

Indigenous Health Leadership: A Kaupapa Māori Perspective from Aotearoa – New Zealand

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ABSTRACT

This article describes the challenge of addressing indigenous health leadership to reduce ethnic disparity in modern healthcare. The indigenous New Zealand population, Māori, are disadvantaged across many health domains including the socioeconomic determinants of health. The Treaty of Waitangi, considered New Zealand's founding document, outlines Māori autonomy and leadership, and can be applied to a model of health equity. Leadership frameworks in this sense must incorporate ethical and servant leadership styles across a shared, distributive leadership model to develop safe and equitable health environments where Indigenous ways of being and knowing are not subjugated. This is a shift from traditional hierarchical paradigms of the past and acknowledges Māori as having the autonomy to lead and maintain equitable health outcomes.

BACKGROUND

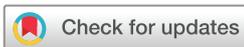
Māori, the indigenous population of New Zealand (NZ) continue to suffer from the effects of colonisation, both historical and contemporary as evidenced through longstanding inequities in health outcomes and access to gold-standard health interventions.¹ Institutional racism is considered the legacy of colonisation as it has created systems that disproportionately disadvantage Māori. The recognition and remediation of the trauma experienced by Indigenous peoples remains a global challenge as indigenous populations around the world encounter less access to the socioeconomic determinants of health.^{2,3} In NZ, the signing of the Treaty of Waitangi (English version) and Te Tiriti o Waitangi (Māori text) reaffirmed Māori rights to self-determination, sovereignty (Tino Rangatiratanga) and equal rights with British subjects.⁴ Despite this, the Treaty has been continuously disputed and challenged as to its place as the founding cornerstone of NZ society.⁵ Synonymous with indigenous peoples worldwide, significant health inequities exist for Māori who experience poorer quality of healthcare, access to healthcare and health outcomes.² The Institute for Health Improvement (IHI), Boston, often considered a paragon for quality improvement in modern healthcare, recognises the importance of equitable care yet does not provide an adequate solution for reducing ethnic disparities.⁶ Te Tiriti o Waitangi lays the groundwork in a national-legislative capacity to help reduce ethnic inequities and to reaffirm Māori leadership as a foundation for providing equitable healthcare for all NZs.^{7,8}

TE TIRITI O WAITANGI, RANGATIRATANGA, AND HEALTH EQUITY

Te Tiriti o Waitangi and the Treaty of Waitangi constitute and codify the relationship between Māori and the British Crown.⁴ Under international law of *contra proferentem* - precedence is given to treaty agreements written in the language of the indigenous population and not the drafter.⁹ In this light Te Tiriti o Waitangi reaffirms Māori sovereignty or absolute territorial authority, which was not clearly acknowledged in the English version, the Treaty of Waitangi.^{4,9} Te Tiriti o Waitangi contains three written articles and was sought to establish a partnership with the British Crown that ratified Māori as *tangata whenua* (people of the land), reaffirming and recognising Māori sovereignty over their lands and people.¹⁰ The relevance of Te Tiriti to health is also legislatively established through the NZ and Public Health and Disability Act 2000, which requires the health sector to 'work towards eliminating entrenched health inequities between Māori and non-Māori'.¹¹

The NZ Ministry of Health recognises three actions in its framework to provide healthcare for Māori: leadership, knowledge and commitment.¹² Engaging and involving Māori in health initiatives remains an important challenge for the healthcare system, perhaps best served by adopting the methodology of shared, or distributive leadership. The shared leadership model begets a culture of collaboration, allowing for a shared mental model and mutual understanding of the attitudes and barriers towards health improvement and health equity.¹³ This model can be used as the basis of developing allegiance and shared vision with indigenous populations, generating an allegiance through collectivism, cogovernance and coleadership.^{14,15}

