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Kimihia Hauora Māori

Māori Health Policy and Practice

Cynthia A. Kiro

Ngāpuhi, Ngāti-Hine, Ngāti Te Rangiwehe

A thesis submitted in fulfillment of the requirements
for the degree of Doctor of Philosophy

Massey University Albany

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Abstract

Health reforms in New Zealand during the 1990s introduced a new term to our lexicon, 'by Māori for Māori providers'. These providers are an expression of a policy attempt to marry two distinctive government intentions in respect of Māori. One intention was the inclusion of Māori to address political concerns such as tino rangatiratanga (Māori control over Māori lives). The other was the devolution of responsibility for Māori health outcomes to the Māori community itself, in line with other neo-liberal policies adopted between 1984 and 1999.

This research examines the effects of the health reforms announced in 1991 in respect of Māori health policy and Māori health services within the Auckland region. In particular, the research is concerned with how North Health enacted these reforms.

North Health was the northernmost Regional Health Authority responsible for the largest Māori population in New Zealand, the largest metropolitan centre, and areas of high Māori health need in Northland, South Auckland and West Auckland. They developed a distinctive approach to Māori health policy that would have pervasive and lasting effects on health policy in the rest of the country. In particular, their identification of three strategies for Māori health purchasing, including support for by Māori for Māori providers, mainstream enhancement and Māori provider development, formed the basis of Māori health services within Auckland for many years.

This thesis is not an attempt to tell the story of the Māori health providers who form the basis of the case studies. Many have started this process themselves. Rather, it is an attempt to place their experiences within the broader context of public policy analysis during a period of considerable change in New Zealand. It also provides an opportunity for understanding the ideas of North Health as the health services purchaser. These ideas remain as significant influences on current Māori health policy through the Health Funding Authority. Furthermore, this more contextualised analysis is consistent with the

Ottawa Charter's emphasis on healthy public policy. Such policy must take account of its impact on the well-being of populations within society. This policy is not limited solely to that of the health sector, but includes all public policy that impacts on health such as housing, education, income maintenance and other significant social factors.

While a great deal has been written about the health reforms in New Zealand, little has been written about the implications of these reforms for Māori. Even less has been written about the specific experiences of Māori providers and the policies that underpin Māori health services and health in New Zealand.

The research found that there has been considerable innovation on the part of Māori policy makers and purchasers in an attempt to shift resources to Māori communities to provide services themselves. This was part of a broader move within government policy to devolve responsibility for service provision and risk to communities of interest from the late 1980s to 1999.

Strategies to promote by Māori for Māori providers enabled Māori communities (especially iwi communities) to become more directly involved in health decisions and service provision, but they also allowed weakened government accountability for Māori health outcomes. While Māori providers have displayed considerable innovation and energy in establishing services. They have developed a distinctive community development approach that is at the forefront of changes in primary care incorporating community health workers, extensive community networks and health promotion programmes. However, these elements are often under-valued within their services and they remain heavily dependent upon the GP service at the core of their health centres.

Mainstream enhancement among large health providers has been largely an afterthought considered too difficult and without the political rewards of independent Māori providers. Yet the overwhelming majority of Māori continue to use mainstream services and therefore require urgent reorientation of these services to better meet their needs.

The provision of local Māori services is an essential complement to what already exists and these should be strengthened and promoted because they provide suitable primary care models of care for all New Zealanders. However, this approach must be part of a broader population based and macro policy approach that informs government policies that impact on Māori health and wellbeing. The provision of highly targeted primary care services will not change Māori health status without the accompanying shift in macro-environments such as labour market participation, cultural pride and greater egalitarianism.

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Māori English Glossary of Terms

Aroha	love
Hapū	sub-tribe
Hauora	lifebreath, health
Hui	meeting or gathering
Ihi	power, authority, rank
Ika	fish
Iwi	tribe
Kai moana	food from the sea
Kaitiaki	guardian
Kanohi ki te kanohi	face to face
Kanohi	face
Kapa haka	form of modern Māori cultural group performance
Karakia	prayer or incantation
Kaumātua	elderly men
Kaupapa	groundwork, topic or subject
Ki	to
Kimihia	seek, look for
Kohanga	nest
Kuia	elderly women
Kumara	native sweet potato
Kura	school
Mana whenua	having rights over this land
Mana	prestige, authority
Māori	native peoples of Aotearoa New Zealand
Māoritanga	Māori culture and beliefs
Marae	Māori gathering place, place in front of the meeting house
Mātaku	fear, afraid

Mirimiri	massage
Mo	for
Nga	the (plural)
Pono	integrity, truth
Puhā	native plant widely eaten
Rangatira	chief
Reo	language
Rohe	district
Rongoa	traditional medicine
Tangihanga	funeral
Taonga	precious or valuable item
Taiaha	traditional weapon (spear)
Taniko	form of weaving
Tapu	sacred
Taura here	literally to bind together, but in this context it means group from another tribal area who bind together
Te	the (singular)
Tika	justice
Tikanga	protocols and practices
Tino rangatiratanga	sovereignty
Tono	told
Tupāpaku	body
Wehi	trepidation
Whakairo	traditional carving
Whakapapa	genealogy
Whakāpiripiri	stick close to, fasten
Whanau	extended family
Whanaungatanga	making of a family

Introduction

In July 1991 a National government announced sweeping changes to the New Zealand health system as a result of an extensive series of public policy changes following its election in October 1990. Assumptions in place since the introduction of the Social Security Act 1938 would be challenged. Changes to the health sector wrought by the Area Health Boards Act of 1983 would be overturned. These changes would have an effect on Māori at a personal and population level. It is these changes and their implications for Māori that form the basis of this research.

The current parlous state of Māori health is a reflection of the cumulative effects of the loss of land, culture and precipitous loss of life following colonisation in the nineteenth century (Pool, 1991; Durie, 1998b; Belich, 1996; Kunitz, 1994; Penney, 1996). While a more benign attitude has existed towards Māori in New Zealand than, for example, towards Aborigines in Australia, successive government and public responses to Māori are characterised by too little, too late. On the other hand, Māori have consistently attempted to influence New Zealand society by preserving those aspects of our culture that are important for our survival as a distinctive ethnic and cultural group in the world (Walker, 1990; Durie, 1998b).

The research sets out to understand the health reforms from the perspective of those Māori who participated in the design and implementation of these policies, as purchasers and as providers in the health sector. These efforts are put into a broader public policy perspective and a population approach is taken in respect of understanding the likely health outcomes.

The thesis is divided into five sections; one on the research process, another on policy analysis, a third considers the evidence from a population perspective of what has happened to Māori during the time of the reforms, the fourth substantively examines the Case Studies, and the final section considers the future debates and draws some

conclusions. The research includes a meta-analysis of Māori health policy and services, augmented with case studies. This analysis emphasises an approach to healthy public policy as advocated in the Ottawa Charter (World Health Organization, 1986).

The thesis provides a detailed explanation of the policy environment of these reforms with the case studies providing a more meaningful interpretation of the reforms at the level of the healthcare purchaser and healthcare provider. It is hoped that this interaction between policy and the actual practice environment, will enable the reader to better understand how these health reforms have been affected by Māori, and will in turn affect Māori as a population.

A literature review is contained in each chapter, and can usually be found at the beginning of the chapters as a means of setting the scene for subsequent discussion. This became necessary because of the scope of the literature that covers areas as diverse as public choice theory, epidemiological transition theory, and kaupapa Māori theory.

Chapters One and Two discuss the research questions, methodology and literature, with Chapter Two attempting to theorise Māori health in its broadest sense. It should be noted that the literature on Māori health research methodology during the period of this research 1996-1999 was extremely limited. However, there is a rapidly growing body of literature in this area. In particular the work of Linda Tuhiwai Smith, Mason Durie, Māori Masters students and various hui have made valuable contributions to this field. Ethical questions quickly become evident when doing research in Māori health. This thesis examines questions about emittic or 'insider' research and the embryonic nature of Māori policy analysis.

Chapter Three discusses Māori development and public policy and reveals an assumption that research on Māori health cannot be separated from the broader discussion about changes to other public policy areas, and cannot be separated from a consideration of Māori development (Durie, 1998a). This Chapter therefore provides a basis for a more holistic analysis of the evidence in Māori health policy and Māori health outcomes. The

Chapter lays out the background of the huge number of public policy changes that occurred in the period from 1990 with the election of the new National government, and which were started by the fourth Labour government in 1984. These changes have had a profound effect on the health of Māori. They also provided the environment for the health reforms. Without these broader public policy changes, the 1990s health reforms would not have been conceived. The relationship between Treaty of Waitangi settlements and Māori development are also discussed in this Chapter.

Chapter Four is an analysis of Māori social policy and examines the links between major policy debates in New Zealand society on Māori. It also tracks the major debates within Māori society and argues that there is a congruence between Māori desire for tino rangatiratanga (self-determination) and government desire for devolution under neo-liberalism. This congruence may be at odds with the interests of Māori. Debates within Māori have been around Treaty settlements, iwi and Māori representation and access to public monies for social services delivery. There has been little attention paid to the macro and micro-policy issues of Māori unemployment and the decline in Māori living conditions. Similarly, increased intra-ethnic disparity has been ignored on the Māori and government policy agenda.

Chapter Five details the 1990s health reforms and subsequent Māori health policy. The reforms are discussed along with their implications for Māori. Specific policy developed by Māori and for Māori is also discussed under the heading of Māori health policy and a definition for this policy is developed. This Chapter examines the major drivers for competition, transparency, efficiency and cost control that have also become evident in other developed economies over the past few years. However, few have overthrown their health system with as much gusto as New Zealand. These new structures are discussed, along with some of the strategies for improving competition in the health sector.

Analysis of Māori health status is addressed as one of a number of indicators in Chapter Seven. It consists of an exploration of major mortality and morbidity trends, and a discussion of 'Hauora' and how this may be differentiated (if at all) from 'Health'.

Chapter Six picks up the socio-economic and cultural determinants literature in more depth in an attempt to theorise about the evidence presented in Chapter Seven. In particular, the link between these broad social and economic experiences and the importance of relativities in health outcomes for vulnerable populations such as Māori are examined.

Chapters Six and Seven consider the empirical and statistical evidence of Māori well-being, adopting a broad perspective including health status, housing tenure, labour market participation, income and educational achievement. These are summarised as indicating a widening or stagnation in improvements of indicators between Māori and non-Māori over the past 16 years. This raises serious questions about the likely benefits accruing to Māori despite the health reforms given public policy and societal cohesion during the period.

Chapter Eight marks the beginning of the case studies, with an analysis of North Health as the purchaser. Their motivations, analyses and implementation of the reforms between 1993 and 1997 are examined. These dates represent the period during which the Regional Health Authorities existed. Like their forebears, the Area Health Boards, they would be rapidly dis-established. A significant feature of this analysis is the way in which North Health sought to grapple with the complexities of a diverse Māori population within a politicised multi-tribal, metropolitan centre. North Health's co-purchasing iwi authorities, Māori Assisted Provider Organisations (or MAPO) are also discussed.

Chapters Nine, Ten and Eleven contain an analysis of the health reforms from the view of Māori health providers within the Auckland region. Six Māori providers were chosen to provide a representative view of Māori providers within Auckland, covering the range of Māori health gain strategies developed by North Health. These strategies are by Māori for Māori health providers, mainstream enhancement and Māori provider development through Māori health consultancy and training. They include two iwi-based and two multi-tribal primary health providers, including the largest urban Māori health provider in the country. The other two providers are a mainstream enhancement Māori provider and a

Māori provider development consultancy company. The emphasis in Chapter Nine is on establishment issues such as contracting, governance, recruitment of staff, enrolment of patients and financing. Common themes are identified between the providers. However, there are also differences between Māori providers and these are described in the following Chapters. Chapters Nine, Ten and Eleven also address the development of other Māori health initiatives in public health and national Māori provider networks as part of the backdrop of Māori health provision within the Auckland region.

Chapter Nine continues the case studies by examining consolidation issues for the Māori health providers. These issues include what it is that Māori health providers do that differentiates them from other primary and secondary health providers. Consideration is also given to how these distinctions may contribute to improved Māori health status, the similarities with good clinical practice in a primary care environment and the degree of Māori patient acceptance of these services. An attempt is made to understand what a kaupapa Māori service might involve, including involvement with marae, other Māori health providers, and other health professionals.

Chapter Twelve discusses recent and future issues for Māori providers including issues around financial sustainability, consolidating clinical expertise, refining management and governance practices, relationships with other health professionals, and managed care and its implications for Māori as providers and patients. It also examines the latest round of health reforms following the election of the Labour-Alliance Coalition Government in November 1999. Contrasts are made between a return to an Area Health Board approach and continuing with a managed care approach.

Chapter Thirteen draws together the key arguments about seeing Māori health policy within the broader public policy context. An argument about the essential need for government to actively partner Māori to achieve economic advancement to improve Māori health status is posited, along with an argument for inclusion of all Māori institutions, not solely iwi, in this process. Māori health status is summarised, along with the changes to the health sector and their effects on Māori. An argument for a more

public health, population-oriented approach is made based on international evidence of the health effects of increasing inequality on populations. Public policy reforms in the economy and social policy areas are discussed with regard to their impact on Māori, and likely future implications are examined, based on demographic data and emerging analyses of Māori children's well-being.

The constantly changing landscape of the health sector during the period of this research made it difficult to identify a suitable cut-off point for the research. Finally, the arbitrary date of 1997 was chosen because of the focus of this research on North Health, given that this was the year in which the Regional Health Authorities were disestablished and replaced by the Health Funding Authority. Further changes occurred during the final write-up stages of this Doctorate, including the announcement that the Health Funding Authority would itself be disestablished by November 2000.

In addition to the many policy changes in this period, there was also a rapidly growing body of research and literature on socio-economic determinants of health and the effects of inequality and poverty on the health and well-being of the general population. Some of this material was incorporated, but it was not possible to do justice to all material. This new material awaits further analysis about its relevance for Māori health.

During the 1990s health policy was consistent with other government policy. This meant it expressed the prevailing ideology of independence from the state, individual responsibility and risk shifting that dominated the early reforms. While health policy could not be said to have contributed to negative socio-economic determinants that affect health, it was an essential part of the government policy puzzle and therefore reinforced a hegemonic policy environment – particularly during the early period of the health reforms.

If as this thesis argues, socio-economic and cultural determinants affect health outcomes, then health can be seen as having acted in a dual capacity. On the one hand it dealt with the cumulative affects of Government policies by providing health services. To this

extent, it attempted to ameliorate the negative effects of other reforms. But health policy and services were also enacted in ways that reinforced the inherent correctness of these detrimental policies by providing positive evidence of their ostensible 'success'.

The achievements of Māori providers were often touted by politicians as examples of the success of the health reforms. Māori (who had good cause to be proud of such achievements) overwhelmingly concurred with this view and therefore provided support to the reforms as a whole even when they did not intend to do so.

Concurrent with these health reforms, government policies were enacted that would erode socio-economic determinants of Māori health. Examples of the effects of these policies are discussed at length in the policy analysis chapters of this thesis. These can be summarised as: (i) the high levels of Māori unemployment through most of the 1990s (having peaked in 1992) following sale of state assets such as the Post Office, Forestry, and New Zealand Rail, (ii) the demolishing of apprenticeship schemes through which many Māori had entered careers such as carpentry, electronics, and glazing, (iii) the introduction of market rentals that impacted most harshly on the lowest income Māori families, (iv) growing disparity in incomes because of the impact of a more-market differential remuneration system instituted in the public sector, (v) the introduction of user pays to public hospitals and increased charges on pharmaceuticals (although most of these were withdrawn following public outcry) impacting most on middle to low income Māori families. The flow on effects are seen most critically in the worsening relative's in Māori social outcomes around educational achievement, home ownership, income, and labour market participation in stable permanent work (increases were in casualised, part-time work during this period).

If Māori accept that socio-economic and cultural determinants affect Māori health, then the net effect of the changes in government policy and economic environment were to be largely detrimental for Māori as a population, even when some Māori benefited from the reforms. These negative impacts were offset by an improvement in cultural determinants

of health during the same period that may have staved off the worst effects of worsening socio-economic determinants.

If a more positive profile for Māori achievements through kohanga reo (started in the 1980s), kura kaupapa, Treaty settlements, and Māori health providers (to name a few) during the 1990s contributed to cultural determinants of health, then this could be so. This thesis raises the possibility that these benefits were not enough to overcome the overall negative impacts of changes that lead to poorer socio-economic outcomes for Maori as a population, thereby affecting the socio-economic determinants of health. This is despite the best efforts of many Māori and Pakeha to address all of these in their efforts to help Māori.

CHAPTER 1

Research Question & Methodology

Introduction

Māori health continues to be the subject of considerable interest in health research because of the huge burden of illness borne by Māori in New Zealand. However, there are also other reasons for examining Māori health policy and services. These include the possibility of applying some of the lessons learned from working differently in the health sector that may lead to improved health outcomes not just for Māori, but for others as well. Clearly, one of the aims of this research is to assist in this process of improving Māori health outcomes. This requires more than a consideration of how well Māori fare in comparison to non-Māori, and extends to a consideration of how concepts of hauora can better service Māori and the rest of society. Such concepts need to be recognised and incorporated at all levels of health services planning, including policy development, implementation and service delivery.

This research focuses on the strategies and policies of North Health, the Regional Health Authority for the Auckland region between 1993 and 1997, and the implementation of these strategies and policies. Other actors include a selection of Auckland Māori health providers who form the bulk of the Case Studies in the research, and the MAPO (Māori Assisted Provider Organisations) who assisted North Health in the co-purchasing of Māori health services.

This research draws on an emerging corpus of Māori knowledge on Māori health policy and services, but this remains limited to a few authors such as Mason Durie and Linda Tūhiwai Smith. The latter researcher draws heavily on the work done in Māori educational research and applies this to Māori health research.

One of the features of the late 1990s has been the expansion in numbers of Māori health researchers and Māori health commentators available to write up Māori experiences.

This has been due in part to an active health research workforce development strategy put into practice by the Health Research Council of New Zealand, the rise in interest in Māori health services following the emergence of a plethora of Māori providers, and sustained evidence of high Māori health need in New Zealand.

This Chapter describes the institutional setting of this research, poses the research questions, provides an overview of the literature in areas as diverse as epidemiology, kaupapa Māori development and public choice theory, and explains the methodology. It provides a framework for a political analysis of Māori health that has been so absent in the literature. Such a framework allows Māori to understand what changes are required in society for Māori health status to be improved. Case Studies in subsequent chapters allow Māori to understand what types of activities services can perform that add value to Māori patients' experiences. This is not however, an evaluation of Māori providers. Such an evaluation is required and should be from a critical perspective, since only this will enable Māori to understand what further changes are needed to achieve the high standards necessary in Māori healthcare service delivery.

Institutional Setting

This research will examine the way in which institutions established as a result of the 1990s health reforms, such as Regional Health Authorities were conceived and developed. These institutions include the Regional Health Authorities (RHAs) who were the 'purchasers' in the new health environment. They were accompanied by a multitude of health service providers, most of who were paid from public funds. This research is mainly concerned with two types of providers in the health sector (excluding the disability and mental health sectors). These types of providers are independent providers such as 'by Māori for Māori' providers, and Crown Health Enterprise based providers.

The four purchasers established around New Zealand provided funds through contracts to health providers, initially through an annual contracting process. These annual contracts were gradually extended in time from one to two years, then two to three or five years. During the reforms a number of new health providers emerged mainly from the private

sector, including those owned by community trusts such as most Māori health providers. These providers were able to 'compete' with other more established providers, who were themselves transformed into new types of Crown Entity providers, such as with Crown Health Enterprises.

During the 1990s further reforms were enacted, once again changing the purchasers and providers. The four purchasers were merged into a single entity in 1997, the Transitional Health Authority. This Crown entity became the Health Funding Authority (HFA) from 1 January 1998. Crown Health Enterprises, who controlled all public hospitals, became, Health and Hospital Services (HHSs) at the same time. A more detailed explanation of these institutions is provided in chapter on health reforms.

Strategies pursued by the Northern Regional Health Authority, North Health, form the locus of this research. North Health's three-pronged strategy encouraged the development of a variety of different Māori providers promoted through the Māori Development Division and through the Public Health Group of North Health.

In particular the increased number of Māori health service providers should be noted (Ministry of Health, 1997). Their purchasing strategies also involved the establishment of a unique form of co-purchasing institution called MAPO. MAPO was an acronym for Māori Assisted Provider Organisation. These MAPO were established entirely according to iwi with mana whenua in the Auckland region, namely Tainui, Ngati Whatua and Te Tai Tokerau (primarily Ngapuhi).

In addition to MAPO, other new Māori service forms would eventuate following the Health and Disability Services Act amendments and the demise of the Public Health Commission. Each Regional Health Authority would become responsible for public health purchasing, although North Health would bear major responsibility for national contracts. Despite repeated attempts by the Māori Health Development Division within North Health to solicit support for separate Māori health purchasing in the respective activities of the purchaser/funder over the years of the reforms, few would take up this

offer. The Public Health Group of North Health was one of the few. In 1996 it purchased a \$700,000, three-year contract for Māori public health in Auckland. Mental health also purchased a number of by Māori for Māori services. The contract established Hapai Te Hauora Tapui Limited with three shareholders: two iwi and one urban Māori (Lawson-Te Aho, Gifford, & Coupe, 1999). Another public health contract was purchased in Northland from Te Hauora O Tai Tokerau (THOTT) (Te Pumanawa Hauora Evaluation Report, 1999), although this organisation did not experience the same complexities as evidenced in the relations within the Auckland region between iwi and urban Māori organisations.

Questions about the right to political representation versus evidence of effective service delivery went to the heart of the debate around institutional arrangements in the Auckland region as a result of the 1990s health reforms. As new institutional arrangements evolved and were implemented, questions about whether rights to political representation or evidence of effective service delivery should be paramount became core elements in debates over these new arrangements.

