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Commentary

Linguistic enablers of Pākehā racism: Excuses from the health sector in Aotearoa New Zealand

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Racism is a modifiable determinant of health that permeates the practices, relationships and environments of the health sector. Having produced and maintained grievous health disparities and injustices for generations, racism has done harm to the wellbeing of communities that is well understood but under-acknowledged. Questions arise as to how racism continues to flourish. We argue that everyday relational discourses within the health sector, especially explanations used by people in clinical, public health and bureaucratic roles, maintain systemic and localised inaction in the face of injustice. In this commentary we curate sets of excuses for racism garnered from our cumulative experience and organise them into narratives: i) resource allocation, ii) responsibility, iii) Māori blaming, iv) too hard, and v) we tried. We highlight the power of words in promoting racist agendas, but also the value of identifying such usage and acting to change the discourse toward an antiracist future. We believe these excuses or similar may be used in other settler-colonial contexts.

Introduction

Despite the 1840 Tiriti o Waitangi (the authoritative Māori text) that guaranteed and protected Māori (Indigenous people of Aotearoa) sovereignty (Waitangi Tribunal 2014), land alienation has left just a tiny fraction of ancestral Māori holdings and Indigenous rights are being eroded by ongoing colonial processes. Systemic racism directed towards Māori constitutes contemporary violations of Te Tiriti (Healy et al. 2012). A wide range of anti-Māori laws, policies and practices have been enacted, including the Tohunga Suppression Act of 1907 which prohibited medical and health practices by Māori expert healers. These injustices perpetuate health disparities that maintain a seven-year difference in life expectancy between Māori and Pākehā (white settlers) (Ajwani et al. 2003). Contemporary breaches detailed in Waitangi Tribunal reports (2019, 2021) are such that the entire corpus of health policy implemented since 2000 was non-compliant with Te Tiriti.

Colonial power manifested through cultural, political and economic dominance, backed by force and imposition, operates primarily within narrative and discursive parameters. Elites and their institutions (education, mass media) constantly refresh the stories, imagery, interpretative tools and linguistic

resources that shape peoples' understanding of their daily lives (McCreanor 2005). Language plays a critical role in shaping meaning, and enabling processes, systems and discourses that define and uphold cultural norms, values, beliefs and attitudes.

Māori resistance and articulations of decolonising practice (Smith 1999) and Tiriti-based transformation of society, such as Matike Mai (2016), provide foundations for Indigenous critical analyses of racism. Feminist scholars (Spender 1980), critical psychologists (Wetherell & Potter 1992) and others (Fairclough 2013) have long argued that language is inherently political and there is significant power in the act of naming and defining realities. Discourse, in this context, is seen as social practice that actively constructs and facilitates shared, collective, but exclusionary, understandings of the world through the interplay of word-choice, sentence construction, emphasis in delivery, narrative arc and persuasive intent.

These phenomena are pronounced in mass media in Aotearoa where multiple studies (Moewaka Barnes et al. 2012, Phelan & Shearer 2009) have found tightly constrained racist discourse characterised by widely recognised themes. Mechanisms such as jokes, blaming, rationalisations and excuses are interwoven with cultural conventions, interests, and power relations. These elements result in material consequences that produce discrimination, resource constraints, and hierarchical outcomes.

Excuses for Racism

Racism entails systems of power and patterns of behaviour (including discourse) that disadvantage one population group while privileging another, usually through a range of social, economic, educational, criminal justice, health and development policy, practice and interpersonal relations. Racism is also inaction in the face of need.

We draw on kaupapa Māori (Māori philosophical) analysis alongside critical discourse analytic traditions of psychology (Wetherell et al. 2001) and sociology (Fairclough 2013), to explore excuses used by health professionals, managers and leaders as enablers for racism. The authors – two Māori health professional scholars targeted by racism (both of whom have passed away since the initial writing of this paper) and two Pākehā activist scholars – acknowledge that racism is experienced by many racialised communities in Aotearoa, but the focus of this commentary is on Pākehā racism targeting Māori.