Precolonial Māori leadership, Rangatiratanga, embodied centralised-transformational leadership approaches of chieftainship and chiefly authority.⁷ Rangatiratanga has been extensively discussed in relation to Te Tiriti; the word 'Rangatiratanga' appears in article 2 encompassing sovereignty, chieftainship, leadership and self-determination.¹⁶ In the late 19th and early 20th century, Rangatiratanga evolved into a more dynamic leadership role that promoted the collective well-being of Māori, mirroring the contemporary approaches of ethical and servant leadership within a distributive leadership model.^{7,15} Rangatiratanga guides the philosophy of bringing people together, learning from one another, sharing wisdom and building *mana* (prestige and mutual influence).^{15,17} Māori leadership embraces collectivism, nurturing relationships, reciprocity and a system of interdependent leadership that merits the common goals of



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all peoples.^{15 17} Rangatiratanga provides a contemporary basis for engagement with Iwi (tribes) and Hapū (subtribes) and is a culturally authentic and self-affirming model of health leadership.^{15 17} It is proposed that leadership systems are influenced by the social and political context within which they dwell and that traditional professional hierarchy in healthcare can limit the development of collectivist, collaborative leadership systems.¹⁸ Where traditional western professional hierarchy centralises leadership, rangatiratanga acts as a suitable rebuff for this barrier in the modern NZ and health environment.

WESTERN AND INDIGENOUS EPISTEMOLOGIES

The IHI proposes that leadership regarding health initiatives should be multidisciplinary, and advocates for leadership systems that foster a ‘culture of accessibility, open communication and advocacy’.¹⁹ The IHI *White Paper* series proposes four key components of leadership as; guarding the learning system, creating psychological safety, fostering trust and ensuring alignment of values.⁶ These principles also underpin Mātauranga Māori (Māori knowledge and ways of ‘knowing’) where responsibilities are intricately connected and shared among communities through tikanga Māori (Māori custom).^{16 17 19} The NZ Health Quality and Safety Commission (HQSC) builds on the IHI principles and proposes that leadership roles must develop actions and set examples for other to follow.²⁰

Internationally, the IHI is recognised in the strive for the *Triple Aim* for quality improvement, yet further endeavours are necessary to allow for equitable leadership that is appropriate for indigenous health structures. The HQSC acknowledges the Triple Aim and, using Te Tiriti o Waitangi as a critical tool to help guide public policy, has made efforts to improve health and equity for all populations.²¹ HQSC recognises the inequity in health access, inequity in health outcomes, net health loss, and resource allocation inefficiencies for Māori compared with non-Māori.^{20 21} However, despite the echoes of Kaupapa Māori and Mātauranga Māori within the IHI framework, the engagement, empowerment and inclusion of Māori in health quality and safety are yet to feature in HQSC’s abstractions. It is argued that the inclusion of indigenous epistemologies within health policy, process and structure is paramount in undoing the effects of colonisation: allowing for self-sovereignty, cogovernance and the alignment of a population’s values.^{22 23}

Incorporating Māori knowledge systems into health leadership will help foster a safe, equitable learning culture.¹⁷ Generally, shifting health leadership to adopt integrative, collectivist and future-focussed models has been associated with improved organisational processes and improved team outcomes.²⁴ Mātauranga Māori and tikanga Māori have largely been suppressed through colonisation despite ethical and leadership principles rooted in social justice, reciprocity and community.^{15 16 25} Māori jurisdiction over the usage and application of mātauranga Māori in contemporary health settings is necessary to ensure the appropriate protections and processes are in place to protect Māori epistemologies.²⁶ Mātauranga Māori is led by Māori and should be at the centre of any service delivered to Māori. In this light, Kaupapa Māori research (KMR) methodology advocates for ethical cogovernance and leadership ‘by Māori, for Māori,’ as western-centric initiatives have not been suitable to address the inequities in Māori health.²⁷ KMR has grown exponentially and the work of Māori scholars has seen it evolve into a space of renaissance within academia.²⁸ Traditional western research paradigms are privileged and upheld as ‘all knowing,’ leading to criticisms of KMR being of limited focus and unsuitable in

quality improvement, despite it providing greater health quality and health outcomes for Māori.^{28 29}