Research Question

The research hypothesis for this thesis is that, 'The health reforms of the 1990s were viewed as effective by Māori and the Government because they enabled a congruence in the political agenda of both parties to come to fruition. However, this congruence has been aimed more at political rather than health outcomes, thus placing Māori health policy at the centre of the debate around Māori representation and iwi development'. Related to this hypothesis is a question, "How did the 1990s health reforms affect Māori health policy and services in Auckland?". This question also leads to others such as, "What ideas influenced the strategies adopted by purchasers and government in respect of Māori health policy during the 1990s?". "How successful were these strategies in addressing key issues in Māori health?", and "How have Māori in purchasing and service provision, viewed these reforms?". The research also poses questions relating to health outcomes such as, "What is the relationship between Māori health policy, Māori health status and Māori health outcomes?". While these latter questions may have no definitive

response and were not the prime focus of this research, the evidence gathered does suggest the need for a change in Māori health policy. The only significant academic work done about Māori and the health reforms comes from Durie (Durie, 1998c), and other Masters and Doctoral theses (Martin, 1997; Penney, 1996). There are also reports for government agencies such as the Ministry of Health, Health Funding Authority and National Health Committee on specific aspects of the reforms, and these have also been used as sources of information for this research. Few of these reports discuss research methodology in any depth.

The research is concerned with how the 1990s health reforms were interpreted and implemented by Māori within the Auckland region, and in particular the period 1993 to 1997 when the Health and Disability Services Act (1993) was introduced. It was during this period that the Regional Health Authorities existed as health purchasers, and it is the development of Māori health policy in North Health (the Regional Health Authority responsible for Auckland) that is of central interest to this research.

The reason for this interest is North Health's significance as a Regional Health Authority and the continued influence of its key staff, following its dis-establishment and transformation to the Health Funding Authority between 1997 and 1999. A detailed description of North Health is given in chapter 5, however it is important to understand Auckland's significance if Māori wish to understand how these health reforms have been taken up by Māori and how they are likely to influence Māori health status. Auckland is the largest Māori population centre in New Zealand, with nearly a third of all Māori living within the region. Most tribal groups are represented within Auckland as *taura here*, or through Māori urban organisations, or by virtue of *mana whenua* occupation. Diversity between Māori is evident, with pockets of considerable Māori wealth, middle-class Māori and many more represented amongst the low socio-economic groups.

The research was concerned with the way that opportunities created in the health reforms of the 1990s impacted on Māori, and because the researcher was a participant in this process, case studies and key informant interviews were chosen as research methods.

These would acknowledge the insights and limitations of being an 'insider' to the research process (discussed fully later in the chapter), and would also enable the researcher to draw on the valuable lessons from Māori health providers. These insights are explained at length in the data collection section, and in the concluding chapters.

The goal of this research is to contribute to the discourse about the usefulness of the health reforms for Māori. Despite the enormous support of many Māori key informants, most research participants saw the pursuit of knowledge for its own sake, as a rather empty goal. They were much more interested in the possible application of research findings to support their claim about the need for Māori to exert greater control over health policy, services and funding.

Health Outcomes

The measurement of health outcomes remains a challenge for those responsible for health policy and also for health services. For example the 1996 Coalition Government Agreement and consequential decision to fund health outcomes rather than health outputs, shows how much interest had developed in health outcomes.

Such measures are currently largely absent relying almost exclusively on measures such as mortality, morbidity and health service utilization (such as hospitalization and GP utilization). Such measures, while they are useful, do not correlate necessarily with either a more holistic hauora conceptualization of health, nor do they provide any gauge as to the quality of the health experience. They are also patently unsuitable for a population oriented health service that may seek to balance individual experience against total population experience.

The difficulty is in finding useful other measures, particularly since so much of what contributes to health outcomes has its genesis in other areas such as labour market participation and housing. This research assumes a number of things in respect of such health outcomes. Firstly, that socio-economic determinants contribute enormously to the health outcomes of Maori. Therefore social and economic indicators provide some basis for anticipating likely impacts on the future health status of Maori as a population. Secondly, that cultural determinants also affect health. This means that there is a unique

and qualitatively different experience for Maori. Researchers, policy makers and services decision makers, do not yet understand the mechanisms for this, but that they are different is undisputed in the evidence of differential health outcomes for Maori compared to non-Maori (Ministry of Health, 2000; Blakely et al., 2001).

Identifying potential contributions to cultural determinants that contribute to Maori wellbeing and health, along with some identification of some of the mechanisms for interaction between these various determinants are the subject of research currently underway (such as the Te Hoe Nuku Roa longitudinal study and Hauora Tamariki Study by Massey University). Meanwhile we use what is available. Even this available data is problematic because of discrepancies in ethnicity data collection across time. Such discrepancies are the product of both conceptual and operational difficulties in gathering data. Both of these are discussed elsewhere in the thesis (see conceptualising ethnicity and discussions on the health evidence).

The development of useful measures is further complicated by current use of misleading measures and comparisons. For example, Maori providers interviewed identified significant improvements in rates of immunization (compared to for example, traditional methods such as GPs or Plunket). The difference in some cases of 45% to 99% rates for children aged 2 years and under. However, on closer examination, it became obvious that such rates were not comparable since the historical GP and Plunket rates (for example), were for total populations, whereas the Maori provider rates were for an enrolled population (a 'captured' population). This does not minimize the enormous achievements of such rates, but it does mean that the comparison is itself not valuable.

Research literature

The research process has involved a lot of learning while doing, partly because of the limited literature available to guide how to do Māori health research correctly. This was especially true during the early part of this research when most of the data was collected. The research timeframe is from 1996 to 1999. During this period a number of valuable

resources became available. In particular two hui relating to Māori research should be mentioned.

The first is Hui Whakapiripiri: A Hui to Discuss Strategic Directions for Māori Health Research in September 1996 at Hoengeka Marae, Plimmerton in Wellington. Organised by Te Roopu Rangahau Hauora an Eru Pomare at Wellington School of Medicine and funded by the New Zealand Health Research Council, this hui would encourage Māori health researchers to discuss the ethical implications of Māori health research, research methods and Māori research workforce development (Pomare, 1996). The other hui was the Te Oru Rangahau Māori Research and Development Conference organised by Te Putahi-a-Toi at Massey University on 7-9 July 1998. Proceedings prepared by Te Pumanawa Hauora would provide an essential resource for Māori health researchers despite the broader Māori research agenda of the Conference (Te Putahi a Toi, 1998).

Some of the most valuable lessons for Māori health research are emerging from another field, namely Māori education. Smith's work on research and indigenous peoples (Smith, 1999) was not available until the period of write-up, and thus did not provide guidance during the design, fieldwork and data collection and analysis phase of the research. However it is a valuable reference for kaupapa Māori research and Māori research methodologies. Some guidance was found in various theses, in particular in Masters of Public Health theses. Smith proposes that research concerning Māori has typically been done from the perspective of outsiders to the culture treating Māori as objects rather than subjects of their research. As outsiders, they are not subject to the same moral codes as those within the community of study, nor do they understand the 'true' dynamics that exist within this community. Outsiders rely instead upon a tradition of western science, which values this experience as being objective while viewing an insider's view as subjective and therefore invalid. This is at odds with aspects of Māori research methodology that, like feminist research, validates insider knowledge as more accurate, since only an insider can understand the nuances of the social phenomenon affecting research participants.

Within each set of ideas are systems of classification and representation; epistemological, ontological, juridical, anthropological and ethical, which are coded in such ways as to 'recognize' each other and either mesh together, or create a cultural 'force field' which can screen out competing, and oppositional discourses. Taken as a whole system, these ideas determine the wider rules of practice, which ensure that Western interests remain dominant (Smith, 1999, pp 46-47).

The suggestion therefore is that Māori need to shape their own research agenda, along with other indigenous peoples, to hear the discourse that has been suppressed. This liberation of thinking provides indigenous energy for change and legitimises those ways of doing and being that feel 'right' to indigenous peoples, including Māori. The rigor for such research emerges from the discipline of the researcher in openly questioning what they do. This helps make them accountable to the community of the researched. The interests of researcher and researched are not divorced from each other, but are inherently bound up in a common commitment to hearing an indigenous discourse.

Despite obvious differences, there are also similarities to the arguments of Durie who claims that Māori health cannot be separated from Māori development (Durie, 1998c). Indeed, Māori health policy has a normative responsibility for enhancing Māori development (Kiro, 2000). Durie explains the difference in emphasis between the aims of self-determination and the aims of positive Māori development.

While both are concerned with social, cultural, and economic development, and Māori delivery systems, the aims of self-determination place more importance on Māori control over resources and greater independence from the state...In practice, however, the differences between self-determination and Māori development may be more apparent than real, especially at local levels. Certainly, since positive Māori development was launched as a preferred option for Māori, self-determination has been closer to realisation than at any other time this century (Durie, 1998b, p 6).

Durie's analysis accurately captures Māori interest in Māori control. This recurred again and again in this research. However, underlying questions of equity versus rights underpinned many of the overt conflicts in Māori health strategy evident in the North Health region, although these were rarely overtly discussed or critiqued (Lawson-Te Aho et al., 1999). Such an analysis moves discussions around Māori health development on from "feel-good principles" to gritty reality in terms of operationalisation of Māori health policy.

Furthermore, while Māori desire for control over health resources and health services remained, this desire would sometimes be used to further a wider political agenda by a government interested in devolving responsibility to communities at risk (Kiro, 1998b).

Any discussion of Māori development is invariably also caught up in a discussion about the Treaty of Waitangi, since it is the Treaty that guaranteed Māori rights to protect taonga and also rights of citizenship in New Zealand. The Treaty will be discussed more fully later in the Chapter.

Two main schools of thought in Māori health research can be identified. One believes there is a distinctive Māori way of doing research, where particular ethics, methods and ways of processing the data are expected. This school of thought is concerned with validating a particular approach in Māori research and has developed a literature around ontology and epistemology to explain it. The other school identifies the research question as driving the research method. Any method (with suitable ethical requirements) is acceptable if it answers the research question and ultimately leads to a better understanding of the dynamics of Māori health.

Research Process

The research process for this thesis was designed in 1995, and has remained relatively unchanged, although the analysis and writing up phases were extended. The research questions arose from my own experience in the health sector, having experienced enormous changes since the late 1980s, but especially during the 1990s. This experience

included a role in health policy and planning, review of health services and consultancy to health providers (both Māori and mainstream).

The first phase of the research was concerned with formulating a research question that took considerably longer than expected. Once formulated, this question would change slightly over the period of the research, since other questions subsumed within the overarching research question, would become evident. Initially, the research question was concerned with the confluence of events that enabled the 1990s health reforms to take place. This included changes in professional practice such as a more evidential base to medicine, a more assertive Māori development agenda following the hui of the mid-1980s which affirmed a by Māori for Māori development agenda, and the neo-liberal political agenda of devolution and government minimisation. This confluence of 'agendas' enabled Māori to take greater charge of the policy and services agenda in the New Zealand health sector, and from this emerged Māori health providers.

Following data collection by interviewing health policy and Māori health providers, this focus changed with a greater interest in describing and explaining aspects of Māori health policy and Māori health services. In particular, policy makers, service providers, academics and researchers wanted to know what features were distinctive to Māori health policy and Māori health providers, so this came to be an important component of the original research question. The data collection comprised the second phase of the research.

During phase two, literature was also being reviewed and gathered. The sources for this literature included books, journal articles, reports from the Ministry of Health, Te Puni Kokiri (Ministry of Māori Development), and Statistics New Zealand, and academic literature such as theses and papers. The books and journal articles included international literature.

Phase three required analyses of the transcripts, which required reading the transcripts and documenting key ideas for reference with other transcripts. This was all done

manually without the use of NUD*IST or similar software analysis. Such software is only useful with large volumes of transcripts. This software provides a means of identifying common ideas with such volumes. However this software may be at odds with a Māori research methodology since it decontextualises the meaning of words, relying instead on repetitions of words to identify themes rather than insider analysis of the meaning or significance of certain phrases and ideas. Given the small number of Case Studies in this research, and the interactive nature of this, such software analysis would have been token and not have contributed much to the research analysis.

Phase four involved drafting the thesis and attempting to integrate the transcripts and literature. These drafts were then distributed to friends with expertise in the chapter areas, and to my supervisors. Comments were received back and incorporated into the final draft of the thesis, which was again, distributed to peers and supervisors for comment. It was at this stage that those quotes that required permission for printing, were sent to research participants for approval or amendment. The thesis was then again re-written and submitted to the University.

Table 1 Summary Of Research Phases

Summary of Research Phases

Phases	Activities
Research Planning	Research question, research funding application, ethics application, contact with research participants, planning of fieldwork
Literature review	Collection and reading of literature including books, journal articles, papers, theses, and reports
Data Collection	Interviewing of research participants
Data Analysis	Reading of transcripts, analysis of these including identifying common themes & ideas, summarising of these.
Write-up	Writing of draft integrating literature & transcripts, feedback from peers & supervisors, final draft feedback

from peers & supervisors, preparation of final thesis
and submission to University

This research process is in keeping with other social research that emphasises qualitative methodology. Quantitative data is not excluded but is subsumed within the policy analysis (which draws on economic and medical data). The theoretical perspective adopted in this research is from the critical, interpretive and positivist perspectives, but the critical perspective is the dominant orientation because of the view that human beings are dynamic creators of their destiny and a political analysis that supports the view that Māori are an oppressed, exploited and alienated group within New Zealand society (Sarantakos, 1993, p 38).

While feminist research methodology sees gender as the nucleus of women's perceptions and lives (Sarantakos, 1993, p 61), Māori research sees Māori culture as the nucleus of Māori perceptions of their lives and seeks to reflect this in the research. The same range of qualitative research methods is available including in-depth interviews, participant observation, document analysis and structured questioning. However, other methods that draw on ethnographic studies are also available. These include deconstruction (historical and structuralism) and semiological analysis (Sarantakos, 1993, p 61).

A number of these research methods can be seen in this research, including in-depth, semi-structured interviews with key informants, document analysis, participant observations (of hui) and deconstruction. The use of these multiple methods, overlaid with a case study approach, allow a form of triangulation to take place whereby document analysis and deconstruction can be checked by in-depth interviews and hui participation.

Qualitative Methodology And The Case Study Approach

Information for this research was gathered using three main methods;

Table 2 Summary Of Methods

- 14 semi-structured, in-depth interviews with key informants including purchasers, providers and health policy analysts (see appendix for interview schedules and outline of semi-structured questions)
 - A focused sample of 5 Māori health providers, including 4 primary healthcare clinics and one bi-cultural CHE based service
 - Documentary review from a wide variety of sources including internal reports, public reports, annual reports, press releases, newspaper articles, journal articles, planning documents, policy documents and contracts.
-

The interviews were conducted between 1996 and 1998 during extended interviews with mainly Māori health purchasers and providers, policy analysts or researchers. One non-Māori health analyst was included because of the importance of his role during the inception of the health reforms.

The sample comprised five Māori health providers across primary, secondary and tertiary healthcare in the Auckland region. The intention was to reflect a range of qualities characteristic of Māori providers within this region, including pan-tribal and iwi managed services geographically dispersed across Auckland, including central, south, west and north Auckland. These providers were chosen by talking with colleagues working with Māori health providers, with the newly established funder and with Māori policy analysts in the Ministry of Health. As such, the sample was chosen based on inside knowledge of the providers and their characteristics. The providers were however chosen in the early stages of the Health and Disability Services Act 1993, when fewer Māori health providers existed for study in Auckland.

This kind of selection can be described as focused sampling which is;

The selective study of particular institutions or key informants on the basis that, because of their special circumstances or experiences, they have the

potential to offer especially illuminating examples or viewpoints (Ashton, 1998, p360).

Case Studies are purposive, but their lack of representativeness or statistical significance is offset by the richness of the data gathered through the Case Studies. When triangulated with other research methods, it allows a fuller understanding of what has occurred. The triangulation within of this research was in the choice of three different methods to confirm the findings of the research. These three methods were documentary review, key informant interviews and review of the health, social and economic indicators. The key objective from the use of these different methods was to validate a key idea in my hypothesis that the health reforms created opportunities for Māori but that these had hidden 'costs' for Māori.

Two of the providers operated under the auspices of iwi, while another two operated under the auspices of pan-tribal Māori authorities. However, all of the providers belonged to organisations with established track records in social service provision in well-established Māori organisations. In addition, all services had been established between 1994 and 1996. This period followed the introduction of new legislation called the Health and Disability Services Act 1993. There were other similarities between the providers although these were not apparent at the time of selection. All primary healthcare providers were closely linked to marae in their area.

Four primary healthcare providers were chosen to provide some basis for comparison between operating styles and to allow for the identification of any common themes and issues which might emerge. This was not possible in selecting the Crown Health Enterprise (CHE) based service, since it was the only one of its kind. Later innovations were added, but these were not available at the time the research was begun, so were not included in the selection. These selections of Case Studies took place in late 1995, which was in the early stages of Māori provider establishment and thus the selections reflect this more limited choice.

Another factor was the likelihood of securing permission to work with these providers. This included preliminary contact with the managers of the various providers, although in two cases I had to approach the Chief Executive of the parent organisation in order to gain permission. All providers agreed and were extremely helpful in providing time and information when requested. However, there was understandable reservation at the first approach for some providers. This was for a number of reasons, including the busy nature of the work at that time, and the lack of clarity about the scope of my research, the potential competition and commercially sensitive nature of their contracts, fear about me being from the health purchaser (because of another role with the purchaser in Māori provider development).

Furthermore, the relative newness of these ventures and their need to settle in before being 'evaluated' in any way was likely to be a factor. A little defensiveness was detected amongst some providers, while others were more concerned with workforce development issues in the recruitment and retention of suitably qualified and experienced staff, and in the intensity of contract negotiations that would figure prominently during the period of Māori provider establishment between 1993 and 1995. Therefore some Māori providers could not necessarily guarantee the time or commitment the research might require. One provider interviewed stated they did not want to participate in research unless it was going to benefit them. They believe that Māori have been over-researched and often for researcher's personal benefit, such as gaining higher qualifications or building a reputation for themselves. Sometimes this had been at Māori expense so the provider was wary of being in this position again.

This view was contrasted with yet another provider who wholeheartedly supported the research and made clear that they would be prepared to provide whatever was needed to get the work done. Each of the providers needed to establish some relationship with me as the researcher. If I knew them, then Māori would build on this relationship. If Māori had not met, they would often ask other Māori about me, "checking me out". Again this may reflect the extent to which Māori need to feel "comfortable" with the researcher before participating and also the perceived vulnerability of things Māori to the prying

academic and wider world. These responses were also borne out in other research, which attempted to evaluate Māori providers.

The purchasers were also keen to demonstrate the success of their strategies and policies. Any perceived criticism was interpreted as a failure to understand the strategy or the people involved.

Despite these concerns, all the providers approached did agree to interviews and the provision of some documentation - a sign of their willingness to contribute to an expansion of critical Māori thinking in health. Managers and staff gave freely of their time and information and the overwhelming majority were extremely supportive of the research. These providers were contacted by phone and then sent information on my research including an information sheet, consent form and contacts (see appendix for copy). The researcher was careful to never discuss any of these providers with each other, as there was some concern by providers about sensitive information finding its way to other providers, or to unsympathetic ears.

The documentary analysis consisted of requesting all policy documents relating to Māori health from North Health and the Ministry of Health. This was checked against literature found during the literature review phase and that offered by key informants during the data collection phase of the research.

Common themes were identified from the policy documents and grouped together after a thorough reading, then re-reading some months later. These were then written up as sections which were later checked when the writing of the thesis began.

In health, there has been a tendency to polarise quantitative and qualitative approaches in debates about an empirical, reductionist research tradition and a more interpretative, 'woolly' approach. However, health research may involve both quantitative and qualitative elements. As Baum explains, public health problems arise from,

Complex social, economic, political, biological, genetic and environmental causes. A range of methods is needed to tackle these and public health researchers are most effective when they are eclectic in their choice of methods (Baum, 1995, p459).

This research combines both quantitative and qualitative methods. The quantitative data provides some evidence of overall trends that allow Māori to make some preliminary conclusions about policies at a macro and micro level. The qualitative data is gained from in-depth interviews and allows an interpretation of the experiences of Māori providers resulting from the opportunities of the health reforms. This material includes a combination of methods such as documentary review, policy analysis and health status data. The qualitative material is derived from in-depth interviews with key informants and Case Studies.

Methodological triangulation is achieved by using a variety of methods to study a single problem or program (Patton, 1990, p 187). Denzin (1978) quoted in Patton, says, no single method ever adequately solves the problem of rival causal factors ... Because each method reveals different aspects of empirical reality, multiple methods of observations must be employed. This is termed triangulation (Patton, 1990, p 187).

Multiple methods were used in this research to achieve triangulation, and to gather information not revealed through other methods.

Methods

The following table summarises the research methods used in this research.

Table 3 Reasons For Methods In Research

Type of Method	Reason for Method
Documentary Review	Identification of policies, plans, evaluations, contracts, financial information
Policy Analysis	Identify purpose and outcomes of policies

Health Status Summary	Reflect trends in health outcomes
Focused Sample	Comparison across similar providers
In-depth interviews	Reflect experience of providers

The case study sample and key informant interviews allow Māori to experience Māori providers direct experiences of the health reforms. This reflection of their social world from the point of the view of the actor is a valuable outcome of qualitative methodology (Bryman, 1984). Triangulation was achieved by using three different methods: Case Studies of Māori providers and purchasers, key informant interviews and policy reviews.

Baum's (1984) schemata for researching public health identifies basic, applied and participative health approaches. Baum argues that research goals, the relationship between the researcher and researched, the role of the researcher and who uses and who controls the research are all points of divergence between basic, applied and participative research. This reference to an external quality beyond the immediate research is part of the enrichment arising from a complex tradition in research, including feminist research. Baum's schema suggests exclusivity between these various approaches. However, this has not been my experience in this research. While this research could be described as applied and participative, combining mostly these two approaches, it also seeks to build something of a corpus of Māori knowledge in these areas under study, and to that extent, also contributes to basic research - particularly in the area of describing Māori health providers.