The racist excuses examined here were experienced or witnessed by the authors and their networks over the last decade. They are deep assaults on the aspirations of our professions and communities, particularly when questions about racism emerge within public health and healthcare. Many of them have the disconcerting character of being contextually 'true' (e.g., financial constraints) while simultaneously distracting from authentic engagement with issues raised. A cumulative list was created, then elements were sorted into categories for detailed analysis informed by critical traditions.

The statements are loosely organised into five overlapping categories for analysis: i) resource allocation; ii) responsibility; iii) Māori blaming; iv) too hard; and v) we tried.

Resource Allocation

1. *It's not a priority for us at this time.*
2. *Please understand we are under a lot of pressure.*
3. *Clinical work needs to take priority otherwise people will die.*
4. *In a democracy everyone must get the same.*
5. *This is wokeness or political correctness gone wrong.*
6. *We are a multi-cultural population.*
7. *There are many other groups with greater needs.*
8. *Something is better than nothing.*
9. *We consulted a Māori.*

This group of statements draws on multiple notions of scarcity, political realism, majoritarianism, priorities, and capital to produce a rationalisation that is robust, 'reasonable' and hard work to rebut. Ideas of 'scarcity' and pressure justify prioritisation, rationing, waiting lists and such devices that both produce and expose a racist valuing of Pākehā wellbeing over the wellbeing of Māori. This theme emerges from a lack of commitment to racial justice and upholding Te Tiriti, and implies that Māori should be grateful for ill-fitting universal provision. Health professionals and leaders are under pressure to save lives; thus they value clinical treatment over public health. From this standpoint it follows that taking time to learn new ways of working will risk Pākehā lives, which is unacceptable. The burden of disease and injury carried by Māori is not recognised as a public health crisis; Māori lives are undervalued, therefore there is no need for urgency (Mills et al. 2012).

This pattern is underpinned by a historical libertarian notion that everyone should be treated equally, which ignores the impact of the historical and contemporary expressions of institutional racism that result in Māori consistently receiving a lesser quality and quantity of healthcare (Robson & Harris 2007). It also fails to recognise the uneven access to the positive determinants of health due to the negative intergenerational impacts of colonisation.

Another problem is the narrow individualism that ignores collective Indigenous rights and assumes health inequities are significantly reduced by universal 'one size fits all' provision. We are persuaded that the more nuanced proportional universalism (Marmot Review Team 2010), coupled with culturally tailored investment in public health, is far more appropriate. Universalism in practice often manifests as racism that serves the cultural needs of Pākehā, marginalises Māori needs and maintains the status quo.

Responsibility

1. *It wasn't in the business plan or budget.*
2. *We don't have the resources, expertise, or knowledge to do that.*
3. *We need to manage the risk around that.*
4. *We have other deliverables.*
5. *We don't have the capacity or capability.*
6. *Everyone is on a continuum of learning; we need to be patient.*
7. *It's going to take quite a while to achieve transformation.*
8. *We don't even see any/that many Māori in our service.*
9. *We got a legal opinion and it's not in the legislation.*

These expressions are avoidance and distraction mechanisms. They use technical justifications for inaction, whereby a target or deliverable not being explicitly written down can be used to avoid responsibility. They add authoritarian dimensions by reference to legal, contractual, and moral norms or practices that undermine, demean, or marginalise arguments for eliminating racism. These excuse resources fail to recognise the significance of Te Tiriti relationships between Māori and the Crown that require individual and collective action around protecting and promoting hauora Māori. They ignore professional and ethical guidelines, and regulations requiring public health practitioners and leaders to engage with Te Tiriti.

The moral arguments use divide-and-rule tactics to undermine commitments to Te Tiriti, split pro-Tiriti, antiracism initiatives that focus on improving health outcomes for Māori, and set Māori needs up against those of 'other' marginalised social groups. This effectively silences both Māori and Tauiwi (inclusive term for settlers) working for such change by questioning their legitimacy without in any way committing to wider improvements. The past outlawing and contemporary marginalisation of rongoā Māori (customary Māori health practices) represent powerful examples of how these excuses are employed.