RANGATIRATANGA, SERVANT LEADERSHIP, AND ETHICAL LEADERSHIP

Flattening leadership hierarchies is encouraged when developing quality health initiatives, allowing for leadership to develop at all levels.¹⁹ Two such leadership theories that exemplify this approach are servant and ethical leadership. Servant leadership is generated from and acts in turn to empower its followership, the people that are led, embodying humility and stewardship but not necessarily based on ethical and moral values.^{30 31} Ethical leadership in turn demonstrates morality and ethics as its core focus and in this paradigm, leaders act to shepherd behaviours deemed moral or ethical and admonish actions which are not.^{30 31} Linking the two theories further allows for the development of an adaptation of the shared and distributive leadership model that incorporates indigenous epistemologies.²³ Shared and distributive leadership in this sense is neither prescriptive nor rigid and allows for close examination and revision to adopt to internal and external organisational factors of a given social and political context.

Leadership extends beyond the command and direction of followers by any one individual or group of individuals, and is instead acknowledged as an inclusive system sharing a common context or goal.³² The shared leadership model, characterised as a dynamic process, has been noted to promote better and more meaningful connections with Māori.³³ Leaders and team members engage in a reciprocal relationship informed by tikanga Māori (Māori customs) through principles of utu (reciprocity) and manaakitanga (nurturing relationships).^{16 17 24} Shared leadership, or collective leadership, is an emergent and self-perpetuating model, where reciprocal influence and dynamic interpersonal relationships lead groups or organisations towards achieving their common purpose and goals.³³ This leadership model better aligns with Indigenous Māori leadership which is informed by holistic and collectivist methodologies.^{15 25} Leaders participating in the shared leadership model act as moderators rather than the ‘heroes’ epitomised in models of vertical leadership.^{34–36} This moderator of shared leadership resembles the integrator of the Triple Aim model, an entity bringing together the three arms of the triple aim to provide equitable quality of care.³⁷

Māori epistemologies privilege and prioritise a healthy and reciprocal relationship between tangata (people) and whenua (land), synonymous with ethical and servant leadership models.^{15 17 25} Developing a positive leadership approach for the shared leadership climate also allows a servant leadership model to develop from within, with the idea that a leadership system acts to nurture and develop its participants to strengthen the quality of its service outcomes.²⁵ Māori as a tribal peoples are not altogether homogeneous with one another and the deliberate destruction of Māori history, epistemologies and paradigms has marked the struggle for Māori self-determination.¹⁷ Ideas and practices related to tikanga Māori and mātauranga Māori may differ among Iwi (Māori tribes) and so the advent of ethical and servant leadership models support Māori rangatiratanga to develop health solutions that are ‘Te Tiriti’ focused, equitable and antiracist.^{15 16 25} A ‘one-size fits all’ approach to rangatiratanga and leadership for Māori is not feasible however, Kaupapa Māori methodology informed by mātauranga Māori can be applied concomitantly with the ethical and servant leadership approaches to support and promote Māori self-determination.¹⁷

Contemporary NZ has shown a strong response to a servant leadership style in healthcare, as evidenced by a strong public support for empathetic public figures such as Mike King, awarded NZ of the Year for his services to mental health and suicide prevention, as well as Hon Jacinda Ardern and Dr Ashley Bloomfield for their response to the COVID-19 pandemic.^{38 39} Furthermore, several holistic Māori health models are commonly utilised within NZ healthcare services and reflect the values of ethical and servant leadership models.⁴⁰ The servant leader is aware of their followers' values, are teachers as well as listeners and act to foster a community of safety and awareness.^{17 25 33} This approach may also coalesce vertical and shared leadership frameworks, allowing easier adaptation to healthcare settings where leadership as a concrete entity is more readily accepted than leadership as an abstract system.^{33 34}

