okay --

>>PROF REID: I'd just like to pick up, sorry to interrupt, a lot of the questions coming through are really about deficit reporting of statistics and I think that goes back to framing. So yeah, we want to monitor, we want to use the statistics and data to monitor Crown action and inaction, and we would report or frame those statistics differently as opposed to them being captured by other people reporting them and framing them in a way that says poor behaviour, poor genetics, poor, I don't know, poor determinants of health, poor poor poor, bad bad, sad mad. And instead of looking at the systems and the non-responsive framing those same statistics in a way that shines the light on the failures of systems and on the failures of society.

So really the problem is, you know, when they say the data speaks for itself. Well, actually it doesn't, we actually speak for data. And so I think we can use the same data to monitor the Crown, it's just that the Crown and many other people who hold it, hold power over the data, report it in a way that aligns the deficit with us as opposed to with the system. So I just wanted to pick up on a few of those questions that have focused on that in the Q&A.

>>RINGA HÂPAI: Kia ora whaea. I think there's a lot of thoughts in there, the data analysis I am very keen on, and I'd also like to pick up on Professor David Tipene-Leach's talk about, kōrero about cultural safety. Currently I'm trying to write cultural safety programme with the help of many people in sexual and reproductive health and that really resonates with me because I literally have all of Post-its, my trusty Post-it Notes in different colours on trying to bring it altogether and how do I do this in an hour, or whatever timeframe I decide and it will be, you know, it could be four days I think before we even get to the tip of what I would like people to be practising in sexual and reproductive health, it's a sticky area for many cultures. And one that I know Professor Papaarangi Reid was heavily involved in. I'm not sure if you are still in the late 80s, early 90s.

There is another great question, I'm just going to go back up -- unless someone else has got something to say about the cultural safety there. No, I'm sure they do. Someone

asked a fantastic question, where has it gone? Another anonymous attendee. "What do you think about transformative ways that hospitals and services can change to run best for our tangata whenua?"

>>PROF TIPENE-LEACH: Yes, I've got something to say. I think that there are two things that we need to think about when we're thinking about hospital systems and health systems. One is Kaupapa Māori, the other is matauranga Māori and they're both quite different. So my simple take on these two really important words is that Kaupapa Māori stuff is where Māori services take on wide health services and begin to do things much better than mainstream health services are doing. Primary healthcare is kind of our classic, where we've got what we call Kaupapa Māori health services who are doing things, you know, the simple one is by Māori for Māori with Māori. The little more complicated one is taking over the institution, having Māori workers, but essentially doing mainstream health.

Then Matauranga Māori is the next step. Matauranga Māori is quite different, often done by Kaupapa Māori service providers. But matauranga Māori is here's the health problem, here's my bit of Māori activity, philosophy, behaviour or thinking that makes this into a healthy way of being. Of course the wahakura was the classic example of that. The problem was bed sharing, so what do you do, get rid of bed sharing? No you don't, you use a traditional way of -- traditional, iconic way of doing to bed share more safely. That's kind of like matauranga Māori, the whole Mahi a Atua movement that's been championed by Di and Mark Kopua, this whole idea that you don't worry about psychiatric illness, you just worry about distress, then you work your way through using pūrākau, talking about something else, talking about something entirely Māori as opposed to talking about me and my deficits and my illnesses and my problems, throwing them all out there and making myself the problem, Mahi a Atua has managed to sort out the distressed who actually just needed a conversation, from the ill, who needed a heavier bit of work. And have decimated waiting lists in some places in the country for psychiatric services.

At the moment I'm working on a thing called Te Whare Pora which is about weaving and it's a clinic, it's a clinic for pregnant women. And what do they do at this clinic? They just weave. And the huge outcomes of this, yeah, they weave wahakura and they weave little heres to tie up umbilical cord and they weave nappy baskets, but they weave and they discover stuff, they discover Māori stuff, they discover health networks, they discover each other, they stick together, and yeah, I mean it's a matauranga Māori antenatal -- it's an original Māori way of being.

And of course at the moment I'm just trying to work with food security and the question, the research question that we're working with now, you know, food security long time problem but certainly thrown into stark relief during these recent Covid times, but does matauranga Māori have something to add to the security, the food security for whānau? I don't know the answer, but it it's an important question. What is it that we can add to services as Māori that makes them revolutionary and harbingers of good outcomes. Yeah, over and out.