This approach employs institutional and organisational factors to block and distract, and takes attention away from individual actions by assuming that 'good people' cannot be racist, as if personally mediated racism is not a feature of the sector. The use of delaying tactics to obstruct engagement with Te Tiriti, antiracism and social justice work (so organisations can 'learn') has been going on for decades, and reflects the low priority accorded to Māori lives and wellbeing. Yet those same organisations that ignored or undermined long-term Māori initiatives about rangatahi (youth) suicide can respond immediately to the threat of unknown infectious disease spreading through a hospital ward.

Māori Blaming

1. *We couldn't get hold of anyone – they were at a hui (meeting).*
2. *But you keep cancelling meetings.*
3. *This is a problem for Māori to fix.*
4. *It was an opportunistic selection.*
5. *I don't get involved in Māori politics.*
6. *We need actual leadership not mātauranga Māori (traditional Māori knowledge).*
7. *We didn't know who to speak to.*
8. *I tried to recruit a Māori staff member but had no applicants.*
9. *There just aren't Māori with the right skills.*
10. *We don't know what they want.*
11. *I wanted to but my manager shut it down.*
12. *I've tried before and that Māori woman got angry.*

This set of ideas assumes that Te Tiriti, racism and equity are Māori interests or responsibilities, and plays on the notion that Pākehā are impeded in making change by failures of Māori commitment, characterising Māori as whimsical, misguided, aggressive, angry or ignorant. Rather than critically reflecting on and taking responsibility for established culturally unsafe practice and micro-aggressions against Māori initiatives or colleagues, these resources question the competence, integrity and leadership skills of Māori. The precarious position of Māori as key navigators for Māori within public health reflects the undermining and marginalising effect of this tranche of excuses. These ideas also manifest as negative stereotypes characterising the 'reality' of Māori whānau (extended families) as healthcare consumers, reinforcing notions that they are undeserving of health care and justifying premature discharge.

These arguments ignore or deny Pākehā privilege and embrace the neo-liberal notion that inclusion and success are a product of hard work and personal responsibility which will improve Māori health outcomes. Context and history are absent from this standpoint, which is underpinned by a distrust of Māori knowledge and expertise.

Too Hard

1. *We tried that and it didn't work out last time.*
2. *I agree with that in principle, but the reality is …*
3. *It takes too long.*
4. *Can you do the cultural component of this project?*
5. *I don't like that terminology.*
6. *I need you to tell me what to do next.*
7. *I don't know where to start (so I haven't).*
8. *I don't know any Māori.*
9. *Māori expectations are unrealistic.*
10. *I only have energy to do my job.*

11. *I'm just here to listen.*

Here the rationale for change appears to meet a level of acceptance, but actions are thwarted by others, 'the system', personal circumstances, or other externalities that effectively block antiracism work. The linguistic form of the disclaimer (Hewitt & Stokes 1975), 'I agree with you, but…', expresses both sympathy (or at least ambivalence) and an often-externalised reason for inaction, while maintaining an apparent and advantageous 'even-handedness' in discussion. This strategy allows a speaker to preserve a measure of coherent self-worth without resorting to the overtly racist authoritarianism involved in the resource sets discussed above, and may also garner sympathy/support from Māori and other colleagues. The rejection of public health measures raised by Māori experts and communities during the Covid epidemic is a strong example (Waitangi Tribunal 2021).

Such approaches can be helpful to speakers who are covertly uncommitted to antiracism work through diminishing their sense of responsibility both for themselves and in the perceptions of others. These nuanced, social psychological dimensions of racism are poorly understood and under-studied but, in our analysis, seem a significant contributor to inaction.