Epistemology And Ontology Of Māori Theory

While Māori may accept as researchers that reality is socially constructed, it is also important to understand how Māori came to know this and how Māori continue to interpret or make sense of this. Epistemology refers to how Māori know things and what counts as legitimate knowledge. Ontology refers to what things there are in the world, how Māori can know certain things, and what counts as legitimate knowledge (Tolich & Davidson, 1999, p 23). Such things are intrinsically linked to philosophical discussions about knowledge and how Māori know what Māori know.

Tolich and Davidson's (1999, p.26) adaptation of Gleen and Peshkin's (1992) explanation of the didactic between qualitative and quantitative research explains succinctly many of the methodological/epistemological/ontological elements which underpin the research carried out for this thesis. Tolich and Davidson identify four major philosophical elements: assumptions, purpose, approach and the researcher's role. ā

Tolich and Davidson (1999) summarise seven key areas of difference between qualitative and quantitative research, including complex and interwoven variables, the use of atheoretical observation language, science is socially constructed, primacy of the method, inductive and deductive reasoning, strict criteria for reliability and validity of knowledge, generalisability of the research (Tolich & Davidson, p 27).

Kaupapa Māori theory and Māori research both question the inherent validity of scientific knowledge as the only 'legitimised' form of knowledge. This is not because either approach rejects positivist scientific method per se, but rather because both of these approaches are concerned with confirming Māori knowledge and approaches. These approaches include distinctive Māori practices such as the use of te reo within the research.

Māori face being outsiders to scientific knowledge and also believe that science is inadequate for revealing the rich tapestry of Māori understanding, either about the natural world, or our social world. Rather theories of research that emphasise an internally consistent meaning within a particular cultural context resonates with Māori understandings of how society functions.

This more critical or interpretivist approach questions assumptions about the validity of the scientific approach, and the ways that different assumptions and methods for determining validity are utilised. Reflexivity is part of this fundamental difference between a scientific approach and critical / interpretist approach. Reflexivity means, 'that

we always remain part of the social world we are studying, so we can attempt to understand that world *only* from our daily experience of life' (Tolich & Davidson, p 37).

This link between research and deep philosophical matters may sound self-evident, but is crucial in Māori health research because of the assumptions made about the ideas circulating within the research. Literature and thinking around these matters is growing rapidly with many more Māori involving themselves directly in Māori health research. Transportation of ideas developed around Māori epistemology and ontology is also being imported from other areas such as education and is being applied to Māori health research.

According to Durie (1996), Māori health research is thought to have three main principles.

- The research contributes to an integrated development – inter-sectoral co-operation and multi-disciplinary activity
- The research contributes to positive outcomes - well-being in terms of economic, social and cultural well-being
- The research contributes to Māori quality of life - cultural affirmation and the opportunity to be Māori

Insider, Outsider

There are a number of matters that Māori researchers must take into account because of their proximity to the Māori community. Māori know each other in ways in which the wider New Zealand community, and international community, do not, and are therefore in a stronger position to both exploit and be influenced by these relationships. As such Māori act as insiders, often gaining access to Māori participants because of this insider status. Such a status raises questions about boundaries for the researcher and research participants since, by virtue of being an insider, there may be access to information via other means than the interview process and documentation.

For Māori researchers this dilemma about what to reveal as an insider, even when information can be corroborated by other sources, is shaped by an ongoing commitment to positive iwi, hapū and Māori development which has cultural, political and scientific resonance. The criteria for inclusion therefore extend beyond what is scientifically provable according to the protocols for social sciences to include these other considerations.

Most research methodologies assume that the researcher is an outsider able to observe without being implicated in the scene. This is related to positivism and notions of objectivity and neutrality (Smith, 1999, p 137).

The Māori health community remains relatively small and it is possible therefore to hear about what is happening within providers in terms of successful contracts, employment, evaluations, and joint ventures, without information coming from the provider. This information tends to be uncannily accurate when confirmed by the provider, which makes it even more difficult to exclude such generalised 'talk' from inclusion in research in some form. The major means of addressing this responsibility for fairness and accuracy is through reflexivity, or what Paulo Friere termed praxis or action / reflection (Friere, 1970). Linda Tuhiwai Smith explains.

The critical issue with insider research is the constant need for reflexivity. At a general level insider researchers have to have ways of thinking critically about their processes, their relationships and the quality and richness of their data and analysis. So too do outsiders, but the major difference is that insiders have to live with the consequences of their processes on a day-to-day basis for ever more, and so do their families and communities. For this reason insider researchers need to build particular sorts of research-based support systems and relationships with their communities. They have to be skilled at defining clear research goals and 'lines of relating', which are specific to the project and somewhat different from their own family networks. Insider researchers also need to define closure and have the skills to say 'no' and the skills to say 'continue' (Smith, 1999, p 137).

Thus there is an additional obligation for Māori researchers to be careful about the validity of such information shared amongst their networks. Confirming with the provider, or through some other means such as external evaluations, or confirmation from the purchaser or similar government departments may allow use of much of this information.

Access to this information in this instance is increased because the researcher has also acted as a consultant to a number of Māori health providers and has a direct interest as a director in Awhi Health. This was recognised by the Human Ethics Committee of Massey University as causing particular concern because of the potential to access information that would not otherwise be available to the researcher.

In addition to this, the Minister of Health appointed the researcher as a Director of the Health Funding Authority from 1 February 2000. While this appointment is outside the scope of the Case Studies of this research and therefore most of the policy analysis, the Health Funding Authority is the successor to the main case study of North Health. This has posed some problems in the latter stages of writing up in terms of ensuring key informant HFA staff are free to consent to quotes, for example.

The agreement was that material gathered in this way would be excluded from the study, but this has proved extremely difficult to monitor. It is hard to 'unknow' what is known and for this information to not shape or influence subsequent analysis, irrespective of how it was gained. Again, seeking corroboration of the information, or alternative sources for this information is probably a more reasonable approach. As Smith indicated earlier, this can sometimes pose additional responsibilities on the researcher because of the expectations of those with whom Māori interact as researchers.

Being an insider means the researched trust the researcher enough to spend some time providing information and consent to being part of the study, but they also expect that the researcher will act in their interests. This makes it difficult at times as a Māori health researcher to identify where the obligation for protecting research participants interests as

Māori begins, and where the researcher's obligation for truth telling begins. Fortunately, these are most often one and the same. It has been possible to tell the truth without comprising the integrity of Māori involved in the research itself. Responsibility rests however on the researcher because of the tenuous political environment within which Māori initiatives continue to exist in New Zealand society.

This raises questions about the kind of information that should be available to an insider researcher, which would not normally be available to an outside researcher. While being an insider has become acceptable in qualitative research (Tolich & Davidson, 1999), in part thanks to the impact of feminist research, it obviously raises serious questions about what information research participants have a right to protect against being made public.

Being an insider is not new to research methodology. Feminist and Māori research methodology assume this because of the necessity for understanding the community being studied from within its cultural boundaries. The problems of objectivity identified by a positivist research methodology are not problematised as such in Māori and feminist research (Smith, 1999, p 137). Smith proposes that a more critical discipline is required of indigenous researchers as a result.

The critical issue with insider research is the constant need for reflexivity.

At a general level insider researchers have to have ways of thinking critically about their processes, their relationships and the quality and richness of their data and analysis (Smith, 1999, p 137).

Considerations around insider/outsider research participation are therefore central considerations in Māori health research and it is more than coincidental that it parallels feminist research in this regard, since both derive from an analysis of an oppressed and exploited group. For Māori however, there are additional assumptions about cultural impositions and an affirmation of another set of cultural values over and above those concerning marginalisation on the basis of ethnicity. Thus the research process seeks to affirm those aspects of Māoritanga that identify Māori as Māori, namely our reo, cultural practices, whakapapa and communitarian orientation.

Relationships

A reliance on relationships has been crucial throughout this research. Access to participants has relied heavily on my personal relationships with either middle-people who facilitated access to key informants, or with these key informants themselves. In every instance key informants and the case study organisations, were given an information sheet and consent form (Appendix A) to read prior to our interview. Agreement to record their interview was sought, usually prior to the interview. Almost all the interviews were taped. Only one key informant was not taped but this was because of a technical problem (the tape recorder broke down). Some other technical problems also occurred. The group interview, for example, was largely undecipherable.

Almost all the key informants gave permission without reservation for taping, and most did not wish to edit their quotes when offered the opportunity to do this by the researcher. They trusted the researcher sufficiently to believe their information would not be misused. Unfortunately these kinds of expectations place additional responsibility on researchers to 'filter' somewhat any comments, which may be damaging or un-intended by the participant. This occurs in qualitative research since transcripts may include the words but not necessarily the intent of what was said. For this reason, I kept the original tapes and checked comments where possible against tapes when my memory of the interview did not assist in understanding the intent of the interviewee. Nearly all the comments make sense because of the context of discussion within which they took place, that is, by reading the rest of the transcripts it is possible to deduce what was intended fairly easily.

Agreements about use of quotes from interviews or reports or data given by the research participants have been dealt with strictly according to these agreements, for example over the use of quotes. However, where information has been gained from other sources such as reports reviewing performance, evaluations and other publications that are already in the public arena, then this information has been used differently since it is already publicly available. I have tried to establish overall patterns and themes amongst Māori

providers. In most cases, these themes have emerged from discussion with the providers themselves following the interviews, discussion with the purchaser, with other providers (including any outside the Case Studies of this research) and with Māori health consultants who work with Māori providers (again, most of whom fall outside the Case Studies identified here).

An additional problem was that of filling lapses in the transcripts. While it has been possible to fill in many of these by reading the transcripts based on my memory of the interview, this was not always so because of the length of time between some interviews and transcription. Where these could not be filled in, these remain, unable to be used in the research. Fortunately these lapses are not numerous for most interviews because participants were able to speak with little prompting from the researcher. The researcher changed practice after the first round of interviews in 1996, choosing to use a non-voice activated tape recorder for subsequent interviews and increasing the turnaround time between interview and transcription so that it was possible to read the transcripts within a relatively short period.

This emphasis on a pre-existing relationship is an important quality in Māori health research. It was necessary to establish a common point of reference with every interviewee. This included establishing whether Māori had known each other beforehand. Following this efforts were made by myself to establish a common connection, usually through a third party, who may have mentioned the research to this person prior to my phoning. This emphasis may reflect a general wariness by Māori about those from academia, or it may reflect the emphasis Māori place on personal contact called *kanohi ki te kanohi*.

Research participants' expectations of the research also varied considerably. Some were utilitarian in their approach asking, "How will this research benefit us?" My response was a generalised, "by contributing to the debate around the usefulness of the health reforms for Māori". Such a response by Māori research participants' should have been expected given the importance of research contributing to Māori development. Other participants

were keenly interested in the development of a Māori 'theory' of the health reforms and of Māori health. This corpus of knowledge for Māori was seen as a reward in its own right. Most participants seemed glad (after warming up) to talk to someone in detail about their work and how they saw things working out. In almost every case, they were overwhelmingly positive about what they themselves had managed to achieve, whether in purchasing or providing health services for Māori. Less positiveness was expressed when talking about the other side of the purchasing/providing equation. That is, providers were slightly more critical of the purchaser than they were of other providers, and purchasers were slightly more critical of providers than they were of other purchasers.

Part of the reason for such care in respect of criticising Māori initiatives is the disproportionate political backlash that accompanies any whiff of incompetence or corruption. The Māori population at large may be affected by the consequences of any research that reflects them in a bad light. However, this consideration must be weighed against the need to act openly in respect of any findings. I was impressed with the degree of trust exhibited by key informants and also their willingness to open themselves to scrutiny in their work. Many were genuinely interested in the research and in any comments made by the researcher about the findings to date, particularly in relation to the wider socio-political policy context of the reforms.

Research in any area associated with Māori development or Māori health is a complex matter that requires careful consideration. However this is the nature of the quest for truth. It necessitated an ongoing and careful consideration of the ethical implications of the work as I proceeded. Sometimes these ethical considerations were around privacy or process, or commercial sensitivity or personal sensitivity.

Benchmarks for Māori ethics in health research are emerging in works such as the Hoengeka Declaration (1996), the work of Mason Durie and Linda Smith and in numerous other Māori academic publications. The Hui Whakapiripiri 1996, in preparing the Hoengeka Declaration for Māori Health Researchers (Hui Whakapiripiri: A hui to

discuss strategic directions for Māori health research, Te Pumanawa Hauora, University of Otago, Wellington School of Medicine, Wellington, 1996), contributed to the development of Māori ethical standards by producing a statement summarising baselines for Māori health research. These were observed in this research.

Other Specific Ethical Issues

Being an insider has had profound ethical implications for this research, in both process and philosophical terms. Ethical dilemmas have arisen during the course of the research, sometimes unexpectedly. A number of these could have been predicted and my application to the Human Ethics Committee at Massey University was very useful for signaling these likely difficulties early on. In particular, concerns about my role as a Director and Consultant for a company that is one of the Case Studies was raised, because of the problems of having insider information that could be used in this research. This has remained an extremely difficult problem to resolve, because despite believing that it was possible to separate the role of working with Awhi Health and working with a wide number of providers and purchasers, this has in effect been impractical. It is not possible to not know something, once learned. It remains the equivalent of trying to put the genie back in the bottle.

All participants have been told of my involvement with Awhi Health. Awhi Health Directors were asked for permission independently and emphasis was given to their right to refuse to include it as a case study. Initially Awhi Health was not included as a case study, but on reflection this would exclude one of the main strategies of North Health from consideration in the research. Awhi Health is the only provider of its kind within Auckland. To not include this case study would be to tell only two-thirds of the story. The emphasis was on protecting Māori providers and the purchaser from information that would be detrimental to them, gained by virtue of working in Awhi Health. Again, this is harder in practice, than in rhetoric. It is complicated by the inevitable dynamics of being an insider to the research community (that is the community of research participants and researchers). My being an insider was also by virtue of being Māori, although this posed

very few obstacles to the research, and indeed was viewed by purchaser, participants and the University as a significant advantage to the research.

Ethics emerges as a powerful theme within Māori health research. These ethical dilemmas differ according to the ethnicity of the researcher. For Māori researchers there are considerations of being an insider and the feelings of trust developed with research participants. A pervasive feeling of mistrust exists within the Māori community towards researchers because of the view that Māori have been studied as objects of research, rather than being able to direct the research themselves. When research participants were contacted for this research, a number asked why they should allow more research to be 'conducted' on them. A number asked how this research would benefit them (their organisation). Some were happy to participate and did not make statements about the research process. What was clear however, was how crucial personal contact and a belief that a relationship of trust existed between researcher and research participant was in allowing the research to proceed.

The central idea in indigenous research, as in feminist research, is the notion of liberation through knowledge. The goal of such research is to empower these communities (Māori and women) to understand their position and act on this knowledge for change. Thus the problem is less that a researcher may be biased because they are a member of the community being studied, but rather, that they are biased if they are not a member of that community.

Positivism and Medicine

Māori have been somewhat critical of the positivist tradition of western medicine because it historically rejected practices and beliefs associated with a more traditional approach to healing. This is less evident in medical training today however, with greater tolerance for complementary medicine and culturally appropriate practice. Western medicine was viewed by a number of key informants as dominating the health sector with an ideology of empiricism that supports a more mechanistic response to health than the holistic tradition of Māori society expects. This section briefly examines the history of

positivism in medicine and the critique of this approach. This is followed in the next section by an explanation of Kaupapa Māori theory. This theory at its most critical, can be viewed as a reaction against such strongly deterministic views promulgated in western science. The danger, however, is in the rejection of positivism because of its underlying association with a rejection of indigenous knowledge and social control, even when it offers the potential for benefits to Māori health which clearly it does with a knowledge of biological systems, environmental effects and an understanding of genes.

Positivism has been associated with ideas of biological determinism and racial hierarchies with attempts at different times to provide scientific evidence of inferiority of one race compared to another. It is however, unfair that positivism be tainted with this as the methods themselves do not espouse a particular position in respect of race. Rather scientific method was able to disprove that a 'superior' English 'race' (for example) had bigger brains than 'inferior' native races during the British Empire expansion of the 18th and 19th centuries.

Modern medical science relies on positivism and in particular the use of a rationalist Cartesian tradition and empiricist theory that originated in sensory experience (Williams, 1994).

In self-justification of this attitude of superiority, modern western medicine rejects as untenable the animistic, demonistic, spiritualistic and magical beliefs it sees as central to the theory and practice of most indigenous medicine on the grounds that (i) the logic of these medicines (because it is teleological) does not accord with the logic of scientific explanation; and (ii) these kinds of belief do not accord with (its own assumption) of scientific materialism (Williams, 1994, p 1).

Western medicine's early roots can be traced back to the civilisation of the Nile in the Tigris and Euphrates valleys where the Ebers Papyrus and the Edwin South Surgical Papyrus were found. While the first consists of mainly spiritualistic medicine, the latter

provides more detailed descriptions of surgical procedures for treating wounds and injuries.

In most histories of medicine the medicine in the Eber Papyrus is referred to as “superstition medicine” whereas that contained in the Edwin Smith Surgical Papyrus is referred to as “rational” or “empirical” (Williams, 1994, p 1).

The next significant phase in medicine would occur with the rise in Greek civilisation where both superstitious and rational elements would continue to be combined in health treatments. Asclepius was believed to have lived around 1000 BC, but later became deified, becoming the Greek god of medicine. He promoted healing sanctuaries located in beautiful settings to harmonise humans with nature. These included temples, mineral water springs, gymnasia, theatres and abator where supplicants would sleep and have their dreams interpreted by priests.

Asclepian medicine seems to have rested on the assumption that health came from healthy living - in other words from living wisely and in accordance with, or in balance with nature's ways. Asclepian sanctuaries seem to have been conceived so as to make it possible to allow the sick or ill person to re-adjust their lifestyles so as to establish this harmony or balance with nature's ways (or nature's inner reason) (Williams, 1994, p 2).

Hippocrates trained in Asclepian medicine but practiced by travelling the countryside “applying his medical knowledge and skill whenever and where it was required” (Williams, 1994, p 2). He would differentiate himself from Asclepian medicine in two important respects; firstly, by “naturalizing” medicine in discussing the “natural” causes of disease and illness; secondly,

Hippocrates adopted the idea that health and disease derived from, respectively, a balance or imbalance within the physical body rather than between the person and nature / environment (Williams, 1994, p 2).

Hippocrates would come to view illness and disease,

In relation to their “natural” rather than their “divine” causes. Yet it is important to recognize that Hippocrates’ appeal to “natural” causes was not at the expense of any belief in their “divine” causation. Like Aristotle after him, Hippocrates adopted a synthetic view of causation and believed that all disease was in a sense, a result of both natural and of divine causes.

Hippocrates’ humoral theory of disease fits closely with Empedocles’ theory of the four basic elements of nature consisting of fire, air, water, and earth. According to Hippocrates these four elements are represented in the four “body humours” - yellow bile (fire), blood (air), mucous (water) and black bile (earth). Health equates to a balance of these four humours Hippocratic medicine continued to constitute main stream western medicine for the next two thousand [years] (Lyod, 1983, p 25).

Medicine was revolutionised again with Rene Descartes in the early seventeenth century. Descartes was responsible for the separation of the world into the mental (*res cogitans*) and physical (*res extensa*).

Separation between final (or teleological) causes, and second, natural (Aristotle’s material, formal and efficient) causes. This separation meant that external physical nature came to be conceived as essentially mechanistic in its manner of operation while all reason and purpose were associated with the mind and its working. External nature, Descartes believed, was most effectively studied and known via its being viewed in terms of hypothetical theories that at best withstood experimental tests. The inner contents of the mind could only be known via introspection and logical analysis (Williams, 1994, p 3).

Thus Descartes opened the possibility for the body to be seen as a machine and its operation in accordance with mechanistic laws. This resulted in an emphasis on physical causes and treatments relying on experimental methods of enquiry.

John Locke would extend this rationalist theory with his empiricist theory originating in sensory experience. This combination of empiricist theory of knowledge and experimental natural philosophy came to be the foundation for New Science, and thus for contemporary medicine (Williams, 1994, p 3). Hippocrates humoral theory would continue to dominate in medicine, until the adoption of germ theory in the nineteenth century through the work of Sommelweis, Pasteur, Koch and Ehrlich. Darwin's theory of evolution eliminated Descartes' idea of a fundamental difference between humans and animals, and Freud,

Would plausibly argue that psychology has a biological base and this further made it possible for Western medicine to assimilate psychological and psychiatric medicine into its mechanistic theory of disease. Thus, while it is still difficult to explain such mental phenomena as consciousness, emotion, thought, desire, etc. in physical terms, it is believed that one day this will prove possible and, that when this is so, psychological and psychiatric disorders will be able to be understood and treated using the theories and practices of modern mechanistic, or scientific, medicine (Williams, 1994, p 4).

Williams' (1994) criticisms of modern western medicine are again not so much a rejection of method per se and its possible application to health, but rather an attempt to illuminate its origins and what it does contribute to our knowledge.

Kaupapa Māori Theory, Māori Centred Development: Systematising And Conceptualising Māori Thinking

Kaupapa Māori theory is best understood as an assertion of Māori thinking but it has its roots firmly in the work of liberation theology and Paulo Friere. It is also fundamentally a response to the positivist tradition that Pihama (1994) argued, provided support for Pakeha dominance of Aotearoa New Zealand.

Pihama's thesis provides a succinct critique of positivism and the development of Kaupapa Māori theory. She argues that environmental theories were used by Pakeha to emphasise cultural disadvantage, deprivation and difference. While these theories

represented a move away from genetic determinism, they continued to reinforce notions of mal-adaptiveness of people within their new environments.