>>RINGA HÂPAI: The end. Whaea Tureiti, anything? Whanau Ora?

>>LADY MOXON: Yes, actually -- that was a perfect answer really. But, you know, we're pushing hard for the -- to stand up the Māori Health Authority. And you know, in 2005 we put a claim to the Waitangi Tribunal to have our own DHB at that time. And you know, when we talk about by Māori for Māori, we talk about that in the sense that it's by Māori for Māori for everyone, for everyone. And we certainly have been able to prove to our whole nation that Māori providers can do the unthinkable.

And that certainly showed through with Covid, with our Covid response everywhere. And the Covid response went not just to Māori alone, although we're still trying to push hard for our people to become vaccinated in some places, what it did was it actually gave a lot of -- in Hamilton city I'll only speak about that, a lot of people the opportunity to come on to the marae, to visit the marae, to understand what that means and what it feels like to be a part of something that's greater than what their own understanding and knowledge of Māori people were.

And we got the most amazing responses and I think we've vaccinated 40,000 people in the city and I can't even say how many we've swabbed during that time. From all ethnicities, absolutely all ethnicities. And they loved it. And the thing that they loved about being on the marae and being a part of our service was that they were treated with kindness, they were treated with respect. We had a sense of humour, we actually cared and manaakied them in a way that they hadn't felt in the health system for a very long time.

Now if we can replicate that in our hospitals, if we can replicate that amongst the clinicians that look after us, all of us, or some of us because some of us die early, but if we can replicate that, then I think we're on the way to resolving a lot of the misunderstandings and misperceptions of Māori people, of us as a people. We have a contribution to make beyond the world. You know, my brother-in-law once said to me, you know, well, he said it to all my staff here at -- his name is Ngāhiwi Tomoana. And he said, you know, "people overseas just love us, they love who we are, they love what we bring, they love everything

about us culturally. It's only here in New Zealand they don't like us." And I actually had to really think about that, and I think that there's, you know, there's something for all of us to take away from today to think about what do I really think and feel about these things, and challenging ourselves to do things differently maybe.

>>RINGA HÂPAI: Kia ora, I love your wero. What I am thinking is I'm thinking about Dr Matire Harwood who works with Professor Papaarangi Reid and she has, with her research, shown that what is good for Māori is good for everyone, and that's popped up on the chat and some of the questions as well, is we know that.

So let's work with that strength that we have and we have the strength in Te Ao Māori, the answers are all there, they've been there all along, so let's start getting people to ask us for the answers. And I know that's been a while, but I really believe that the answers have been around for thousands of years. And I'll stop there before I have a little -- another question.

Okay, I'm going to pitch this one to Professor Reid. This is from Jackie Paenga-Rennie. "Do you think that the new Māori Health Authority will be able to address these inequity and lead transformational change?"

>>PROF REID: Well, we certainly hope so. But I think that we need -- and you know, there's some good people involved in it, and some people who I think have got a really good analysis on the situation. The challenge I think is whether or not they'll be permitted, allowed, supported and resourced to do that, or whether the remit that they'll be given either through legislation, policy, funding or staffing will constrict us back into the same old same old. What is challenging for me is that the first two years are what they call roll-over years, and so very little will change in terms of contracts in the first few years.

But if we have to have a radical change and the change won't be in terms of who is now the funder or the contractor for this service or that service, but how do we change the constitutional arrangements for the services, how do we change the heart of the services, how do we change a service to love our people, how do we change the service to serve our people, how do we change the people involved in the service, to understand what that means. Those are big projects. How do we change the variability of funding so that more work is -- so it's rearranged so that more -- funding ensures access, ensures safe provision etc.

So I think changing the name and having a Māori Health Authority in and of itself has some permissions, but it's not enough unless we change some of the fundamentals; permissions, staffing, relationships, you know, what do we mean about changing

rangatiratanga, how does kāwanatanga happen properly, what do we do about our whakapapa, our connectedness, what do we do about whanaungatanga, the way in which we relate to each other, what do we do about manaakitanga, how do we -- what's the reciprocal support for each other in this relationship. I think we need to really answer some of those fundamental questions. And I'm sure Lady Tureiti has been part of that system will have some -- is busting to say something.