We Tried

1. *We have a draft policy document around that.*
2. *We have a Treaty of Waitangi book.*
3. *We were well intentioned.*
4. *Sometime in the future we will pick this up.*
5. *Let's give it a Māori name.*
6. *We could put some artwork on the wall.*
7. *Let's give the project a cultural overlay.*
8. *We do waiata (singing) on a Wednesday.*
9. *We have karakia (blessing or prayer) if someone asks for it.*

This final tranche of excuses supports performative practices that are seen to be constructive but do not result in the kinds of transformation necessary to improve Māori health. These practices can be constructed as being carried out in good faith but they do not translate into material improvements. Work of this kind preserves an individual's sense of self-worth and can centre self-reflection about personal power and privilege.

Reflection

Our commentary identifies five categories of excuses for racism that are frequently used within the health sector of Aotearoa. These resources are powerful enablers of racism that perpetuate systems of power and patterns of behaviour that privilege the dominant ethnic group, Pākehā, while disadvantaging others, notably Māori.

Social systems, including health systems, are deeply rooted in the worldviews and social practices of specific groups. Discourse entails social practices that shape who is heard, how ideas develop and what is acted upon. Too often within the health sector, these words and phrases lead to Pākehā voices being preferentially heard (Came et al. 2019), and the development of and allocation of resources to Pākehā programmes that disproportionately benefit Pākehā (Came et al. 2018). Based on our collective experience, we assert the words and phrases outlined in this paper are key enablers of racism in the design, delivery and monitoring throughout the health sector.

This research aligns with the framework proposed by Wetherell and Potter (1992) demonstrating how language is used as a powerful tool to preserve white supremacy and maintain the status quo, with the effect of oppressing Māori whānau, hapū, and iwi. Through the strategic use of words and phrases that constitute a long-established 'commonsense' among settler peoples (McCreanor 2012), often rooted in systemic and historic racism, narratives are constructed that privilege Pākehā interests (Borell et al. 2018) while silencing Māori voices, ignoring calls for equity and racial justice, perpetuating inaction, and silencing discussion about Te Tiriti obligations.

These words and phrases also interweave into a wider narrative that problematises Māori (both as workers and as consumers) within (and beyond) the healthcare systems that have been entrenched through colonial processes. This narrative links in turn to broader pro-colonial stories about sovereignty, rights, values and nationhood that bolster forms of majoritarian 'democracy' seeking and serving to marginalise Māori actions, claims and aspirations for social justice, decolonisation and mana motuhake (autonomy).

This discourse not only maintains white settler normativity but oppresses critical Māori voices and denigrates the experiential, social and political perspectives of Māori. Within the contemporary healthcare landscape, Te Tiriti responsibilities and cultural safety are overshadowed by clinical fiscal priorities despite Māori health inequities dominating co-morbidities and death rates (Mills et al. 2012). There is a concerning professional apathy towards personal critical reflection and transformative change that serves to maintain the status quo and ignores urgent calls for equity and justice for Māori.

Walking the Talk

Responses need to be tailored to the context in which they identified. In practical terms, those witnessing the use of the excuses exposed here need to be aware of power dynamics and the risks of challenging more senior colleagues within hierarchical organisations. Addressing racism within the workplace requires everyone involved, including bystanders, to bring our most constructive selves to the table. We have learned from multiple experiences that evoking shame and guilt and expressing anger is unlikely to persuade perpetrators into antiracism. Table 1 presents some possible responses to the identified excuses for racism.

Sets of excuses	**Deeper responses**	***One-line responses***
Resource allocation.	This is an opportunity to do something different. What we have been doing has been maintaining inequities. The solution to inequities lies beyond business as usual.	*This isn't working, let's try something different.* *As the problem changes, new approaches are needed.*
Responsibility.	All settlers that come to Aotearoa are bound by the conditions of Te Tiriti. It is everyone's responsibility to contribute within their sphere of influence. For health professionals, this is often a requirement of our professional competency documents, ethical standards, and code of conduct.	*Honourable kāwanatanga (governance) requires Tauiwi participation and responsibility.* *Te Tiriti is about the rights and responsibilities of all citizens.*
Māori blaming.	Māori are not homogenous. There are diverse Māori realities; it is unrealistic to expect one singular view.	*Māori may prefer consensus decisions.* *Māori are diverse.*