DISCUSSION

The union of western and Indigenous Māori health models of care is a difficult task exemplified by the persistence of Māori health inequities and NZ stands poised to demonstrate its initiative by incorporating Kaupapa Māori as part of leadership heuristic. Although indigenous populations worldwide are non-uniform in their epistemologies, philosophies and ethics, almost all have suffered significant health challenges resultant of colonialism and systemic racism.^{22 29} The foundations pertaining to shared and distributive leadership are deemed suitably adaptive in their theoretical basis to generate an appropriate leadership framework for modern indigenous leadership. Māori, like many indigenous populations worldwide, are often tasked with the responsibility of indigenous health in NZ, yet rarely is the authority to lead such initiatives shared.^{5 22}

Despite improvements, ethical and servant leadership is required to eliminate health inequities for Māori and indigenous peoples.¹⁵ These strategies are shown to enhance the social responsibility, reciprocity and care embedded in tikanga Māori and mātauranga Māori by maintaining the reciprocal balance between people and land.⁴¹ Health leadership through mātauranga Māori should ideally promote social, collective responsibility as well as individual health.^{15 42} Health and well-being, and the improvement of quality therein, benefits from this shared and holistic approach both on an organisational and population based level.^{15 42}

The combined ethical and servant leadership approach is almost dichotomous with the traditional hierarchical approach of leadership favoured by the medical profession.¹⁵ Leadership in the traditional health organisational setting is typified by an imbalance of power distributed unevenly along a vertical hierarchy, leaving little room for creativity and psychological safety among its constituents.⁴³ The ethical and servant leader in this context would see leadership as a shared system where individuals are empowered to work towards a common goal.³⁶ Developing this approach would require a robust stakeholder analysis, system-wide education and a wider cultural change with a focus on collectivism, altruism, empathy, stewardship and cultural authenticity.^{15 25} Mātauranga Māori acts as a vehicle to provide cultural constructs for improving Māori health and well-being and the delivery of healthcare and services in Māori communities. Furthermore, mātauranga Māori is starting to be incorporated into healthcare as evidenced by the increase in Kaupapa Māori health organisations. Although unique and all-inclusive, incorporating mātauranga Māori into western health models runs the risk of archotyping mātauranga and tikanga Māori for all.^{15 17} Frameworks that adopt these leadership ideals must,

therefore, be flexible and the ethical leadership approach is an appropriate step towards fostering a genuine and reciprocal relationship with indigenous populations to achieve equitable health outcomes.

The IHI and, building on their work, the NZ HQSC, acknowledge that a shift from the traditional hierarchical paradigms of health leadership is necessary to lead equitable health quality initiatives. The answer to the challenge of leading health initiatives that include, engage and benefit Indigenous Māori lies in Te Tiriti and ratifying pre-existing rights for Māori to self-determination. Te Tiriti was designed to promote cogovernance and shared leadership and, through mātauranga Māori, leadership relies on a reciprocal relationship between people and environments. Māori should be given equal opportunities and representation in leadership and the way forward requires sharing the reigns. These ideas are not entirely unique, yet their coming together conceivably is. Their convergence in this sense details a leadership approach that incorporates elements of indigenous Māori leadership, servant leadership and ethical leadership. This need not require one unifying approach across all health initiatives but must involve tailoring leadership systems from atomistic to holistic, encompassing the mātauranga Māori.

POSITIONALITY STATEMENT

This article seeks to improve the challenge of leading health quality initiatives that include, engage and benefit indigenous populations. The three authors reside in Aotearoa, NZ, and are all currently working in the surgical field. DSP is a surgical resident with an interest in clinical governance, health systems, and an is an advocate for vulnerable patient populations. J-LR is also a surgical resident and an expert in the field of Māori health and KMR. JK is a highly accomplished general surgeon and clinical Associate Professor of Surgery at the University of Auckland. He is also a leader in the field of Māori health, KMR and surgical care.

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Contributors DSP is the guarantor for the overall content. DSP devised the project, the conceptual basis of the manuscript and researched the theories described pertaining to leadership models, leadership styles and Kaupapa Māori. J-LR and JK expanded on the conceptual basis of the manuscript. J-LR and JK helped research and authenticate the Kaupapa Māori, te Tiriti o Waitangi and mātauranga Māori arms of the article.

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