>>LADY MOXON: Okay, very good. Yes, well yeah, I absolutely agree with everything that's been said. But, you know, unless we've got our belief that we can do something that's better than we've ever had before and take it into the future, and that's what it takes, it takes all of us to make that happen. It takes all of us to think about what we're doing and why we're doing it, to actually push this forward. And yeah, because one of the biggest issues that we have is that when we have changes of Government, for example, and those changes of Government will take us with them or they don't take us with them and quite often they don't take us with them, they dictate to us.

But it's time for change, and certainly the Māori Health Authority as being the first cab off the rank is certainly, and from my perspective, the beginning of something that's greater that should happen in every single Government department in our country.

>>RINGA HÂPAI: Kia ora, yes, okay. I get really excited, so I'll settle back down, because I love that you've extended that to everywhere, it's not just at the top, everywhere needs partnership. Okay, wow.

>>PROF TIPENE-LEACH: I just wanted to comment on both of those comments. Yes, the Māori Health Authority is an exciting opportunity, but it's about changing the health system, it's about trying to fiddle with the institution, trying to fix the institution. I'm much more interested in what Ngāhiwi said to Lady Tureiti about actually, you know, they like us overseas, they just don't like us here. Now I mean I think that's really important. If people liked us here, you know, and I think that there is some progress, I think there is some progress, but if people really celebrated that 20% of this country was Māori, that 20% of this country had a different trajectory and a different set of needs and wants, not completely different, you know, every Māori wants the benefits of Pākehā society, but not every Māori wants only Pākehā society. We want to be able to be ourselves.

You know, I think that things like the Māori history curriculum, for instance, that's being introduced by this Government is a big move. And you know, you look around and you hear that there is a lot of pushback against that. I think that, you know, the pushback is likely to be, you know, racists come out of the woodwork when they need to come out, and

so we're seeing the conservatives come back. I'd like to think that part of it was ignorance and apprehension and a little bit of fear, and that if we put things in the non-threatening manner that we're talking about, that these people could turn around.

But actually there are moves, there are moves to understanding us and if only we didn't have to change the institutions, if only what we did was we changed the fabric of our society so that actually we were a valued part of this society and not just when there was an opening of a new road, because everybody was worried about taniwha and car accidents.

>>PROF REID: I'd like to pick up on it, again because I know looking at the time we haven't got much time left. I want to go back to the, you know, the title of this part of the workshop in terms of Audre Lorde's quote and Audre Lorde's essay on the master's tools. And we have to be really careful as Māori that we don't get caught up in teaching Pākehā people not to be racist, teaching Pākehā people to be nice or to be responsive or whatever, and we're always serving the needs of Pākehā people, and we're not really serving the needs of Māori.

So I think, and it's a tension, because sometimes you see the other ones that's the problem, they're standing in the way, and it's hard to find allies who you trust enough to do the work. But yeah, so there is that tension there and I think that's a significant piece of work. I wouldn't like the Māori Health Authority or people like that to end up being, you know, spending all their time trying to fix the health New Zealand's problems, but rather that we get on to rebuilding what we need as Māori to thrive.

>>RINGA HÂPAI: Kia ora. We've got 3 minutes left and 46 questions, so here I was, I had my questions, I clearly didn't need to worry about that. And that just shows that people really want to know, they want weapons and tools and techniques and models to put in their kete. This is a kete my tāne toa, my husband gave me and, well, it's pretty heavy, I can hear some rattling in there.

I think what my last thing that I want to say is that we are creating safe, brave and uncomfortable spaces for people. We are all going to be uncomfortable in this kōrero. And we need to be brave and courageous. Lady Tureiti Moxon I've heard you use that word courage is what we need to have these uncomfortable kōrero, to create safety but not too safe, because then we just stay where we are, and I'd like to open it up, I've got a whakatauki to finish off with.

Does anyone want to say anything before I close? Shall I finish with my whakatauki then we could do a karakia to finish up. Kapai. So one of my favourite people, Princess Te Puea Hērangi has a whakatauki about dreaming and it's ngā moemoeā. (Te reo Māori) "if I dream, I dream alone; if we dream together, we will achieve."

So I hand it over to Professor David to finish with our karakia and I thank you everyone for listening and for your overwhelming, I mean the chat has just blown up, and inspiring kōrero.

>>PROF TIPENE-LEACH: (Te reo Māori) the wonderful things that you've put out there for everybody to think through today. (Te reo Māori). Kia ora tātou.