She goes on to argue that cultural deprivation theories were the yardstick which Pakeha culture used to measure Māori culture. Te reo and tikanga Māori were viewed as antithetical to educational 'success' promulgated through assimilationist views since they were considered as reflecting a society long passed and only of historical anthropological interest. Manifestations of Māori society have thus been viewed as evidence of the gap between a nostalgic but irrelevant past and a globalised and relevant present. Such views, argue such theorists like Pihama, mask underlying notions of superiority of Pakeha culture over Māori culture and thus, underlies racism in New Zealand society.

Smith and Pihama in particular take exception to the deterministic nature of positivist theories that were challenged to some extent by a group of theories known as 'critical theories' that originating in the Frankfurt School in Germany. These theories would prove attractive to oppressed peoples since they offered the possibility of a future that could be altered. If reality was socially constructed, then it was possible for human intervention to change that reality if there was sufficient political will and insight to do so.

Critical theorists actively critiqued positivist frameworks and expose ways in which they serve to perpetuate existing power relations that benefit particular interest groups. The central concept is emancipation through which oppressed groups identify and act against unequal power relations. It would however be an overstatement to suggest that Māori reject positivist method, rather, many Māori researchers remain wary of the way that such frameworks have been used historically to exclude indigenous discourse in science. According to Māori theorists, Kaupapa Māori theory is indigenous and asserts the validity and legitimacy of te reo and tikanga Māori. It challenges dominant ideologies that serve to marginalise and make invisible te reo and tikanga Māori, thereby transforming oppressive reality by contesting unequal power relations between Māori and Pakeha.

Kaupapa Māori theory is a 'reassertion of Māori epistemological constructions of the world'. Pihama argues that there is a need to deconstruct dominant constructions imposed on Māori through overt and hegemonic violence, allowing Māori to move outside dominant institutions to reconstruct Māori institutions. Such a view was reinforced by many discussions between myself and other Māori researchers who pragmatically use positivist methods but often in an eclectic way combined with 'Māori' elements such as hui, iwi networking, te reo and Māori concepts such as manākitanga when using methods such as interviewing.

Examples such as Kohanga Reo and Kura Kaupapa Māori, which are proactive initiatives defined, constructed and controlled by Māori are often cited as examples of successful Māori initiatives that originate within a Māori epistemology and ontology. The question of whether such initiatives could have eventuated within a positivist framework is almost impossible to answer, however it is unlikely. Positivism is largely concerned with the exclusion of extraneous 'cultural' variables, searching instead for universal principles based on the natural world. As such, the basis of kohanga reo and kura kaupapa probably could not have been conceptualised since these initiatives rely almost entirely on cultural validation for their existence.

Knowledge and use of te reo and tikanga in these two initiatives were viewed as of paramount importance, with specific child-care or educational skills as of secondary importance. This was particularly so during the early phases of the movement when kohanga reo and kura kaupapa relied on the voluntary efforts of whanau, kuia and kaumātua because funding came from private Māori contribution and not from the state

Positivist theorists argue that scientific knowledge will take the place of religious dogma (such as superstition). The social sciences have attempted to pattern their approach on that of the natural sciences. This includes focusing on the facts and the measuring of facts objectively applied to the study of people. Smith (1999) explains that positivism became a framework through which to explain the human condition in an objective,

value-free and scientific process. Kaupapa Maori theory is not posited as a denial of scientific knowledge which has contributed valuable information for the improvement of Māori wellbeing. As an example village sanitation in the early 20th Century was promoted by Pomare based on his scientific knowledge and advocacy which resulted in an improvement in Māori health through adoption of more sanitary toilet practices within Māori villages.

While biological determinism and environmental theories are firmly located within the positivist tradition, according to Smith and Pihama, one of the things attempted by Kaupapa Māori theorists is to see if it is possible to re-position these, in particular, to re-position environmental theories without the historical focus on maladjustment to a set of dominant cultural norms.

This critique of positivism suggests that it ignores the complexities of truth, assuming there to be one quantitative truth and tolerating one experience. It therefore fails to deal with the complexities of 'health' and the myriad of aspects that constitute this in a social situation. Habermas claims that positivism emphasises objectivity to mask underlying intentions of control.¹ Furthermore this objectivity is legitimated through reification of the social world through laws of human nature. However, he suggests that this is an inadequate paradigm for analysis of human society.

Three of the interviewees cited examples of environmental theories of cultural deprivation that emphasised a deficit rather than strengths framework for Māori. Such a view reinforces notions of Māori maladaptiveness rather than identifying and reinforcing those things that Māori do well.

Theory and practice within critical theory is related to Paulo Friere's analysis of praxis and emancipatory thinking. The body of theories known as critical theories is

¹ For a fuller discussion of Habermas, see *Critical hermeneutics : a study in the thought of Paul Ricoeur and Jürgen Habermas* by John B. Thompson. Cambridge ; New York : Cambridge University Press, 1981.

emancipatory because they make explicit power relations within society. To this extent, Kaupapa Māori theory acts as a politicising agent for conscientisation and emancipation in a manner consistent with Friere's analysis. It is about deconstruction and reconstruction of explanations of the human condition. Thus critical theories are located in the structural rather than in the individual explanations of the human condition.

Kaupapa Māori theory avoids reinforcing Māori as 'other' because it is firmly located within the validation of te reo and tikanga Māori, with accompanying principles of tino rangatiratanga and Māori perspectives. These are a continuation of Māori resistance to colonisation and are a reassertion of Māori activism (Walker, 1990).

Kaupapa Māori theory analyses the way in which dominant groups construct "common-sense" and "facts" to provide justification for maintaining inequalities and oppression of Māori people. In this way it reinforces a Māori epistemology and ontology.

This analysis is itself firmly located in the theoretical thinking of the 1970s of structural explanations and concern with power relations. However such critiques fail to address a romantic ideal of Māori history, by firmly laying the blame for Māori experiences solely with Pakeha dominant society and colonising forces. Māori are not merely passive players and while Kaupapa Māori theory certainly doesn't advocate for this, it is a new form of portraying Māori as victims because Māori are primarily seen as reactors to other actors, rather than an essential part of the interaction with their environment. This is not to underplay the structural features that create a destructive or supportive milieu within which their decisions and actions are shaped, but rather to suggest that interactionism is under-valued in Kaupapa Māori theory because of its reliance on structural explanations of oppression.

There is little doubt by those aware of New Zealand's history that Māori are the victims of deliberate and sustained colonising practices which have eroded traditional values and structures, but this fails to account for the part which Māori themselves play in shaping their own reality. Māori have always had a far more active role than Māori are led to

believe in Pakeha pre-conceptions of history. There is no question however, that Māori are often in the position of responding to government or industry agendas rather than independently shaping their lives.

Kaupapa Māori theory consists of a number of underlying tenets. This includes its location within critical theory with an emphasis on critique, resistance against oppression, and a struggle for emancipation through enlightened action (conscientisation). It comprises a number of different disciplines, reflecting its eclectic origins from education and health sectors. Unique Maori characteristics comprise the core of this theory. These include Māori values and structures such as whakapapa. Whakapapa emphasises the value of whanau, hapu and iwi relationships. Whanau is the closest form of social organisation affecting all Māori, even when hapu and iwi may not be considered important to the identity of Māori individuals. Kaupapa Maori theory affirms te reo as important because of its centrality as an expression of Māori culture. Te Reo locates a distinctive Māori experience and reflects Māori values and ideas within the language. It is an essential component of tikanga. Tikanga ensures cultural principles in behaviour based around Māori concepts and cultural practice. Rangatiratanga confirms a research agenda that is about Māori benefits and advancement and not just about the research process. Rangatiratanga is an enabling of Māori aspirations through the research process for Māori ends.

Thus this type of research is therefore about being Māori and identifying as Māori. As such it reflects those values and behaviours that reinforce this identity and that distinguish Māori uniqueness. These are therefore an integral part of research around Māori health.

Treaty Of Waitangi

The Treaty of Waitangi signed in 1840 is important to any consideration of Māori research theory and methodology because it acknowledges the legitimacy of Māori ways of doing things. If Māori knowledge of research and method is a taonga, then the Treaty guarantees Māori the right to express and practice this. This research contributes a small

part to this reclaiming of Māori research theory and method by articulating the ideas and processes used in research around the study of Māori health.

The Treaty of Waitangi is often cited as a covenant between two peoples, Māori and Pakeha through their agent the Crown, and Māori agents, the rangatira of various hapū and iwi. While the Treaty was a document of 1840, it has proven capable of reinterpretation in light of subsequent developments between the Crown and Māori. The Treaty needs to be considered when discussing Māori health research because of the application of core cultural principles such as iwi, hapū, mana whenua and whakapapa.

However the Treaty of Waitangi, while important, is not the final document in respect of Māori relations with the government. The Declaration of Independence in 1835 predates the Treaty of Waitangi 1840 and also contributed to an emerging sense of Māori as a nation.

In particular, questions about who has the authority to speak on behalf of Māori (representation) based on whakapapa, but also on a new sense of identity, are to the fore of Treaty debates. They have become more important because of arguments around Treaty settlements and resulting assets, and also because of the emphasis on less state intervention and greater iwi autonomy enacted de facto in various government policies. While the government pursued mainstreaming for Māori during the 1990s, this has accompanied an iwi-centric approach to policy making congruent with the Ka Awatea policy duality that on the one hand expected Māori need to be met through mainstream Government agencies, while on the other encouraging iwi independence from the State. These are important considerations in this research, not only because of the substance of the debate, but also because of the implications for research processes. Such delicate political balances make negotiations around Māori health research within such an environment, infinitely more complex than if there were a single approach to Māori health policy, strategy and research.

Māori Health Research Including Kaupapa Māori And Other Types Of Research

Māori health research emphasises Māori control of research about Māori. Māori no longer remain passive recipients of researchers' inquiries. There is an expectation that the language used, and way in which researchers approach and discuss their questions, will be comfortable for Māori participants. To some extent this reflects a growing strength amongst consumers generally and tightening-up of research ethics, particularly in human sciences. There is also an expectation that this research will contribute positively to Māori development and that the knowledge and understanding gained from the research will lead to improvements in Māori conditions. This should not be about self-interest in pursuing a tertiary qualification, but about a genuine interest in the needs of those Māori researched.

It is more accurate to describe Māori methods as philosophies and theoretical considerations in research methods, rather than actual methods themselves. However, this is contested by Māori theorists who see an emerging Māori validation of our approaches (Smith, 1999; Te Putahi a Toi, 1998). Most of the literature concerning Māori methods comes from two areas in particular and the methods that dominate these fields are highlighted disproportionately; namely education and health. Kaupapa Māori theory is considered later in the chapter and can be conceptualised as one end of a research continuum for Māori. While the discussions emerging from Māori health research tends to encompass a greater variety of research methods, it also favors qualitative methodology. This approach is discussed in reference to the work of Mason Durie and is represented at the middle of the continuum. At the other end of the continuum are all those methods which are not designed for Māori use, and where there is an assumption of generic application. The methods themselves are less important than the philosophical and theoretical orientations that underpin their use. There is a limited amount of literature available on Māori research methodology and methods. The distinction between research about Māori, research for Māori and research by Māori is also a part of a continuum in Māori research.

Furthermore, it is important to understand that these philosophies and theoretical positions may reflect a spectrum of views about what is appropriately Māori, depending on the degree to which a particular piece of research is Māori centred. For example Kaupapa Māori theory may reject the need to incorporate western methodologies or methods and instead seek to redefine what is quintessentially Māori in approaching a particular research question.

Durie seems more inclusive, arguing that Māori should use whatever method seems appropriate and allows them to find the information they seek. He argues for recognition of diverse Māori realities and therefore diverse solutions.

Kaupapa Māori theory as a basis also recognises that there are differing social environments but would argue that there are some elements which are fundamental to a Māori identity and which distinguish Māori from non-Māori.

Holistic approaches to both discussions on health, health service delivery and health research are likely to increase in future as a result of two parallel trends, consumer movement and indigenous peoples movement. Durie has identified a number of elements associated with a Māori-centred development (Pomare, 1996).

- Principles Whakapikipiki tangata, Whakaurunga, Mana Māori
- Purpose of research Health gains for Māori, Māori as positive, Māori development
- Practice of Research Active Māori participation, multiple methodologies, measures relevant to Māori

These principles reinforce the importance of considering the impact of the research conducted about Māori and for Māori, rather than seeing research outcomes as separate from the ethical considerations that drive both the choice of subject matter and research process, including methods. Rather, all of these interact in a way that should preserve the

interests of the research participants while allowing the evidence of what occurs in the research to be revealed.

Most importantly, Māori-centred research is concerned with expressing Māori cultural values in ways that accurately record Māori experiences and then reflects this back in the interpretation and findings. These principles are elaborated upon by Linda Smith and Mason Durie, and amount to an expression of Māori identity within a cohesive political analysis that allows the research question to be answered.

Conclusion

A number of research principles can be distilled from the researcher's experience. The first is the need for the research to be Māori centred. It should be concerned to reflect a range of Māori ideas, values and ways of working in the design, collection of data, interpretation of results and dissemination of findings. This is an important requirement expected by the Māori community, as well as by the research community.

Secondly, there is a questioning of the assumed universality inherent in a positivistic western scientific tradition that makes Māori health research more aligned with feminist research. However, it would be a mistake to over-compensate for this view by rejecting the usefulness of methods that allow Māori to interpret our experiences in health using these methods. The challenge therefore is in the way in which research questions, methods and findings are conceptualised and dealt with, rather than the exclusion of certain methods per se.

Thirdly, there is a need for a multi-disciplinary approach to questions around Māori health policy and Māori health services. These questions are inevitably multi-factorial and require methods and skills drawn from a wider range of expertise, from medicine, to economics, to social history to te reo. All of these have the potential to contribute, but care is needed to understand the framework within which such an analysis takes place.

Durie's (1998) principles of whakapiki tangata, that promote enablement, enhancement and empowerment, are an expression again of Māori autonomy or rangatiratanga. But they are also an affirmation of cultural identity and confer a preference for a more community development approach to health analysis than has hitherto been the case. The reason for this preference is complex, but is in part a reflection of the holistic nature of the definition of hauora (Māori health). There are links to culture, identity, social standing, historical events, and whakapapa. These ideas are central to Māori health research and should not be left to the periphery in the research process.

Over-riding many of these principles is also the central theme of mana Māori, where Māori control over knowledge is reclaimed. Tino rangatiratanga, Māori expression of self-determination, is therefore an important part of the research and therefore recurs as a theme in any analysis by either research participants or Māori researchers. The ultimate expression of this for Māori, is that researchers of Māori health should be Māori. Only then can the Māori derived ideas of the researchers and the emitic insights they bring, drive the research and protect rangatiratanga.

CHAPTER 2

Theorising the Wider Parameters of Māori Health

Introduction

The literature for this research is diverse, encompassing health reforms, Māori development and social policy. It also includes a rapidly growing body of literature on Māori conceptualisation of health and Māori epistemology and ontology. In particular the application of a Māori epistemology in education called Kaupapa theory is increasingly applied to health along with a more moderate Māori-centred approach. The review of literature in this chapter does not include specific discussion about public sector reforms, health policy, health status and the health reforms. These topics will be included in the following chapters. Rather it focuses more on the research process itself and therefore serves to provide the canvas for the rest of the painting created in this thesis.

This is not an exhaustive literature review because of the scope of the literature; however, this Chapter is intended to help theorise the policy chapters that follow. Further literature is presented in each of the Chapters and Chapter 6 covers more recent literature on socio-economic and cultural determinants of health.

The literature covered also includes a growing body of Māori material emerging particularly through Masters theses on important topics for Māori health. These include: the characteristics of Māori communities and primary health services; medical literature on Māori health status; debates within epidemiology on the place of poverty, socioeconomic status and culture; social science literature around concepts of ethnicity, race and class; and the discourse surrounding the rationale for and effects of social and economic policy changes in Aotearoa New Zealand from the mid-1980s.

Much of the thinking within the literature intersects, reflecting common concerns about the effects of neo-liberal policies on health outcomes, particularly amongst vulnerable populations, and the debates within medicine itself around the nature of health and health

care. There is also an attempt to grapple with the meaning of Hauora Māori. There is some overlap with the World Health Organisation definition of health as a state of complete emotional, physical, mental and social well-being rather than just the absence of disease. However an assumption of the research is that hauora includes broader social and economic principles and is not concerned solely with physical, mental or emotional well-being. This fits with much of the literature on socio-economic determinants.

Race, Ethnicity And Culture

The debate around race, ethnicity and culture is as important today in New Zealand as it was 100 years ago, and is furthermore of importance in discussing health policy because the tendency has been towards increasingly ethnic specific targeted services (Cheyne, O'Brien, & Belgrave, 1997, p 155). While notions of race may be discredited based on biological and other scientific grounds (Smaje, 1995), it continues to be operationalised as if race continued to be a valid basis for differentiating between groups of people (McKegg, 1995). Race is described as a “social construction that has a common sense meaning ... [and its] once accepted scientific status is now rejected by the biological services as inappropriate when classifying human groupings” (Spoonley, Macpherson, Pearson & Sedgwick, 1984, p 10). Such understandings were linked to the expansionist European colonial experience that sought to differentiate peoples according to phenotype. Inherently these definitions sought to highlight the differences between the superiority of one ‘race’ over another. New Zealand has struggled with these concepts since British colonisation in the nineteenth century. Te Poata-Smith explains.

This shift [from definitions based on biological criteria called race] primarily reflected the influential growth in national liberation struggles against Western imperialism, together with the international emergence of new social movements in the West from the late 1960s. These movements represented a fundamental rejection of old notions of biological determinism in favour of more liberating ideologies (Poata-Smith, 1997, p. 166).

Part of the refutation of such primordial notions of race relates to the scientific realisation that,

The amount of variation within a racial group is considerably greater than the average genetic difference between races. Clearly the genes responsible for the morphological features that allow us to classify individuals into broad racial groupings are atypical and extremely unrepresentative of the true degree of interracial genetic difference (Poata-Smith, 1997, p. 166).

Thus while Māori have moved away from a relatively meaningless biological definition (in scientific terms) to a more encompassing definition of ethnicity, many people *act* as though these historical notions of race were still valid (McKegg, 1995). Furthermore there are inherent tensions between the primordial and instrumentalist constructions of ethnicity, which limit our capacity to use both to explain the practice of ethnicity (Smaje, 1996a, pp 1-3). Ethnicity can best be described as 'essentially an identity that reflects the cultural experiences and feelings of a particular group (Spoonely, 1993, pp 36-37). To elaborate,

For an ethnic group to exist, there need to be cultural practices or beliefs that define it as different from other groups in society. [These are listed as] particular kin structures, diet, religious beliefs, rituals, language, dress, economic activities or political affiliation to the group (Spoonley, 1993, pp 36-37).

Ethnicity is therefore an intimate reflection of culture and is complex and dynamic in nature, and often self-defined. Ethnicity is not merely an expression of personal preference but rather an inherently political choice 'that tells Māori much about individuals' and groups' values and orientations towards the issues related to cultural politics' (Bell, 1996, pp 145-146).

Te Poata (1997) goes on to explain that,

The fact that real phenotypical difference has social 'effects' only when some social significance is attributed to that difference. Such approaches emphasise not the biological superiority of some 'races' to others, but the 'cultural' differences between 'ethnic' groups. Such 'cultural' or 'ethnic' explanations for Māori inequality tend to assume that identities are

primordial, that they originate in the unknowable past, and that they are relatively unchanging. In this way, ““Ethnicity” or “culture” is conceived as a fate from which those it embraces cannot escape. Although acknowledged as a product of (usually caricatured) history, it is no longer amenable to further change by human action: it has become effectively part of nature (Poata-Smith, 1997, p. 167).

A new racism has emerged (Spoonley, 1993) with rhetoric of cultural difference with its underlying belief that this form of racism is natural behaviour for human society.

Such arguments about the permanence of particular forms of human behaviour are extremely spurious. Indeed, a substantial amount of anthropological and cross-cultural evidence confirms, first, that what is considered ‘natural’ behaviour for human beings changes radically throughout history and, second, that individuals and/or collectivities ‘manipulate’ their ethnic identities to fit different social situations (Poata-Smith, 1997, p. 167).

Whanau, Hapū, Iwi

Whanau, hapū and iwi are considered the basis of Māori society, forming the social structures that encompass Māori social activity. The erosion of these social arrangements linked by common whakapapa, is thought to have greatly contributed to the erosion of Māori tikanga and society. These extended family structures are considered to be anathema to western industrial society’s valuing of the individual. This has repercussions for Māori health as Penney explains.

The western medical approach, being individualistic had little or no concern for the significance of whanau / hapū issues as they impacted on an individuals health. Whanaungatanga which has been identified as essential to health and well-being of Māori was largely disregarded by the health services ... The extended family is the group who support the individual through a crisis and families receive sustenance when they feel that they have an important contribution to make to the community they live in. However, the health care systems’ disregard of whanaungatanga to health, further set up cultural conflict for Māori - creating barriers to the

usual expression and demonstration of cultural practices (Penney, 1996, p 23).

While the erosion of both social structures and practices are an experience in common with all other colonised indigenous peoples, there is some dispute about the exact nature of these social arrangements in traditional Māori society. This discussion has become important because of the political support for iwi as the preferred channel for Māori development arising from government policy changes in the late 1980s and 1990s.

Iwi, hapū and whanau are often used together (so much so in this claim that Mr Boag, the Waitangi Tribunal's expert witness, described the expression as a 'mantra') in a way that suggests a hierarchy of descent groups, from a broad-based numerically strong iwi or tribe, made up of a number of hapū federated together, with the hapū, in turn, comprising a number of smaller but even closer-knit whanau or extended family groups. The conception that all these groups function in much the same way, but are found at different levels of the organisational hierarchy, (that hapū are sub-divisions of iwi, and whanau are sub-divisions of hapū) may be a Eurocentric view of Māori society, where power is seen to reside at the top with its exercise delegated to the people below. The Māori reality prior to European contact appears to have been quite different. It was the whanau and hapū that were the effective and autonomous units of Māori social and political organisation. This provided a person's primary source of security and identity, because members lived and acted together as a community. Rangatira signed the Treaty on behalf of hapū, not 'iwi' (Waitangi Tribunal, 1998, p 17).