Too hard.	It may be hard to disrupt racism, but it is harder to experience racism. Solidarity involves people stepping up and leaning in.	*Colonial racism is a powerful force.* *Let's use our privilege for good.*
We tried.	It takes stamina and determination to reverse the effects of historical and institutional racism. There is no magic bullet – it is about having a go, reflecting, and having another go. It is a journey not a destination.	*When things don't work, that is a learning opportunity.* *You didn't give up when you were learning to drive, why give up on racial justice?*

Table 1: Possible responses to excuses for racism

Effective interventions need to be clear, considered and must maintain mana. Emotions need to be managed and it important to avoid making Māori responsible for this. It is useful to remember that micro-aggressions cause a cumulative harm to those targeted by racism (Geronimus 1992). With systemic workplace racism it is useful to collectively organise and engage with those targeted by racism. This is essential as Māori are likely to have to navigate the rising tensions that poorly formulated interventions might provoke.

Conclusion

Racism is an all-encompassing feature of colonial praxis expressed in both the most blatant systemic violence and highly nuanced interpersonal and internalised expressions that brutalise. To combat entrenched excuses for racism, which are manifestations of a profoundly compromised system, we need to change the culture of the health sector. Organisations, leaders and professionals need to be both supported in addressing inequities within their sphere of influence and accountable for them. This accountability needs to be embedded within job descriptions, performance reviews, promotion processes and all aspects of health policy and praxis. Transparency, perhaps via visible dashboards to monitor antiracism practice and progress towards equity, enables accountability on key performance indicators to guide leaders and organisations.

Health sector planning needs to consider the next seven generations, not the next election cycle. We need to move beyond the neo-liberal drivers of healthcare, and notions of scarcity, to a recognition of healthcare as a social good and embrace the social return on investment. We need to end the underfunding of Māori health (Ministry of Health 2024, Waitangi Tribunal 2019), reorientating investment into Māori public health and addressing the wider social, economic, and historical determinants of health that will, in turn, decrease the financial burden of healthcare.

Mandatory training standards, embedding of cultural safety measures into clinical systems, educational initiatives and embracing mātauranga Māori will be part of the solution. Māori healthcare professionals should have access to kaupapa Māori education and research, cultural supervision and rongoā allowances. Models like co-governance, Matike Mai (2016) and authentic Tiriti-based partnerships hold promise for challenging existing norms and fostering transformative change within healthcare institutions.

In short, we need to challenge the credibility of excuses with evidence, rational arguments and audible commitments that open hearts and minds to our shared responsibility to uphold Te Tiriti and address racial injustice. We need to be alert to the linguistic enablers of racism and be prepared to disrupt such damaging and distracting discourses of misinformation and hate.

Obituaries

The passing of Toni and Dougal this year has been a profound tragedy for Māori health and critically for their friends and whānau . We will continue the mahi and carry their dream of equity and tino rangatiratanga with us as we wield our pens.

Toni Shepherd (Kai Tahu, Kāti Māmoe, Rapuwai, Waitaha) Toni was a māma of four, a friend, a partner, a scholar, an activist, an environmentalist, a clinician who was devoted to protecting the aroha and mauri of whakapapa. She was bright, sparkly funny and had the best belly laugh ever. Prior to her tragic passing earlier this year, she was the Tumu Whakarae of Starship Child Health. Toni led TamaAriki Ora who daily fight for child health equity and social justice. Their mission to ensure that we continuing moving towards a mokopuna-centric, whānau focused and whānau led child health system.

Dougal Thorburn (Ngāti Pou) Dougal embodied the words "Ko au te whenua, ko te whenua ko au (I am the land, the land is me). Those who knew Dougal will remember his positive energy, his integrity, his love of nature and how much he adored his children. He was a gifted athlete, dedicated GP and Public Health specialist. These qualities were exemplified in his 2013 World Record for the fastest 10km pushing a buggy (32 minutes 26 seconds), with his youngest daughter aboard the buggy, and accompanied by a message about sustainable transport.

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