There is considerable historical evidence of an increased homogenisation of iwi, suiting a government requirement for clarity in their dealings with Māori (Ballara, 1998). This left little room for the dynamic and pluralistic nature of iwi and hapū to be maintained. Western society demanded an identifiable entity that could be held legally accountable. As indicated previously, the notion of whanau, hapū and iwi as a fixed social structure belies the changing nature of Māori society.

The tendency of eighteenth-century hapū to organise themselves in communities often derived from the way they used their land and resources. There is a certain vagueness about hapū in the evidence of many nineteenth-century Native Land Court witnesses; this is often because they were being asked to put labels on a nebulous reality—the ownership in hapū terms of a specific and limited stretch of land ... scattered, independent colonies of descendants over a wide extent of country, interspersed with groups of descendants over a wide extent of country, interspersed with groups from other iwi and/or major hapū, were more common than otherwise (Ballara, 1998, p 194).

In Auckland and Northland there are major iwi groupings who are identified as having mana whenua. These claims were legitimised through a series of government agency decisions that gave preference to these iwi in service delivery contracts during the 1990s. A challenge to this de facto and actual policy was the basis of a challenge by Te Whanau O Waipareira who lodged a claim with the Waitangi Tribunal. These iwi claims are linked to the application of the 1840s rule (Kiro, 1997), which states that those hapū / iwi who had use of lands at 1840, are the legitimate owners of that land. This is to a large extent a Pakeha convenience that has been rigidly applied to settle Māori disputes. Some of these pre-date the Treaty of Waitangi. Given the prominence of iwi in the strategies pursued in health purchasing, it is worth considering some of the historical evidence and current political debate around the claims of iwi and other Māori organisations.

Most of this historical evidence stems from the eighteenth and nineteenth centuries, although whakapapa recounted by whanau and hapū, goes back to Io - the Māori supreme being. Belich (1996) identifies four kin zones in Northland by the nineteenth century.

Nga Puhi were quite cohesive genealogically and had up to 150 hapū but by the early nineteenth century they fell into three competing and co-operating hapū groups: western, or Hokianga, and northern and southern Bay of Islands. South of Nga Puhi, and linked to their western section, were Ngati Whatua. They are said to have come from the Far North, and their carving styles share more features with Aupouri than with Nga Puhi,

but they also had some links with Tainui. Perhaps as late as the eighteenth century, Ngati Whatua displaced the previous inhabitants of southern Northland and the Auckland isthmus, including the Kawerau and Waiohua peoples ... Ngati Whatua absorbed these groups as much by intermarriage as violence, and possibly acquired their own tribal identity in the process. They were a powerful tribe at the end of the eighteenth century, a match for Nga Puhi; though they shared modern-day Auckland with another tribe from further south: Ngati Paoa (Belich, 1996, p 92).

Belich observes that Ngati Whatua and the northern tribes also had 'associations outside the region, especially with Coromandel and, through it, with the East Coast' (Belich, 1996, p 92). Like the Nga Puhi federation in the North, Tainui spread - from Kawhia in the south to encompass Waikato, Ngati Raukawa (further south), and Ngati Paoa of Hauraki, along with their allied tribes. Again, the overlaps between tribes highlighted links between Tainui to Arawa in the south, Auckland in the north and Coromandel in the west (Belich, 1996, pp 92-93).

Thus the picture of tribal identity is complicated by a number of factors, including historical alliances, and contemporary Treaty settlements. Durie explains.

Nor should it be presumed that Māori are homogenous, even though they share many physical and cultural characteristics. Tribal identities and tribal management of resources remain vital for an understanding of contemporary Māori society. Some tribes, iwi, claim nation status for their tribe, insisting that attempts to describe Māori as if they were a single group are forced. Others are able to recognise the role and relevance of tribes but ascribe equal validity to a collective Māori identity or a single Māori nation. It should be pointed out that not all Māori have active links with any tribe, even though they may be able to demonstrate tribal descent and even have shared interests in Māori land. As urbanisation has escalated, issues relating to Māori who are alienated from tribes have assumed greater importance, especially in urban New Zealand, and they have been further highlighted by the search for a formula for the

distribution of assets such as those derived from Māori fishing quota (Durie, 1998b, p 5).

In particular, the claim by Te Whanau O Waipareira warrants discussion because of its significance in challenging government and Māori tribal views about the morality of channeling all Māori development through iwi agencies. These debates have become intensely political and have concentrated Māori attention over the past decade. Obviously such a discussion requires close attention to the Treaty of Waitangi which provides the constitutional framework for the discussion about relations between the Crown and Māori.

The Waitangi Tribunal report on Te Whanau O Waipareira's claim that 'the Crown's actions were 'significantly prejudicing Te Whanau O Waipareira's ability to implement the delivery of necessary Social Services Programmes to the West Auckland Community'' (Waitangi Tribunal, 1998, Appendix II, p 255). The claim specifically concerned the allegation that the Community Funding Agency (CFA)², had adopted a somewhat narrow definition of iwi and their Treaty obligations such that it prohibited the exercise of rangatiratanga by Māori organisations like Waipareira who are capable of exercising this rangatiratanga (Waitangi Tribunal, 1998). This claim is important because it lays responsibility on the Crown for a more expansive interpretation of the Treaty that includes recognising those Māori groups capable of contributing to Māori development. An evaluation of Puaote-Ata-tu³ suggests that strengthening Māori networks through the devolution of power and resources can encompass Māori organisations outside of that considered 'iwi'. The Waitangi Tribunal suggests a particular irony in Waipareira's claim against the CFA.

² The CFA is an arm of the Department of Social Welfare and is responsible for funding community organisations, 'allocating resources and support to community groups and organisations working in the area of social services delivery'. (DSW document quoted in Waitangi Tribunal Report, 1998, p 81)

³ Puaote-Ata-tu is the report of the Ministerial advisory committee that reviewed the Department of Social Welfare in 1986. It focused on the experience of Māori in the services and highlighted the need for a bicultural approach by strengthening traditional Māori structures.

At a time when the Government is beset with problems over who represents tribes, for the purpose of settling claims, Waipareira is one of the few districts where representation for a very large community has been resolved, but its status for the purposes of Treaty obligations is unrecongised. And while the Government has difficulties in determining an appropriate Māori face to deal with for negotiations, here the roles are reversed. Waipareira has settled coordination problems but is prejudiced by a lack of coordination amongst the many Crown agencies. The Crown has many faces, but Waipareira cannot find a single Crown face to deal comprehensively with its concerns (Waitangi Tribunal, 1998, p 227).

The significance of this report for this research is that it supports the view that there are 'many Māori faces' capable of delivering appropriate services to Māori, and that these faces deserve support by the Crown. In this respect, it supports Durie's contention of diverse Māori realities (Durie, 1995) and suggests that adherence to a dogmatic iwi-centric stance in respect of Māori social service delivery is ultimately acting against the spirit of the Treaty of Waitangi.

Te Mana Māori

Some of the arguments developed in this research suggest that Māori need to feel part of what is happening in our society in order to stay well. Alienation and feelings of worthlessness have serious costs for the whole of society and are an entirely predictable outcome of not seeing yourself as participating in society. For Māori the balance between material well being and spiritual well-being is essential. These ideas are best expressed through Māori concepts of mana, wehi and ihi. However, these terms remain cloaked in mystery. The terms mana, wehi and ihi relate to the authority, standing, essence of a person and their status in Māori society. Tapu refers to sacredness and aroha to affiliation, love and attachment.

The Williams Dictionary of the Māori Language (1975) is regarded as an authoritative translation of Māori, however, Māori terms are not easily translated and with multiple layers of meaning. Williams defines mana as, "authority, control" and "influence,

prestige, power” and a “psychic force”. Wehi is defined as, “be afraid” and “terrible”. Whakawehi means to “terrify” or alternatively, to “safeguard or protect”. Wehiwehi means “awe, regard”. Ihi is defined as, “power, authority, rank, essential force”. Ihi can also mean “terrify” when used as whakaihi.

Tapu is defined as “under religious or superstitious restriction”, or “beyond one’s power, inaccessible”, and “sacred”. Aroha is defined as, “love, yearning”, “pity, compassion”, “affectionate regard” and to “feel love or pity” and “show approval”.

Durie describes a multi-axial framework for Te Hoe Nuku Roa⁴ including “four interacting dimensions - paihere tangata (human relationships), te ao Māori (Māori culture and identity), nga ahuatanga noho-a-tangata (socio-economic circumstances), nga whakanekeneketanga (change over time) (Durie, 1998a, p 57). While this framework is not designed explicitly for Māori health, it incorporates key aspects associated with Māori well-being that are useful when thinking about hauora Māori.

A part of being healthy also involves participating in cultural practices. For example, Ta Henare Tate explains why Māori return to their ancestral homes for tangihanga.

I liken it to kawai kumara (the runners of the kumara) coming back to te putake (the tap root). Cut off from the root, the runner shrivels. It can only take in food by joining itself at the root (Tate, *The unseen world*, New Zealand Geographic, 1996).

He goes on to observe that:

In traditional Māori terms, ignoring the principles of tapu is the same as declaring spiritual suicide. Yet a society that favours material over spiritual values has systematically violated and belittled these beliefs, labeling them superstitions and relics of paganism, and declaring them to be of no importance in the modern world. The reality is this; a failure to address tapu is a failure to grow. Your mana remains stunted, moments of

⁴ A longitudinal study of Māori whanau based at Massey University

achievement slip through your fingers and your life journey becomes frustrating ... The relationship between mana and tapu can be compared to the workings of an artesian well. The water source deep underground is like tapu; the gushing of water up through the bore and on to a thirsty land is like mana. Failure to address tapu drives the water back down the bore, and the land dries up ... There are three ways of addressing tapu: through tika (justice), pono (integrity, or faithfulness to tika) and aroha (love). By continually striving to act with tika, pono and aroha in day-to-day life, tapu flourishes and mana radiates outward like the ripples of a stone dropped into a pond (Tate, The unseen world, New Zealand Geographic, 1996).

The reform process has attempted to reinterpret these traditional Māori values and express them within Māori healthcare providers. This practice has been termed Kaupapa Māori and is discussed later in this thesis.

Does Class Or Ethnicity Matter?

To some extent the answer to this question rests on our understanding of ethnicity and its interaction with culture as a more accurate description of those attributes which distinguish groups of people. Many researchers have argued for the more accurate use of ethnicity and have discussed a possible relationship between ethnicity and class with respect to health (Davis, 1984; Smaje, 1995; Spencer, 1996).

The interaction between ethnicity and class is gathering interest, largely because of the work being done on socio-economic status and health. Evidence that Māori are disproportionately represented in low socio-economic groups is overwhelming (National Health Committee, 1998; Te Puni Kokiri, 1998). This coincides with evidence of increasing disparity between Māori and non-Māori following major macro-economic shifts in New Zealand from the mid-1980s (Statistics New Zealand, 1998; Statistics New Zealand, 1999; Te Puni Kokiri, 1998).

One of the difficulties in health research has been the confusion of biological definitions of race that are scientifically discredited and social categories such as culture. The debate around race and ethnicity has been discussed earlier, what matters in this discussion is the relationship between race and socio-economic status or class. These terms are not necessarily inter-changeable, but for the purposes of this discussion are those features that ensure relative material deprivation within a particular society.

Class is an important concept because of its Marxist roots. In a globalised market economy, Marxist ideas have gained a new currency in explaining the effects of an unequal relationship in respect of sharing the benefits of this relationship between ownership of capital and provision of labour. Smaje (1996b) explains.

Marxist theory has persuasively described the way in which class differentiation surreptitiously reproduces social and material inequalities, and several theorists have suggested that ethnic categories are essentially class fractions serving the interests of capital ... while ethnic groups often act *like* classes in service of economic demands there is nothing in this observations which tells us why it is the *particular* significations associated with extant ethnic categories which inevitably result from the logic of class differentiation, rather than other kinds of difference. Moreover, while strongly class determinist theories of ethnicity avoid the essentialism of primordial theories which treat ethnicity as a social category *sui generis*, the explanatory totality of an essential 'ethnic sentiment' is merely displaced by one relating to a particular economic relation. In this way, the fertile possibilities of materialism for theorising ethnicity as practice are narrowed into a reductionism of ethnicity to class (Smaje, 1996a, p 3).

Thus Smaje is arguing that it is not possible to reduce ethnicity to a de facto class, in part because ethnicity is reliant on the specificity of its form and meaning (Smaje, 1996b, p 3). Despite these and other reservations, there are associations between ethnicity and social class obvious in the socio-economic determinants literature emerging in New Zealand and internationally.

Davis explains the interaction between ethnicity and class.

There is no straight forward interpretation of the effects on mortality of the interaction of social class, ethnicity and the forces of social and economic development in New Zealand. To some extent it might be tempting to interpret these results as supporting a cultural life-style interpretation of differential mortality. That is, one could look to diet, self-care, smoking, drinking and other aspects of life-style to account for the Māori disadvantage and also to explain the social class gradients in the 'disorders of affluence'. Yet it is also clear that racial and social class differences in life-style are not independent of material condition (eg. poorer diet, excessive drinking and smoking may just as plausibly explained by stress and deprivation as by cultural difference). Nor can it be assumed that the recorded ethnic group differences are fundamentally cultural in nature and hence relatively unconditioned by inequality of circumstance; e.g. both unemployment and inequalities of access to health care are greater for Māoris and Pacific Islanders than would be predicted from knowledge of their class position alone (Davis, 1984).

Interestingly Davis found that socio-economic determinants accounted for 20% of health outcomes, and ethnicity for 80% (Pearce, Davis, Smith, & Foster, 1984, p 32). This may well be changing with increasing gaps in equality that may shift the balance between these two structural features.

There is a view reflected in Māori patterns of smoking and risk-taking behaviourbehaviour, which would suggest that the greater influence is socio-economic circumstance, not culture on precipitating this behaviourbehaviour. However, it cannot be explained as one or the other, but rather the multiplying effect of ethnicity and socio-economic status that mutually reinforces disadvantage and lends to this type of behaviourbehaviour. Culture is a potentially contributory factor, particularly as it is relied upon increasingly to define our difference from others or to separate our various common identities. As Spencer (1996) points out, culture is itself dynamic and will often

incorporate elements of the dominant culture, while also influencing that dominant culture in subtle ways.

We do not currently know the extent to which socio-economic factors and factors related to ethnicity contribute to illness, however the evidence does suggest that,

Poverty and discrimination (the so-called double jeopardy) experienced by most ethnic minority groups accounts for the greater part of the differences (Spencer, 1996, p 141).

Work done on aetiology suggests a relationship between compromised immune systems brought on by stress and a history of inequality caused by discrimination, unequal opportunity and deprivation. Furthermore, a developing body of literature on the effects of inequality suggests that this can have an effect not only between similar social groups but also within social groups where a hierarchy exists (such as Marmot's Whitehall research in the UK (Marmot, 1995)). These ideas become more important when considering increasing inequality as a result of macroeconomic and public policy shifts with Aotearoa New Zealand.

Theories Of Health

Health is a complex matter. The way Māori think about health is a reflection of the way in which Māori have come to conceptualise it, therefore determining the kind of research questions and treatment options Māori identify.

Our health system has evolved into an equally complex matter. There is no doubt that our health system is based on the dominance of medical approaches to diagnosis and treatment. Medicine is based on western scientific principles and is primarily concerned with physiological explanations of illness. Treatments therefore are either physical or chemical in nature, both affecting the biophysical nature of our self. It is also premised on individual cases (Krieger, 1994).

In the late twentieth century, health is primarily thought of in two ways, as a genetic pre-disposition and as an outcome of lifestyle. For example, Māori genetic pre-disposition is

reflected in the argument that Māori were susceptible to certain types of illness, such as influenza, because of their lack of immunity to certain illnesses on contact with Europeans. Māori illness has also been attributed to a substantially changed lifestyle with a high intake of processed foods leading to illnesses such as diabetes. This is contrasted with traditional foods such as watercress, puhā, ika, kai moana and kumara. The following simplistic schema summarises the major explanations for Māori illness in relation to non-Māori.

Table 4 Contemporary Ways of Conceptualising Māori Health

<p><u>Biological</u></p> <p>Illness & premature death arises from physically located problems related to germs or genes. These emphasis vectors for infections, toxic physical conditions or physiological pre-disposition to certain ailments. Does not exclude one explanation from others (as with the following explanations, they can be understood in tandem, although there is a tendency for one type of explanation to dominate).</p>
<p><u>Behaviour Behaviourism</u></p> <p>Māori engage in high risk behaviour behaviours which lead to poorer health status such as smoking, drinking and driving, domestic violence against women and children, homicide and vehicle crashes. Health outcomes such as life expectancy or rates of illness are linked to lifestyle approaches that dominate current public health advice. Behaviour Behaviour is linked to cultural norms, class and educational values that are important variables for determining health outcomes.</p>
<p><u>Structuralism</u></p> <p>Māori are the victims of institutionalised racism. This racism affects their social position within society and their ability to participate in society positively. Māori are discriminated against and their poorer social status determines their health status. The socio-economic determinants arguments come from this school</p>
<p><u>Psychological and Physiological Maladaption</u></p>

Māori are physiologically ill prepared for the modern world. Psychologically they are ill prepared for the isolation, stress and pace of modern society and their cultural values are at odds with expected norms of behaviour, leading them to respond inappropriately to certain triggers.

Culturalism

Māori culture sets them apart from dominant Western European culture. The inability to access cultural resources (such as reo, marae, hapū / iwi, tikanga), results in Māori who are alienated from society. Their identity is weakened and they are in conflict with the world they live in.

Lifestyle approaches have dominated public health approaches in the last few decades. This can be seen most clearly with concerns about how diet and exercise and particular practices such as lying your baby on its back to protect against SIDS, can avoid the 'risk' of certain illnesses.

Underlying both of these lifestyle approaches assume a series of individualised responses. While avoiding the earlier pitfalls of talking about 'race', there are underlying ideas about genetic superiority and susceptibility (immunity) built into these explanations and expectations about behaviour. For example there is little questioning of the underlying normative ideas and how these are made. For example SIDS education promotes babies sleeping in their own beds on their backs or sides. This may be at odds with shared sleeping practices of Māori perpetuated at marae hui. Another example would be teenage pregnancy. While Māori retain younger fertility patterns for childbearing, the Pakeha population has shifted to a later childbearing pattern (Shirley, Koopman-Boyden, Pool, & John, 1997). These changes in fertility patterns now identify Māori fertility patterns as 'dysfunctional' since they are no longer congruent with dominant fertility patterns. Such views betray a strongly normative interpretation of what constitutes healthy childrearing, rather than any biological imperative.

Recently there has been a renewed interest in the effects of social inequality on health. The Black Report (1982) provided a blistering critique of the effects of social phenomena on health outcomes in the United Kingdom. It was preceded by work such as Susser and Watson (1971) who attempted to identify the connections between the economy, population and health in the United States. During the 1990s, work done by Benzeval, Judge and Whitehead (1995), Wilkinson (1996), Kawachi (2000) and Spencer (1996) on the way in which inequality in society has a profound effect on the health status of populations, has added more evidence to these earlier arguments. Each individual within a particular society may have a health status that may be better or worse than that of the total population. It is the pattern of illness that is of interest here.

The argument can be summarised as the greater the inequality within a particular society, the poorer the overall health status of the population (Wilkinson, 1996). Health is therefore the product of more than the aggregation of individual cases and therefore necessitates a more ecological analysis than is currently offered in conventional medicine (Krieger, 1994).

This argument may contradict the neo-liberal policy agenda of the last two decades. These policies promote income polarisation as an inevitable consequence of meritorious society where individual effort is rewarded, with incentives to achieve, produce more and take greater risks. The greater the effort and risk (so the ideology goes), the greater the returns one can expect. Those who are not wealthy are believed to be so because they have not taken the risk, worked hard enough or had a bright idea at the right time. Irrespective of this ideology in economics, the health evidence seems to suggest that there are negative health consequences from pursuing such policies.

Preventative Medicine

Rose argues in his seminal work, "The Strategy of Preventive Medicine", for the adoption of a more population based approach to medicine, which better reflects the contribution of medicine, while recognising its shortcomings in the treatment of illnesses. He outlines a number of dilemmas, which affect health, not least the tendency for medical

practitioners to view the treatment of disease in individuals as the foundation of their vocation.

Rose effectively questions the nature of disease by pointing out the disparity between the biological processes of identifiable disease and management of disease, which requires much higher levels of certainty than medicine can really offer. This tendency to see disease as yes / no, rather than as the continuum which most diseases fall on (Rose, 1992, p 11), has massive repercussions for treatment and for the way in which the public perceive health.

His argument is that the application of population based approaches in respect of many diseases would deliver greater benefits across the whole population where the aetiology indicates it, rather than merely relying on a high risk individual strategy. However such a shift requires a fundamental shift in the 'ethos and organization of medical care' (Rose, 1992, p 43). Essentially, the total burden of illness across the whole population may be greater with common, low level ailments rather than the traumatic, life threatening conditions which tend to preoccupy the resources of our health system (Rose, 1992, pp 22-27).

Rose highlights the treatment paradox of a population based approach which is that, "a preventive measure that brings large benefits to the community offers little to each participating individual" (Rose, 1992, p 12).

Despite this shortcoming this seems beneficial and yet has received much less attention than the high-risk strategy in which 'efforts are focused on those individuals who are judged mostly likely to develop disease. This avoids the wastefulness of the mass approach" (Rose, 1992, p 13). Such advice would suggest that, for example, diabetes educational programmes should be targeted at those most likely to develop the disease, rather than a mass approach. Thus it may be wiser to invest in educational programmes that target Pacific Island and Māori populations who are more susceptible to factors that precipitate diabetes.

Scientific methods, particularly those relying on case-control studies, which have the most legitimacy with medical research, have major shortcomings because of the need for statistical size and power and the shaping of hypotheses. Rose argues that,

Preventive medicine, like the rest of medicine, should be as scientific as possible, but we should not expect to find more than a few islands of firm ground, and for the rest we must learn to live with uncertainty and to be satisfied with best judgements. Most decisions on health policy are provisional, and they are subject to review in the light of experience and new ideas (Rose, 1992, p 28).

Yet, policy analysts and politicians and medical practitioners manage ill health as if there were certainty. Māori know that health policy reflects the best knowledge available at the time, and that the public wants clear advice from public health advisors. Yet it is not always possible to give such definitive advice. Rather this advice is a reflection of what is known at the time and other variables such as values and cost.

Rose sets out the criteria for adopting a population based approach, despite recognising that 'Illness is a personal not a collective event' (Rose, 1992, p 29). Doctors' 'subsequent professional ethos will be founded on accepting the responsibility for patients. Indeed, in some specialties this individual-centred approach is so dominant as to exclude almost completely any other view of health problems' (Rose, 1992, p 29). Thus prioritising concern 'for action at the level of needy individuals' (Rose, 1992, p 29) drives clinical definitions of need and shapes professional obligations amongst medical practitioners.

Furthermore, he argues that, 'politicians and governments favour action confined to a needy minority rather than any recognition that health could reflect national or social policies. They argue that individuals, with support from their doctors, should be held responsible for their own health. Thus among doctors, public, and governments alike the natural focus for preventive medicine is action for individuals' (Rose, 1992, p 29).

Advocates such as Spencer and Wilkinson have promoted this link between social policy and health. An article in the GP Weekly stated,

Social policy is the main influence in poverty and child health ... you can't escape from the influence of social policy on health. It does appear that social policies that attempt to overcome differences in terms of access to food and access to health services are probably ones that are to be, in the end, beneficial as far as children are concerned' (Wright, 1997).

Spencer goes on to make an argument explored by Wilkinson that poverty and income disparity, have profound health outcomes.

If you take as a measure of poverty those people who earn less than 50 percent of average income, that has increased very rapidly in Britain over the last 20 years. And whereas the income of the top 10 percent has increased 60 percent, the income of the bottom 10 percent has gone down 30 percent in real terms over that period (Spencer, 1996).

He compares some developed countries with undeveloped ones, arguing that undeveloped countries can sometimes 'buck the trend' of greater burden of ill health where certain qualities are in place such as,

Political and social will to tackle the problems; relatively equitable income distribution; equitable distribution, throughout rural and urban areas, of public health and primary health measures; education for all, with high levels of female literacy; and nutrition programmes (Spencer, 1996).

Spencer identifies vastly different explanations for the kind of disparities in SIDS and mean birth weight in babies; one which sees there is a,

Culture of poverty and the poor people smoke more and have more unhealthy lifestyles... By contrast, the structural school says it is a function of the structural inequalities of society which make it harder for one group to be healthy compared with another ... He says those who suggest you should try and change the behaviour actually tend to minimise the complexities and ignore the uncomfortable evidence (Spencer, 1996).

This trend can also be seen in New Zealand. Income polarisation is, it seems, an inevitable consequence of trade liberalisation, multi-national investments and new right social policy agendas (Hazeldine, 1998; Jesson, 1999). This raises a question about the degree to which economic gains for New Zealand populations, and Māori in particular, cancel out the negative costs of high unemployment and decreasing real incomes for most families. It also raises questions about the long-term consequences of such policies.

Māori are a vulnerable population and therefore are most susceptible to market vagaries (Kiro, 1998b). Again, there are implications for the health of these populations.

Society exists as an entity and not only as a collection of individuals or families. Each society has its own distinctive collective characteristics, including many that influence health. These social risk factors may change, and when they do so, their distributions tend to shift as a whole, reflecting the coherent nature of society (Rose, 1992, p 95).

Categorising health services as personal or public health has been a convenience and suggests an orientation and underlying philosophies that are substantially different. To a large extent those working on a public health approach have been more concerned with the big picture, including the impact of public policy on health and population based analyses of health. Personal health has been the major focus of health services in Aotearoa New Zealand and this is reflected in both the funding and practice orientation of health professionals.

If Māori begin from a perspective of population and historical analysis Māori look to answer vastly different questions than those that are concerned with individual behaviour. Wilkinson argues that looking at health from the standpoint of society rather than of individuals can lead to a radically different view of the determinants of health (Wilkinson, 1996).

A challenge is therefore before us. How can Māori ensure that Māori have greater control over our own health, prescribed not just by the obligations of following the Treaty of Waitangi, but also indicated by the international research on health? Such an approach

requires that non-Māori continue to face their responsibilities in respect of the historical antecedents of Māori illness, and requires support for an integrated public policy approach which acknowledges the inter-dependence of the whole. As Benzeval, Judge and Whitehead explain,

The international evidence on inequalities is compelling. People who live in disadvantaged circumstances have more illness, greater distress, more disability and shorter lives than those who are more affluent. Such injustice could be prevented, but this requires political will (Benzeval, Judge, & Whitehead, 1995).

Susser and Watson proposed a related argument in 1971 that,

In many disorders, the occupation and social circumstances of the victim are important in the onset and diagnosis of the disease as well as in determining the chances of successful treatment (Susser & Watson, 1971, p vii).

Collective Versus Individual Interests

The dominance of the economic rationalist discourse in social policy in Aotearoa New Zealand from the mid-1980s has highlighted a debate about collective versus individual interests. An idealised 'homo economicus' assumes the rational pursuit of economic maximum utility by the individual raises serious questions about how New Zealanders should behave towards each other in respect of 'public good' activities such as health care provision (Hazeldine, 1998; Jesson, 1999).

This view of homo economicus was expressed in public policy as a public-choice ideal. Cheyne et al (1997) explain.

The application of public-choice theory and monetarism has characterised public sector reforms in New Zealand since 1984. The key outcomes of the neo-liberal critique of the welfare state have been: a reduction in the role of the state in the provision of services, emphasising private rather than public provision of services; the development of contractual arrangements between the state and service providers; and the separation

of the funding and provision of services through the development of what has been called 'quasi-markets' (Cheyne et al., 1997, p 85).

These authors go on to identify social services and health, as examples of these 'quasi-markets' proposed by Le Grand and Bartlett (1993). Competition inherent in these 'quasi-markets', serves to encourage efficiency and responsiveness amongst these providers. To explain further;

The libertarian critique of government is what is called 'public choice theory'. Public choice theorists begin with the assumption that the behaviour of political actors (voters, pressure groups, bureaucrats, and politicians) is dominated by self-interest. The impact of this in the public sector is that politicians seek to maximise votes. Bureaucrats strive to expand the size of their organisation because it is through having more staff that they will receive larger budgets. Ideas of 'public good' and 'social justice' as the basis for action are rejected. Because the costs of state actions do not affect politicians and bureaucrats directly, they have no incentive to use resources efficiently and profitably. In this process, interest groups seek to influence government decisions. Public-choice theorists argue that this increase in the size of government caused or at least aggravated the 1980s economic recession because publicly provided services consume an excessive portion of a country's resources. Cutbacks in public expenditure and retrenchment of public services are, therefore, required. In particular, public-choice theorists oppose this expansion of the state because they fundamentally question the pluralist concept of a neutral state, which acts 'in the public interest' (Cheyne et al., 1997, p 86).

The public policy debate also serves to highlight inherent tensions in the collectivist values promulgated by Māori society and the self-interested behaviour of political elites. It inevitably raises questions about the value of public health approaches that are premised on notions of public good and a counterpoint, individual responsibility that has come to dominate political discourse internationally and in New Zealand (Beaglehole & Bonita, 1997).

Public Health And Population Approaches

Public health advocacy has often intersected with political interests by challenging those things in peoples' lives that affect or create illness. Public health 'issues' have changed over time according to a complex mosaic of patterns of illness, lifestyle, environment and social conditions. In their 1997 book, Beaglehole and Bonita make this point in stating that last century, public health was about drainage, sewerage and sanitation. Following this, infectious disease epidemiology and prevention dominated the field. Now non-communicable disease studies and molecular epidemiology dominate as explanations (Beaglehole & Bonita, 1997).

Beaglehole and Bonita challenge their colleagues to take a broader view of the threats to human health since many practitioners are too narrowly focused on disease eradication and on medical studies, which ignore the social and global origins of disease. They exhort their profession to consider the bigger issues that impact on health such as war, poverty and global environmental problems. To do this, today's public health students are more likely to be guided by economists, social scientists and policy experts than by physicians (Beaglehole & Bonita, 1997).

Public health and population-based approaches to health care are of considerable importance to Māori because they are vulnerable populations and are net beneficiaries of approaches which emphasise 'public good' and universalism (Kiro, 1998b). Social and economic policies which lead to increased unemployment, lower home ownership and increased rents and families under stress, cannot be considered as contributing to healthy outcomes for Māori. There is considerable evidence that the result of the reforms from 1984 have had these effects for Māori (Durie, 1998b; Statistics New Zealand, 1998; Te Puni Kokiri, 1998; Williams, Frater, & Stephens, 1999).

These approaches often reflect a wider social consciousness, in addition to being aligned to illness prevention strategies. Public health literature also reinforces holism and recognises the interaction of lived social experience and health outcomes, in ways which a more reductionist medical approach does not. All of these make the approaches more

consistent with traditional Māori values and also maximises their beneficial effects for Māori. How this happens is proposed in the discussion in the first few chapters.

One of the ideas developed in this research is that Māori patterns of morbidity and mortality follow (for most diseases) roughly the same pattern as that of non-Māori. The reason for this may be related to the fact that Māori are also members of this society, and while Māori share distinctive characteristics, Māori also benefit from improvements within the rest of society. Similarly, declines in well-being amongst Māori have implications and effects for the rest of society. It is not possible to isolate Māori interests without imposing greater damage on a group already experiencing social exclusion. The dilemma in this argument about Māori interests being tied to that of the rest of the population, poses an additional dilemma for Māori since mainstream Pakeha interests may cut across Māori desire for tino rangatiratanga. Rangatiratanga can only be expressed within the New Zealand political body as a separatist experience for Māori given the rejection by Pakeha New Zealand for the exercise of Māori authority in ways that affect them.

These critiques on the nature of health and benefits of medicine emerge from a growing body of literature, which to varying degrees questions the sanctity of medicine as the repository of knowledge on health. Critics do not reject the usefulness of medicine but suggest a more moderated consideration of its benefits and limitations. The attraction of a dichotomous approach to health, which sees people as either sick or healthy (Rose, 1992), may well be due in part to the difficulty of managing causes for illness which are multi-factorial and are political, as much as the requirement for scientific rigor. This literature suggests that there are major benefits from adopting a more expansive approach to health, which is consistent with Māori holism (Durie, 1998c).

Preventive medicine seeks to,

Reduce the number of sick individuals, who form a clearly definable minority; by implication the majority of the population is normal and should therefore be left in peace. This approach rests on the traditional

principle of medical diagnosis, which assumes that, with respect to each disease, the world falls into two classes, namely those who have it and those who do not (Rose, 1992, p6).

Furthermore, “There is no known biological reason why every population should not be as healthy as the best” (Rose, 1992, p 1). The tendency of medicine to see health and illness as dichotomous is extremely problematic for most conditions. Again, as Rose points out, “Disease truly forms a continuum of severity, but its management requires a system of unambiguous labels” (Rose, 1992, p 10).

Another key influence in this argument is that developed by Wilkinson in his book, *Unhealthy Societies*, (1996) where he suggests that health is more affected by social cohesion than the traditional risk factors studied by medical researchers. This would suggest that the increasing gap between rich and poor in developed societies is a significant indicator of who will be well, and who will be ill in any given society, “Society tells us about health, and learning about health tells us about society” (Wilkinson, 1996, p 15).

Durkheim’s view that society is more than the sum of individuals within it is borne out in Wilkinson’s thesis that the only accurate explanation of the health evidence is that the way in which social relations are structured affect our health outcomes. Other well known research on the effects of social relations and inequality on health outcomes can be found in the work of Marmot, amongst others. Wilkinson concluded that when, “Looking at health from the standpoint of society rather than of individuals can lead to a radically different view of the determinants of health” (Wilkinson, 1996).

The implications for Māori of this thinking are developed in subsequent Chapters in the analysis of social policy, critique of the health reforms and discussion of the evidence emerging amongst Māori providers about health services and Māori health gains.

The main assumption made in this thesis is that this more structuralist approach to health is more suited to addressing the underlying causes of the disproportionate burden of illness in the Māori population.

Epidemiology

Epidemiology is the science of public health, identifying patterns of association and causation for diseases amongst populations. This may include identifying disease pathways. A debate is occurring between those who see epidemiology as seduced by the “scientific arcana of disease causation” at the expense of public health, or “physician-scientist role to society” (Rothman, Adami, & Trichopoulos, 1998, p 810). This criticism refers to the tendency for epidemiologists to become more consumed with the minutiae of scientific investigation rather than on the factors that prevent the occurrence of these phenomena, such as upstream features like poverty. As Pearce (1996) argues, epidemiologists prefer to study, “decontextualised individual risk factors” rather than the causes of health problems. He identifies the danger of ignoring the historical and social context as,

Attempting to eliminate the influence of other causes of diseases - in an attempt to control confounding- [which] strips away the essential historical and social context (Pearce, 1996).

This debate within epidemiology is seminal to this research because of the underlying assumption that what affects the health of Māori lies more outside the gambit of the health sector than within it. A threshold may well exist which means that those beyond a certain level of income (relative to others within society at that time) can make choices and deal with factors that influence their health, in particular, those related to lifestyle, environmental factors or stress.

In his 1995 publication on Humane Medicine, Miles Little suggests that in the fact of uncertainty and expectation, reality diverges when looking at what it is doctors do, and what it is patients expect them to do. These ideas are heretical to medicine. As Wulff et al suggest,

What is at stake is the medical profession's investment in the biopositivist model. Since the days of Claude Bernard, medicine has been seen increasingly in realist, materialist and reductionist terms, and the scientific component of medicine has steadily grown at the expense of the hermeneutic component from which medicine presumably originated (Wulff, Pederson, & Rosenberg, 1990, p56).

It is interesting to note that this question continues to be raised despite the move to a more empirical basis through evidence based medicine. This literature review has identified a small number of those who believe that social medicine (including traditional public health exponents) provides a more lasting and profound solution than addressing strategies to individual risk management of increasingly niche-oriented medicine.

The advent of critical methods and the evolution of schools of physiology and pathology put the epistemological foundation of medicine on a new base (Canguilhem, 1988, p 57).

The biopositivist model's success has led to the communication difficulty perceived by patients (and some doctors).

Success with reductionism and objectivism has emphasised the primacy of the British empiricist philosophical tradition within medicine ... The Mannheim and Frankfurt traditions of German philosophy, however have continued to develop the hermeneutic direction initiated by Heidegger (Susser & Watson, 1971, p 58).

Habermas has extended this concept by using 'ideology' as a central concept in analysing the process of communication. Ideologies are sets of beliefs and theories that societal groups use to communicate amongst themselves and to cement existing power relationships.

Medical schools are attempting to introduce a more humanistic approach into their courses and improve communication skills.

It remains to be seen whether these moves will improve the communication skills of medical graduates or change the orientation of

medical research away from its present reductionist objective toward outcome investigations which relate more directly to societal needs, or whether established authority will preserve the status quo (Susser & Watson, 1971).

How Do Māori Explain Health?

Modern, western conceptions of health spring from the early Greek and French philosophers. Descartes and the separation of mind and body proved too great a challenge to the ancient Greek holistic tradition. Within Polynesian society there remained intact a corpus of knowledge and skill which was passed on within tribes, including supernatural explanations of illness.

Modern medicine is a relatively new phenomenon and is premised on the positivist, empirical tradition of western science. This tradition has been criticised by a number of scholars, including those promoting Kaupapa Māori Theory. Others view the empiricist tradition as a welcome addition to another box of tricks in understanding, diagnosing and treating Māori illnesses. Clearly the focus of medicine has become the relationship between individual sick patients and doctors who intervene through chemical alterations, physical interventions (surgical procedures) or behaviourbehavioural adjustments to lifestyle.

The following chapters evaluate these approaches with respect to their underlying assumptions and their application to Māori health, as part of building a picture of health, which is not located within one tradition and does not see the location of illness as the definition of health. These critiques include major orientations in explaining the nature of illness and disease; namely, biomedical orientations, including genetic pre-disposition, life-style and behavioural explanations and lastly the structuralist arguments emerging in socio-economic determinants literature.

These different ways of conceptualising health are not independent in thought from the rest of what is happening in society. As Spencer points out,

This aetiological debate, itself not new, has far-reaching health and social policy implications. If poverty is no longer seen as a major health determinant and health inequalities are thought to arise as a consequence of unhealthy patterns of individual behaviour, then financially hard-pressed governments have a justified argument for the further reduction of social support and welfare programmes, and primary preventive strategies would be more concerned with changing individual behaviour than with social and environmental change (Spencer, 1996, p xi).

Socioeconomic Determinants Of Health

The examination of the extent to which there are social and economic determinants of health is a relatively new phenomena, but offers much promise as a way of expanding our understanding about the link between social policy and health outcomes.

It is no accident that this approach occurs at a time when there is a growing pre-occupation with genetic explanations of health where everything to do with health is reduced to the level of microscopic explanation. While socio-economic determinants explanations of health tend to deal with the societal level, it is not mutually exclusive of genetic or other explanations of health.

Research on socio-economic determinants in New Zealand, such as Howden-Chapman, Cram (1997), Jackson (1998) and National Health Committee (1998), show that our social and economic and cultural environment are important determinants of Māori health. They suggest that broader societal trends than individual behaviour affect our health outcomes. In particular, the importance of work, income, housing, education and the interaction of these various components is key to understanding likely health outcomes. The evolving work of Wilkinson (1996), Beaglehole and Bonita (1997), Pearce (1996), Davis (1984) and Spencer (1996) also suggest links between the wider social experiences of people and their health outcomes.

Such research provides supporting evidence for the view that the disparity between Māori and non-Māori is likely to be deleterious to Māori health. This is an important proviso

given the recent increases in inequality within New Zealand (Chatterjee & Podder, 1998; Easton, 1997b; Statistics New Zealand, 1998). Improvements are related to socio-economic and social position and how one has been affected by the subsequent and massive social and economic reforms which have gripped Aotearoa New Zealand since 1984, but in particular since 1990.

There is also a growing interest in the way in which culture positively affects health, for example the longitudinal research of Te Hoe Nuku Roa at Massey University and National Health Committee Report (1998). Culture here is conceived of as different to socio-economic factors. It is a reflection of tikanga, te reo and those concepts discussed earlier in the chapter, as a means of achieving hauora. This will be discussed more fully in the rest of the thesis.

Conclusion

The way that Māori conceptualise health is important because Māori have distinctive cultural characteristics that can only be understood fully within the context of that culture. This inevitably influences the research question, process and interpretation of findings. Importantly however, it shapes the way that knowledge is constructed and applied during research.

Māori challenges to positivism arise from their history of exclusion in such processes and knowledge and the difficulty in affirming knowledge that comes from a different tradition. An emerging tradition of ideas in social epidemiology suggests a possibility for a marriage of useful ideas between Māori and medicine, because it highlights the ecological basis of illness and wellness without decontextualising the experience of populations within it. The analysis of the population is understood within this tradition as emerging from the social context of behaviour, a contextual multilevel analysis and developmental life-course perspective which contribute to understanding the relations between and within populations (Berkman & Kawachi, 2000; Kawachi et al., 2000). Such explanations are necessary to answer the question about why some individuals get sick and others do not.

The literature reveals growing support for structuralist explanations of health, particularly when considering why it is that some populations experience very different health outcomes to other populations. These differences suggest that it is the relative experience of populations within society that matter in terms of health outcomes. If this is true, then any analysis of health needs also to analyse the social milieu within which these populations live. Public policy is part of the force that shapes this social milieu.

CHAPTER 3

Public Policy Reforms: Welfare State to Market Economy

Introduction

Since 1984 New Zealand has undergone massive economic and social changes designed to spur economic growth and individual responsibility among other things. These changes have become known as the 'reforms' and they substantially changed the basis of the relationship between government (the state) and the public (Cheyne, 1997; Williams, 1999; Boston, 1999; Easton, 1997; Kelsey, 1993). In particular, neo-liberalism came to dominate policy thinking in government and was enacted in a series of public policy changes affecting the New Zealand economy, social services and lives of individual New Zealanders (Boston, Dalziel, & John, 1999; Cheyne et al., 1997; Easton, 1997a; Kelsey, 1993).

As a result of policy changes to the labour market, income, housing, education and health, New Zealand society changed significantly (Boston et al., 1999; Cheyne et al., 1997; Easton, 1997a). These changes have been especially accentuated for Māori because of our position of economic and cultural vulnerability (Kiro, 1998b). While neo-liberal economic and social policies posed new opportunities for Māori, such as in the provision of health services, the policy changes affected Māori detrimentally as a population (Brown, 1999; Kiro, 1998b; Statistics New Zealand, 1999; Te Puni Kokiri, 1998; Williams et al., 1999).

There is growing empirical and qualitative evidence to support the view that these macro and micro-policy shifts by government have had a profound effect on the health of populations (Macdonald, Pearce, Salter, & Smith, 1982; Wilkinson, 1996; Woodward, 1996). In particular, there are serious questions arising from empirical data on the effects of these economic and social reforms on the well-being of Māori across a range of indicators such as income, labour market participation, housing, education and health. In particular, it appears that inequality within society leads to predictable detrimental health

outcomes (Benzeval et al., 1995; Brown, 1999; Davis, 1998; Howden-Chapman & Cram, 1998; National Health Committee, 1998; Wilkinson, 1996; Williams et al., 1999; Woodward, 1996).

The marriage of macro and micro-policy effects with a more specific health sector analysis allows Māori to examine the overall impact of the health reforms in Auckland on Māori, within a more contextualised framework consistent with an ecological approach. This approach is developed in the conclusion of this thesis as a model for future health policy analysis.

This chapter identifies key elements of the welfare state and subsequent economic and social reforms in New Zealand from 1984, including the health reforms. Social and economic indicators enable Māori to draw some conclusions about the relative importance of the 'health reforms' discussed in chapter 4, in terms of the effects of the whole platform of reforms on Māori health and well-being. These indicators are closely linked to the literature on socio-economic determinants of health, specifically on the effects of inequality on the health of individuals and populations.

The following analysis begins with a discussion of the welfare state in New Zealand. This starting point has been chosen simply as a matter of convenience. Although Māori had an established economy prior to European settlement in the nineteenth century, a consideration of this lies outside the scope of this thesis. For a discussion of this early economy and pre-welfare state social policy see Ruwhiu (1999), Belich (1996), Durie (1998), chapter 2, Easton (1997), chapter 3 and Cheyne et al, (1997), chapter 2.

The Welfare State in New Zealand

The welfare state in New Zealand dates from the late 1930s although its genesis lies in the Fabians' socialist traditions of the United Kingdom and in the development of the State in New Zealand during the nineteenth century. Welfare itself has come to mean different things to different people at different times in our history, with a more 'pejorative edge' lately, associated as the term is with referring to income support by

government (Thomson, 1998, p 3). The welfare state was introduced by the First Labour government through legislation such as the Social Security Act of 1938. The new welfare state was intended to meet the needs of those in poverty (Cheyne et al., 1997, p 34) and was based on an 'applied Christianity'⁵ where people's access to services was based on need and not on their ability to pay (Boston et al., 1999; Cheyne et al., 1997). These ideas about the welfare state reflected a political consensus that has lasted for forty years (Boston et al., 1999; Cheyne et al., 1997). This consensus however, has existed for only a brief period in New Zealand. New Zealanders have tended towards a more self-reliant attitude in respect of families and individuals with Victorian values of 'independence, hard work, thrift, family responsibility, and loathing of 'welfare dependence' more the norm (Thomson, 1998). The deserving poor were tightly prescribed even when more 'liberal' innovations such as the Old Age Pension were introduced in 1898 (Cheyne et al., 1997, p33).

This de-coupling of state welfare and poverty accelerated with the Great Depression where too many people were unemployed to attribute unemployment to 'individual ineptitude or moral laxity' (Thomson, 1998). This experience spurred a new way of thinking about the balance between the state (government) and the market place.

Ware and Goodin characterise the welfare state in three models; a residualist, minimalist or needs-based model; an insurance or contributions based model; and a social citizenship or rights-based model (Ware & Goodin, 1990, pp 5-8). These models can be seen in historical examples and in contemporary examples in various countries. The residualist model reflects those ideals of self-reliance and individual responsibility that originated within classical liberalism and have been advanced more recently by market liberals and neo-conservatives (Henare, 1999, p 6).

The New Zealand welfare state was repealed in another series of sweeping reforms by the Fourth Labour government between 1984-1990. Momentum to overturn the welfare state

⁵ Quote attributed to Prime Minister Savage

did not diminish with Labour's 1990 electoral loss because successive National governments continued to implement neo-liberal reforms designed to reduce the role of government.

Why Did The Welfare State Change? Neo-Liberal Reforms In New Zealand

Legislation underwriting the contract between the state and New Zealand public was swept away on a tide of neo-liberal reforms begun with the election of the Fourth Labour government in 1984. When the National government came to power in 1990, they pursued these reforms with renewed vigor until the late 1990s when 'reform fatigue' set in. This reform fatigue from the late 1990s occurred around the same time that the health reforms were beginning to bed down through the Health and Disability Services Act. These reforms are the canvas for the health policy reforms painted in this thesis..

Pressure for these reforms emerged from two main sources, one ideological and the other pragmatic. The ideological impetus involved a series of criticisms of the welfare state which are summarised by Boston (1999): a failure to reduce poverty or overcome disadvantage, providing disproportionate assistance to those who need it least, encouraging dependence on welfare benefits, promoting 'provider capture' and generating large, insensitive and inflexible bureaucracies, undermining the traditional family unit, displacing voluntary and private welfare, undermining personal responsibility and creating perverse incentives, thereby discouraging employment and undermining economic growth (Boston et al., 1999, p 4). The pragmatic pressures consisted of New Zealand's deteriorating economic position with rising unemployment, a growing balance of trade deficit and high interest rates brought about in part by the Muldoon government's big idea, 'think big' projects (Easton, 1997a). The New Zealand economy had evolved as overly dependent upon one sector, agriculture, and one market, England, which created major problems during the 1970s as a series of fundamental structural shifts changed the international economy (Easton, 1997a).

Neo-liberalism has provided a framework for answering questions around the flagging economic performance of New Zealand in the late-1970s and early-1980s, such as rising

unemployment, high interest rates, rising demand for government assistance and high inflation rates. The solution was a redesign of the welfare state to encourage investment and competitiveness (Maitra, 1997, p 36). This was done through a series of economic and social reforms which included removal of trade tariffs, liberalisation of the labour market through the introduction of the Employment Contracts Act 1991, sale of state-owned assets, adherence to a low inflation policy under the Reserve Bank Act 1989, and a raft of other changes that effectively sought to introduce the market as the primary mechanism for policy interactions in both the public and private sector (Boston et al., 1999; Cheyne et al., 1997; Hazeldine, 1998; Jesson, 1999; Kelsey, 1993; Kelsey, 1994). Such reforms were intended to invite overseas investment in New Zealand and to stimulate economic growth through entrepreneurial business development.

The newly elected National Government's expenditure and income intentions were signaled in a statement released in December 1990. These intentions were implemented in their 1991 budget and resulted in considerable cuts to government expenditure and reductions in taxation and government assistance levels in 1991-92. New Zealand Treasury explained the National Government's reforms as consisting of:

An extensive agenda of macro and micro-economic reforms has allowed the price system to emerge as the dominant signal for investment, production and consumption decisions. The major changes implemented include removal of controls on prices, interest rates and wages; a free float of the New Zealand dollar; extensive taxation reform aimed at reducing marginal rates and broadening the tax base; removal of agricultural subsidies and price supports; removal of quantitative import controls and sharp reductions in tariffs; deregulation of the oil, banking and transport industries; deregulation of the labour market; privatisation of State-Owned Enterprises; and wide-ranging public sector financial management reforms (Treasury, 1997).

The market reforms led to an increase in government revenue from a broad range of tax sources including Goods and Services Tax. This increased revenue has been used to repay public debt (private debt has continued to grow in New Zealand).

Governments have achieved a budget surplus for much of the 1990s. Allied with these macro-economic policies of inflation control and labour market flexibility were other policies aimed at reducing personal income tax and government expenditure. These were all consistent with neo-liberal monetarist management.

An important component of government strategy for better economic performance was reduction in government expenditure. This included removal of trade tariffs but also led to a reduction in support for social policy areas such as welfare income maintenance for low income families, health and education.

This series of macro and micro-economic changes implemented by government during the 1990s negatively multiplied the effects of underlying structural features relating to Māori labour force participation, educational achievement, home ownership and income. All of these had an effect on the overall well-being of Māori as a population during the period of the reforms, and more particularly in the years following the reforms.

Trade liberalisation and employment legislation increased the number of unemployed in New Zealand to unprecedented numbers. Further changes to taxation and benefit assistance further depressed incomes of middle and low income families during the 1990s (Easton, 1997b; Statistics New Zealand, 1999).

Public Choice Theory, Agency Theory and Transaction-cost Theory

New Zealand's economic and social reforms from 1984 were the most sweeping and wide-ranging of any in the western world (Easton, 1997a; Jesson, 1999). They reflected serious criticisms by successive governments about the inefficiency and ineffectiveness of how things were being done in New Zealand. These criticisms contained a number of assumptions and an ideology about the type of solutions that would work based on an international experience of globalisation, and in particular, the global mobility of capital.

Amongst the host of criticisms about the welfare state was a view that bureaucracies, voters, pressure groups, politicians and professional groups act in their own self interest. This self interest generates distortions which are then played out within the policy polity. Public choice theory and monetarism was used to explain these neo-liberal reforms in New Zealand (Cheyne et al., 1997, p 85). To elaborate, public choice theory suggests that because of this self-interested behaviourbehaviour;

Politicians seek to maximise votes. Bureaucrats strive to expand the size of their organisation because it is through having more staff that they will receive larger budgets. Ideas of 'public good' and 'social justice' as a basis for action are rejected. Because the costs of state actions do not affect politicians and bureaucrats directly, they have no incentive to use resources efficiently and profitably. In this process, interest groups seek to influence government decisions (Cheyne et al., 1997, p 86).

Thus continual upward pressure for budget increases by government departments are explained by public choice theory. It ignores however, alternative explanations for increases in government expenditure such as increased populations through immigration or natural increases in fertility, and furthermore assumes increased government expenditure as 'problematic'.

Public choice theory is often accompanied by two other theories used to highlight the shortcomings of the welfare state: agency theory and transaction-cost theory (Cheyne et al., 1997, p 86). Agency theory argues that contracts should form the basis of state provision of services since it would ensure a clear specification of responsibilities between the parties to the contract, particularly between the principal and the agent. The agent agrees to carry out particular tasks on behalf of the principal and is rewarded accordingly (Cheyne et al., 1997, p 87). However, an imbalance exists because the agent often has the greater knowledge and access to information. A reliance on contracting is evident in the health sector as a direct result of the 1990s health reforms. The information and expertise asymmetry that exists between health providers and purchasers has been the subject of criticism, as has the narrow way in which complex health outcomes come to be defined within imperfect contracts. Contracts by their nature need

to specify outputs, but health may be more about long-term and more interactive health processes to achieve outcomes, rather than about outputs. Thus contracting may be an overly mechanistic tool for effecting beneficial changes in health.

Transaction-cost theory is also associated with public choice theory and agency theory. This theory explains the benefits of competition within markets by developing explanations of ways in which organisations seek to control their environments by taking over their competitors (Cheyne et al., 1997, p 87). Again, there is evidence of this thinking applied to the health sector during the 1990s health reforms. The separation of purchasers and providers and the development of multiple, competing providers were intended to create efficiencies by forcing reductions in transaction-costs between competing providers. Ironically, transaction costs increased as a result of these reforms, particularly so for more complex, community based providers such as in mental health (Ashton, 1998).

Economic Growth as a Marker of Social Well-being

The view that market driven economic growth would promote social well-being has prevailed to the present day despite evidence that the market has no 'moral sensibilities' (Anonymous, 1994). In particular marked changes to incomes arising from these reforms should be noted because they indicate a material advantage and disadvantage resulting directly from the reform agenda and because of the implications for increased inequality suggested by the literature. This increasing income polarisation has affected those countries that have pursued neo-liberal reforms internationally. This inequality is explained as follows:

Income inequalities arise from the independent actions of individuals with different skills and assets who are rewarded according to what consumers and producers are prepared to pay (Anonymous, 1994).

These income differentials have important implications for health and will therefore be discussed in chapter 6. There is growing evidence in New Zealand and internationally of socio-economic status as a determinant of life expectancy and morbidity.

The balance between equality and economic efficiency has been changed in New Zealand as a result of more-market policies over the last 15 years.

Such growth in inequalities is a direct reflection of the redistributive decisions of governments in these countries, as well as the degree to which markets correct for such inequality. The extent and nature of this trade-off between equality and economic efficiency (at least in theory) is a political decision. In New Zealand the decision has been made to reward economic efficiency and forgo equality (Kiro, 1998b, p 296).

Neo-liberalism, which is also known as New Right thinking, contains a set of normative ideas about how government and society should function. It draws upon a critique of the welfare state and argues that the welfare state creates distortions which make it inherently inefficient, ensures mediocre performance, restricts individual choice and prevents maximisation of individual utilities (Tensenbel & Gauld, 2000). Shirely, Easton, Briar and Chatterjee (1990) explain these more fully as 'doctrines' of the New Right:

The first doctrine of economic individualism assumes without question, that markets are beneficial and governments harmful, and that individual freedom and government action exist in inverse ration to each other. The second strand emanates out of extreme libertarianism which bases its case for laissez faire capitalism on moral grounds and the third strand comes from Friedrich Hayek and the Austrian school of economics [monetarists] ... It is strongly rooted in the tradition of welfare economics which maintains that all human behaviour is conditioned by the hedonistic aspirations of individuals wanting to maximise their productive capacities. It ignores the fact that individual desires are themselves the products of a particular social process and thus, even when advocates of economic individualism claim that they are motivated by progressive and humane interventions, they inevitably view individuals as one dimensional beings thereby ignoring their cultural history, the institutions they have established and the reality of power differentials. (Fougere, 1990, p 20)

This implied cultural juggernaut must raise concerns for those more marginalised cultures in a globalised economy.

It is simplistic however to portray neo-liberalism as monolithic. Successive governments have revealed very different assumptions about the role of the state in legislation. For example the Fourth Labour Government's Reserve Bank Act 1989 was designed to deal with inflation and, "deploys state power to restrain the demand side of the economy" (Bertram, 1997). Thus Labour "retained some corporatist elements in its approach to the supply side" (Bertram, 1997, p 44). In comparison the National government's Employment Contracts Act 1991 relies instead on individual interactions between actors in the market based on a view that:

The level and structure of real wages emerging from an unregulated market have greater moral authority (that is, are closer to the social optimum) than the old system of collectively negotiated awards and explicit relativity comparisons, operated under the actively of the state. That presumption, in turn, springs from individualist skepticism about the capabilities of the state itself, and active hostility to the collectivist assumptions that formed the founding principles of the union movement. (Bertram, 1997, p 43).

While government efforts were initially focused on the stimulation of the economy as a means of generating wealth and well-being, attention also turned to addressing the shortcomings of the welfare state in respect of service provision. The welfare state was attacked because of the shortcomings identified earlier in this chapter. Governments between 1984 and 1999 pursued a common neo-liberal agenda in respect of their role. This agenda included the reduction of the role of the state in the provision of services; development of contractual arrangements between the state and service providers; and separation of funding and provision of services through the development of 'quasi-markets' (Cheyne et al., 1997, p 85).

These quasi-markets (as described by Le Grand and Bartlett, 1993) can be seen clearly in the health reforms and will be explained more fully in chapter 5 on the health reforms. The New Zealand experience is interesting because it is possible to see the clear

application of this theory in practice within the government sector. This has therefore affected those most reliant on government assistance or support in the marketplace.

Chronology of Reforms

The neo-liberal public policy reforms were implemented between 1984 and 1999, although two clear periods are discernable. The first was following the election of the Lange Labour government in 1984. Within a few months a massive number of reforms had occurred to stimulate and 'free-up' the New Zealand economy. This reform impetus slowed as a result of mounting public opposition and internal Labour party rifts that saw the government lose the 1990 election.

The second period, followed the election of the Bolger National government in 1990 which, contrary to public expectation, increased the pace of reforms. The momentum of the reforms subsequently slackened with successive coalition governments following the 1993 and 1996 elections, where National was forced into policy concessions to retain power, first with the United Party and then with the New Zealand First Party.

There is arguably a third phase of the reforms, namely the election of Jenny Shipley as Prime Minister and ousting of Jim Bolger, which occurred in 1997. Shipley was widely seen as increasing momentum for market reforms at a time when Bolger was beginning to ease off.

Finally, the election of the Labour-Alliance Coalition Government in 1999 heralds yet another significant shift in public policy that is outside the scope of this thesis to analyse. This will also affect the functioning of the welfare state with many promised repeals of neo-liberal policies.

The neo-liberal reforms were a response to major economic problems. Muldoon's lengthy period of government had created what was sometimes referred to as a "fortress New Zealand" (Easton, 1997b). This had led to an insular and false society that could not be sustained with growing levels of international debt and unemployment. However, what is

noticeable is the unrivalled extent and speed of the reforms in New Zealand compared to the rest of the world. This speed and scope reflected a fundamental belief by key political actors in government, government departments, commerce and academia that not only could the problems be clearly identified, solutions were also clearly identifiable. As a result, the same treatment was prescribed irrespective of the problem: less government and more market.

Easton (1997) argues that the implementation of the first series of reforms was inevitable considering the mismatch between the way that New Zealand's internal economy was organised and the external changes sweeping other world economies (Easton, 1997a; Easton, 1997b). This was due in part to a highly regulated, but inappropriate set of economic tools used by government. The exchange rate is just one example of an economic tool, which experienced a number of problems. These problems included the viable real exchange rate, an overvalued exchange rate, the need for a compensating exchange rate with the removal of import protection and export subsidisation, and an appropriate equilibrium for the exchange rate to ensure that the current account could attract overseas investors to stimulate the economy (Easton, 1997b, p 120). All of these suggested a need for an exchange rate policy where the real exchange rate would find an appropriate level by a 'search and test' mechanism (Easton, 1997b, p 236). The Government's March 1985 policy decision to float the New Zealand dollar in a 'dirty float' highlighted the flawed assumptions made about the New Zealand economy.

There seemed to be the view that monetary and fiscal policy could be detached from exchange rate policy, and even one from the other. This latter statement may seem a bit odd, but about that time a phrase attributed to the American economist Robert Mundell, 'tight money, loose fiscal' was used to justify the large deficits of Reaganomics ... The Treasury [New Zealand] even seemed to tolerate a higher deficit under a float when it said: 'with a floating exchange rate, there is less risk that poor monetary and fiscal policies will impoverish those industries exposed to world trade while generating spiraling external debt problems'. Ironically, the

tradable sector was to experience impoverishment and external debt was to rise following the adoption of the Treasury advice (Easton, 1997b, p 237).

However, he argues, that the actual reforms pursued by the government were not required to achieve their stated aims. Rather a slower pace of reforms and more effectively constructed set of economic reforms would have delivered superior economic performance and furthermore, not produced the chronic social side effects experienced by many New Zealanders. The effects of these reforms in the labour market, housing policy, income support for low income people and education costs would have profound effects for vulnerable populations such as Māori.

The Effects Of The Reforms

The ideas that drove the economic and social reforms in New Zealand between 1984 and 1999 were based on a view of rational human behaviour where individual effort and risk were rewarded. These rewards were therefore not shared equally throughout society, but presumed a steep gradient between people. In this respect, inequality was an inevitable result of these ideas. A review of income and employment clearly showed a growing gap between Māori and non-Māori (Statistics New Zealand, 1998; Te Puni Kokiri, 1998). The effect of this increasing inequality on health is indicated in the health literature on socio-economic determinants, in particular the evolving theory about the relationship between inequality within societies and health status (Wilkinson, 1996).

Conclusion

This chapter lays out the groundwork for understanding the economic and social reforms in New Zealand over the past 15 years, as a pre-cursor for considering the ways in which these reforms have subsequently affected the conditions shaping Māori. In particular, questions arise about the extent to which a more holistic analysis of policy highlights the negative effects of successive government policies on Māori health when considering the overall impact on the population. These can be due to changes to income (through reductions in government assistance to low income families, and reductions in taxation to the wealthy) and through government labour market policies (with extremely high levels

of Māori unemployment). Such policies create an environment that shapes health outcomes (Berkman & Kawachi, 2000).

When considering the 1990s reforms in respect of the health sector, the same themes that have driven health reforms internationally emerge. A noticeable feature of the reforms of the past 15 years is the way in which personal choice has been emphasised at the expense of ideas associated with 'public good'. Neo-liberalism has permeated all sectors of New Zealand society with its implied values enshrined in economic and social policies until 1999. There is an emphasis on the paramouncy of the individual that dominates neo-liberalism that is at odds with the more collectivist values of traditional Māori society.

Health researchers have attempted to grapple with the impact of various policies on the health outcomes of populations and individuals for many years. There is a growing consensus about the way in which various social and economic conditions act as determinants for health for particular populations and individuals (Davis, 1998; Howden-Chapman & Cram, 1998; National Health Committee, 1998). There is evidence that inequalities within society have profound effects on health. This therefore necessitates an interest in those social, economic and cultural factors outside the health care system (Beaglehole & Bonita, 1997; Benzeval et al., 1995; Black, Morris, Smith, & Townsend, 1992; Crampton & (Eds), 1996; Davis, 1984; Spencer, 1996; Susser & Watson, 1971; Wilkinson, 1996; Williams et al., 1999; Woodward, 1996). Evans, Barer & Marmor (Eds) go so far as to conclude that;

Factors in the social environment, external to the health care system, exert a major and potentially modifiable influence on the health of populations through biological channels that are just now beginning to be understood. (Chapman & Cram, 1998, pp 4-5).

We also know that periods of considerable change in human society are likely to lead to significant health events such as epidemics.

Epidemics appear, and often disappear without traces when a new culture period has started; thus with leprosy, and the English sweat. The history

of epidemics is therefore the history of disturbances of human culture (Virchow, 1847).

New Zealand society has undergone massive change in the past 16 years. This change is likely to have a profound affect on the health of New Zealanders. In particular, the evidence of increased inequality suggests that New Zealand Māori will be negatively impacted as the result of such changes if theories of relativism in health and socio-economic and cultural determinants continue to be borne out in health research. For this reason chapters 6 and 7 examine these ideas around health and the evidence of the impact of these changes in more depth.

CHAPTER 4

Māori Development And Māori Social Policy

Introduction

During the period of the 1990s health reforms, Māori can be characterised as engaging with the Crown (or State) in two ways simultaneously: by settling historical grievances, and by participating in the dismantling of the monolithic state by providing services through contracting with government agencies. These two processes were an expression of tino rangatiratanga by allowing for recognition of past wrongs done to iwi and by enabling them to participate in current and future health services in a way that was intended to improve Māori outcomes across a range of social indicators. However, a more critical analysis has been largely absent from the discussion about the way in which these two tensions were at times contradictory or were used by the Crown to secure Māori agreement to a process that was actually about the Crown's risk management of them.

The welfare state has been accused of further undermining Māori autonomy and independence, creating a culture of dependence leading to Māori detriment (Durie, interview 1997, Tamihere, interview 1996). However this analysis is an oversimplification of the relationship between Māori and the state, because during the period of the welfare state Māori well-being continued to improve according to a number of major indicators. These indicators included life expectancy, educational achievement, home ownership and labour market participation. There were exchanges in the relationship between Māori and the Crown/State during the period following World War II. The uniform and conformist nature of the welfare state encouraged an assimilationist approach to Māori development that gave little leeway for tino rangatiratanga. In exchange, the near universal provision of health care, pro-natal family policies, commitment to full employment and widespread provision of social services on the basis of need not ability to pay facilitated Māori urbanisation during the 1950s and 60s.

Māori development is integral to any consideration of Māori health and well-being (Durie, 1999; Durie, 1998c). This chapter sets out to examine the major strands of Māori development during the period of the 1990s health reforms to better understand how this dynamic has influenced both the shaping of Māori health policy and service delivery practices examined in subsequent chapters.

Māori development is defined in policy terms as those policies that contribute to positive Māori outcomes. This includes a number of elements such as those that contribute to Māori self-determination and Māori delivery systems, including greater emphasis on “Māori control over resources and greater independence from the state” (Durie, 1998b, p 6). However, Durie points out the aims of positive Māori development are not necessarily inconsistent with government policy (Durie, 1998b, p 6).

The relevance of intra-ethnic disparity is discussed because of its growing significance to an analysis of Māori health and well-being. The increased polarisation within New Zealand society is reflected as a mirror image within Māori society also. This has major implications for the formulation of any future Māori health policy. It relates to a wider discussion about Māori and non-Māori disparity that is essentially concerned with equity of outcomes between ethnic groups.

A critique of this disparity approach is that it compares Māori unfavourably with non-Māori and that a more accurate approach would be to compare groups within Māori society. This could perhaps even build upon an analysis located within whanau, hapū, iwi and Māori networks. However such an analysis may also serve to shield Māori from the true nature of the problem since it may ‘hide’ much of the problem, subsumed within the intra-Māori analysis rather than across the wider society. Such an analysis may minimise significant differences in health outcomes within Māori society rather than focus our attention on meaningful Māori measures that allow a more sophisticated understanding of what is occurring to various sub-populations of Māori. This more sophisticated analysis awaits the development of appropriate measures.

The Treaty settlements and the Waitangi Tribunal processes cannot be under-estimated in terms of their importance for Māori society over the period of the reforms. These Treaty settlements have brought much of the debate and energy within Māoridom into sharp relief because of their link to policy formulation within government and the raising of fundamental questions about representation. There are, for example, inevitable discussions resulting about the preferential treatment of iwi over other Māori organisations during the 1990s. Treaty settlements were concerned mainly with the settlement of historical wrongdoings and restoration or compensation to hapū for tāonga. Thus Treaty settlements are primarily concerned with Article II rights rather than the more generalised Article III rights that encompass health. These latter rights accrue to all Māori irrespective of their hapū or iwi affiliations.

This distinction is not always so clear cut however, with some claims to the Waitangi Tribunal including health assets such as Dommett Ave in Auckland and Rotorua Hospital. There were also differing opinions among iwi about the extent to which the Government could reasonably expect Treaty settlements to enable iwi to be able to invest into redistributive practices and the provision of iwi prioritised services, including some in health. It was clear to iwi that settlement of Treaty grievances did not curtail the Crown's obligation to provide services to Māori by virtue of their citizenship rights. What was not so clear was that iwi may have been expected to exercise a degree less dependence on the state as a result of greater economic independence and 'handouts' from Treaty settlements, at least in the minds of a growing portion of the New Zealand public. Such independence from the state, would certainly have been in keeping with the Government's thinking during this period.

These discussions occur within an even larger debate about the relationship between Māori and the Crown / State. Since 1984 the reforms have ostensibly delivered a greater number of opportunities for Māori engagement in social service delivery (including health), and have thus drawn on enormous support among Māori. However, the view that

this is more consistent with tino rangatiratanga may be flawed since it allowed a neo-liberal agenda to be enacted whereby responsibility for dealing with the were transferred to that very community of need.

This devolution of responsibility may be more consistent with Māori ways of working and facilitate greater Māori participation, but it does not address the broader population outcomes and longer term implications of supporting such an approach. The analysis around this has been largely absent from the literature and research agenda. This will therefore be discussed at length in this chapter. The welfare state may have been assimilative by undermining the expression of unique Māori characteristics such as iwi tikanga but it may also have delivered superior benefits to Māori as a population.

Such a discussion is important when considering the effects of socio-economic and cultural determinants of health and when considering equity of health outcomes, particularly from a population health perspective. Interest is fueled not only in the effects of various public policies affecting these indicators, but also in the pathways by which these become determinants of particular health outcomes (the policy etiology).

Māori have been especially affected by the shifts in government economic and social policies which have turned Aotearoa New Zealand from a welfare state into a market economy. The changes in policies around Māori development and the fundamentally ambiguous nature of the relationship between Māori and the Crown require elaboration.

Over the past decade mainstreaming of Māori has not led to the desired improvements in terms of outcomes for Māori. In many cases, the evidence suggests the reverse is true in that these indicators are trending toward negative outcomes with disparity between Māori and non-Māori growing during the period of the late 1980s and late 1990s. Benefits resulting from these reforms must be tested against the wider ramifications of economic and social policies that have resulted in increased stresses for many Māori whanau. Such stresses are believed to be one of the pathways by which indicators such as unemployment affect health outcomes (Macdonald et al., 1982, p 1). This chapter

examines the evidence with respect to this transition period in New Zealand public policy.

A relationship exists between individual phenomena and national phenomena in respect of health outcomes and this was demonstrated in the seminal work of Brenner between 1976 and 1979 (Brenner, 1976; Brenner, 1977; Brenner, 1979). Brenner was able to demonstrate that a 1% rise in unemployment would lead to a 2% rise in mortality, 4% rise in suicide rates, 6% rise in homicide rates, 3% rise in admissions to mental hospitals and 4% rise in admissions to state prisons in the US. This relationship was examined further and explained within a more structuralist framework by Wilkinson, with regard to societal inequality and its effects on health (Wilkinson, 1996). The reason for interest in these arguments for Māori is obvious. Māori are a group who experience social exclusion on the basis of a normative cultural criteria applied in New Zealand that excludes Māori values and beliefs. Social exclusion, whether through high levels of unemployment or through the exclusion of Māori world views from the public domain, has significantly contributed to the poor health outcomes experienced by Māori.

Government Policies And Māori Development

A major philosophical debate which surrounded Māori issues from the late 1980s concerned whether New Zealand should operate a policy platform based on universality for all New Zealanders, or one which supported positive discrimination, particularly for tangata whenua. There has been some strong public sector support for a targeted approach, especially among public health medicine specialists and, ironically, economists and Treasury officials. The latter's support is not, however because of an acceptance of Treaty principles, rather it is associated with the notion of 'niche targeting' to minimise economic inefficiency inherent in universality.

The two main responses by successive New Zealand governments to Māori have been to either mainstream Māori 'issues' or alternatively to promote Māori self-management. Those organisations that promote Māori self-determination have always been preferred by Māori however "in practice the differences between self-determination and Māori

development may be more apparent than real” especially with regard to local level interventions (Durie, 1998b, p 6). Mainstreaming has been government’s preferred approach with regard to Māori in New Zealand. This contrasts with approaches taken in North America and Australia, countries who have tended towards a more separatist development in policy development and service delivery. There is interest from the indigenous peoples of these countries in New Zealand’s approach because mainstreaming may have led to a more inclusive approach than parallel systems (as with separatist examples).

Following the dis-establishment of the Department of Māori Affairs into the Ministry of Māori Affairs, and then later in the decade, the Ministry of Māori Development, mainstreaming took on a particular ‘flavour’. Iwi development marked a new phase which emerged in the late 1980s, arising in part from the Treaty of Waitangi legislation and from requirements for regard for the Treaty to be incorporated in other legislation of the period. This approach was based on the view that iwi are the historical and sole guardians of tikanga because they represent the familial interests based on whakapapa at the level of public polity within Māori society. This debate will be examined more fully later, since it has profound implications for future and recent Māori policy debates.

District Māori Councils originated within urban Māori communities as a response to these new experiences. They provided a nexus for Māori community activity and grew to provide a political voice for Māori at local and central government levels. Efforts during the 1980s culminated in recognition of iwi through the Iwi Runanga Act 1990. Councils and Runanga were both vehicles for Māori voice within the polity, but both forms of Māori voice relied on government funding and support to be effective. They were however able to independently implement their own agenda without reference to other public institutions. It is difficult to assess the intentions of those who established these through the lens of the 1990s. What is clear is that Māori have maintained a continuous momentum for self-determination, irrespective of the social particularities. What constitutes self-determination may however change over time. While District Māori Councils were pan-iwi bodies reflecting concerns of newly urbanized Māori, later forms

of Māori representation emphasised iwi development as the main vehicle for Māori development. This may have been in part a response to Māori relocated from urban back to tribal territories, or the erosion of Māori Councils to appear a strident and independent enough voice for Māori.

The tendency of some commentators to view Māori policy as a linear progression is flawed. A more accurate description would be to see Māori policy as more diffuse than that, with periods of intense activity, periods of little activity and the periods of revisiting old ideas in new clothes. The policy approaches of separate development, Māori development, iwi development and mainstreaming can all be present in the policy mix, although one form tends to dominate over others.

Māori Policy Institutions

Four distinct periods can be seen with regard to policy making for New Zealand Māori. These are summarised as hapū policy, operational policy (based around public health and hospital services), strategic and substantive policy and kaupapa Māori policy. These are reflected in the following modes of service delivery: separate hapū development, Māori development, iwi development and mainstreaming.

The period of hapū development relates to pre-European New Zealand when Māori lived within village and hapū based social arrangements. Hapū rangatira determined 'policy' relating to their group, although it would be easy to overstate the manner in which this occurred without regard to the place of other tribal mechanisms to counter-balance rangatira authority. Whanau, hapū and iwi formed the basis of Māori society (Ballara, 1998) and therefore the basis of political structure in traditional Māori society. These groupings are not solely based on whakapapa linkages but also reflect political patronage and historical allegiances with other hapū, iwi and Europeans. There were rangatira who acted as spokespeople for their hapū and/or iwi. It is now almost impossible to know the extent to which Māori society was hierarchical because colonisation has so strongly filtered our perceptions. Historical accounts suggest a much greater degree of variation

across the country with respect to the extent to which rangatira could act unilaterally without the need for a hapū polity consensus (Ballara, 1998; Belich, 1996). Hapū formed alliances with other related hapū during times of threat or expansion. These alliances are what many of Māori today think of as iwi. These larger aggregations of hapū could operate more effectively as an economic and military unit, although it is possible to overstate the degree of cohesion or permanence of these groupings (Ballara, 1998; Belich, 1996).

New Zealand has often adopted a dual approach to policy making with regard to Māori. These include a Māori-specific approach, where de facto policy advice was relegated to 'Māori' organisations such as the Māori Women's Welfare League in part because of their obvious advocacy role with Māori women and children. The other approach is where mainstream organisations are deemed responsible for delivery of services to Māori to meet Māori need, but within the context of delivery of services to the whole population. The Department of Māori Affairs sat between these two in that it was responsible for delivery of Māori specific programmes but on behalf of a Crown agent. Therefore, there was the added dimension of ownership and kaupapa of the agent implementing the policy in identifying the spectrum for delivery of Māori social policy.

There have been a number of identifiable Māori actors and events that contributed significantly to the formation of Māori policy. These are summarised in Table below.

Table 5 Summary of Māori Actors and Events Shaping Māori Policy

	HAPŪ POLICY	OPERATIONAL POLICY - PUBLIC HEALTH AND HOSPITALS	STRATEGIC & SUBSTANTIVE POLICY	KAUPAPA MĀORI POLICY
<i>Characteristic</i>		Service planning centralised	Creating the framework localised structure	Māori philosophical base Population
<i>Māori Actors</i>	Iwi	Māori Trust Boards Māori Women's	Māori policy analysts - Ministry of Health,	Runanga Iwi Māori Urban

Responsibility for formulating Māori policy was often devolved to institutions specifically set up for the task, as with the Department of Māori Affairs (Kiro, 1998b). In addition to policy advice on Māori matters, the Department of Māori Affairs provided a wide range of training and support programmes for Māori, including trade-training for Māori males in areas such as carpentry and electrical trades. These Māori-specific programmes were provided by the Department up until the late 1980s when the Hon. Koro Wetere, split Māori Affairs into a Ministry and Iwi Transition Agency.

The Department of Māori Affairs enjoyed a vexed relationship with Māori and government, and was often criticised for being inefficient and too paternalistic in its approach (Butterworth and Young, 1990). It did however have an inter-sectoral approach to Māori Affairs, it employed many Māori staff and it provided many direct services to Māori communities. Following the Hui Taumata in 1984, the Hon. Koro Wetere as Minister of Māori Affairs, released a document titled *He Tirohanga Rangapū*. This Māori Affairs policy document recommended splitting the Department of Māori Affairs into two separate arms; one responsible for policy development and monitoring (Manatu Māori) and one responsible for devolving services to iwi authorities (Iwi Transition Agency). Translated into formal government Māori policy from 1987 - 1990 as *Te Urupare Rangapū*, the Iwi Transition Agency would be “responsible for overseeing the transition of government operational programmes to (representatives of) iwi over a five-year period” (Cunningham & Kiro, 2000).

The government also attempted to reflect ‘iwi’ in law to enable enforceable contracts to be negotiated between the Crown and iwi with the *Runanga Iwi Act 1990* (Durie, 1998b). This Act would enable ‘tribal councils’ to “enter into contracts with the Crown, own property and be subject to both Crown agent accountability and accountability to their tribal membership” (Cunningham & Kiro, 2000). This Act was repealed by the National Government who believed that mainstreaming was a more appropriate policy response for Māori than the devolved iwi structure proposed by the previous Government. However, strands of this policy would later emerge through various elements of the health reforms in respect of health policy.

	Hapū Whānau Tohunga	Welfare League Women's Health League Māori Councils	Ministry of Māori Affairs, Ministry of Māori Development	Authorities Wananga Māori
Significant Events	Treaty of Waitangi Declaration of Independence	Hospitals Act 1870s Public Health Act 1900 Area Health Boards Act 1983	Hui Taumata Hui Whakaoranga Te Ara Ahu Whakamua	
Legislation	Tohunga Suppression Act Māori Councils Act	Māori Community Development Act Māori Trust Boards Act	Māori Affairs Restructuring Runanga Iwi Act Health and Disability Services Act	
Policy Statements	NA	Māori Affairs Act Health for the Māori Māori-European Standards of Health The Hunn Report	Te Urupare Rangapū Ka Awatea Whaia te ora mö te iwi	
Policy Reviews				
Providers	Hapū	Mainstream providers, Hospitals General Practitioners Nursing Services	Growth of Māori Providers	Kaupapa Māori Providers
Policy Analysis	NA	Public health analysis Māori solutions suppressed	Mainstream analysis of Māori disparities Māori solutions starting to be enabled	Māori analysis of disparities and solutions enable
Māori Health Status	Māori life expectancy poor Māori health declining	Māori life expectancy improving, disparity with non-Māori reducing	Māori life expectancy static, 5 year disparity with non-Māori	

Source: (Cunningham & Kiro, 2000).

	Hapū Whānau Tohunga	Welfare League Women's Health League Māori Councils	Ministry of Māori Affairs, Ministry of Māori Development	Authorities Wananga Māori
Significant Events	Treaty of Waitangi Declaration of Independence	Hospitals Act 1870s Public Health Act 1900 Area Health Boards Act 1983	Hui Taumata Hui Whakaoranga Te Ara Ahu Whakamua	
Legislation	Tohunga Suppression Act Māori Councils Act	Māori Community Development Act Māori Trust Boards Act	Māori Affairs Restructuring Runanga Iwi Act Health and Disability Services Act	
Policy Statements	NA	Māori Affairs Act Health for the Māori Māori-European Standards of Health The Hunn Report	Te Urupare Rangapū Ka Awatea Whaia te ora mö te iwi	
Policy Reviews				
Providers	Hapū	Mainstream providers, Hospitals General Practitioners Nursing Services	Growth of Māori Providers	Kaupapa Māori Providers
Policy Analysis	NA	Public health analysis Māori solutions suppressed	Mainstream analysis of Māori disparities Māori solutions starting to be enabled	Māori analysis of disparities and solutions enabled
Māori Health Status	Māori life expectancy poor Māori health declining	Māori life expectancy improving, disparity with non-Māori reducing	Māori life expectancy static, 5 year disparity with non-Māori	

Source: (Cunningham & Kiro, 2000).

Responsibility for formulating Māori policy was often devolved to institutions specifically set up for the task, as with the Department of Māori Affairs (Kiro, 1998b). In addition to policy advice on Māori matters, the Department of Māori Affairs provided a wide range of training and support programmes for Māori, including trade-training for Māori males in areas such as carpentry and electrical trades. These Māori-specific programmes were provided by the Department up until the late 1980s when the Hon. Koro Wetere, split Māori Affairs into a Ministry and Iwi Transition Agency.

The Department of Māori Affairs enjoyed a vexed relationship with Māori and government, and was often criticised for being inefficient and too paternalistic in its approach (Butterworth and Young, 1990). It did however have an inter-sectoral approach to Māori Affairs, it employed many Māori staff and it provided many direct services to Māori communities. Following the Hui Taumata in 1984, the Hon. Koro Wetere as Minister of Māori Affairs, released a document titled *He Tirohanga Rangapū*. This Māori Affairs policy document recommended splitting the Department of Māori Affairs into two separate arms; one responsible for policy development and monitoring (Manatu Māori) and one responsible for devolving services to iwi authorities (Iwi Transition Agency). Translated into formal government Māori policy from 1987 - 1990 as *Te Urupare Rangapū*, the Iwi Transition Agency would be “responsible for overseeing the transition of government operational programmes to (representatives of) iwi over a five-year period” (Cunningham & Kiro, 2000).

The government also attempted to reflect ‘iwi’ in law to enable enforceable contracts to be negotiated between the Crown and iwi with the *Runanga Iwi Act 1990* (Durie, 1998b). This Act would enable ‘tribal councils’ to “enter into contracts with the Crown, own property and be subject to both Crown agent accountability and accountability to their tribal membership” (Cunningham & Kiro, 2000). This Act was repealed by the National Government who believed that mainstreaming was a more appropriate policy response for Māori than the devolved iwi structure proposed by the previous Government. However, strands of this policy would later emerge through various elements of the health reforms in respect of health policy.

During the 1980s a 'positive discrimination' philosophy was supported through a Māori policy articulated by the Labour government of the time. Central to the implementation of this Māori Affairs policy was the Runanga Iwi Act, 1990 which sought to provide a legislative underpinning to 'tribal councils' who could enter into contracts with the Crown, own property and be subject to both Crown agent accountability and accountability to their tribal membership. Although not ideal from a Māori perspective, particularly in terms of any Crown agency relationship, the Act did provide for Runanga to be enabled by iwi to operate in ways only determined by the iwi itself. The Runanga Iwi Act was soon repealed in 1991 by the incoming Minister of Māori Affairs, the Hon. Winston Peters. This left a void in terms of addressing iwi representation. Ironically, and perhaps as a positive testimony to the Runanga Iwi policy, iwi groups such as the Ngai Tahu of the south have recently sought legislative status for their own Runanga.

By the late 1980s the Labour government had become wary of incorporating Treaty clauses in legislation, following Māori legal challenges to its reform agenda in the public sector. National, when it came to power in 1990 repealed the Runanga Iwi Act and was less inclined to include the Treaty of Waitangi in subsequent legislation. The health reforms legislation was just around the corner and the philosophy of universality in legislation was to prove attractive to National.

The Hon. Winston Peters (National's Minister of Māori Affairs between 1990-1991) announced a new policy, Ka Awatea, based on a view that Māori interests were best served by mainstream organisations responsible for quality outcomes for Māori as New Zealand citizens rather than by virtue of their ethnicity. Mainstreaming refers to the inclusion of Māori as a part of the rest of the New Zealand population and provision of services and political representation on this basis. Although tinged with aspects of autonomous Māori development, mainstreaming remained in force through many of the 1990s policies. In practice however, the interpretation of various government agencies ranged from iwi-centred (as per the earlier Labour position), to a continuation of the more

paternalistic Department of Māori Affairs position, to the more assimilationist mainstream position.

These various institutions responsible for Māori Affairs reflected the ambiguous relationship between Māori and the state, as Cunningham and Kiro explain;

The reasons for separating out these responsibilities can be seen from two opposing viewpoints. On the one hand, it may reflect a concern to ensure that consideration of Māori matters is not lost within the public policy melee that is government. Alternatively, it could be seen as a sop to Māori and an attempt to assimilate Māori by subsuming their representation under a government department with ultimate accountability to its political masters (Cunningham & Kiro, 2000).

Despite Pakeha colonisation, remnants remain of Māori institutional arrangements responsible for determining Māori / Hapū policy. While the influence of these institutions has waxed and waned following colonisation, they have been maintained in some form in many areas. Thus traditional Māori institutions such as whanau, hapū and iwi have continued to co-exist along with institutions established by government and organised by Māori to deal with Māori 'issues'. Along with whanau, hapū and iwi, Māori were also able to act as individuals, as communities of interest and as confederations to ensure rangatiratanga and representation with the Crown (Durie, 1998b, p 220).

The loss of the Department of Māori Affairs impacted on Māori by removing our main access to home ownership mortgage lending (for first and second mortgages). Māori home ownership has continued to decline relative to non-Māori as a result. In the late 1980s Vote Māori Affairs reached a peak of \$450 million (although some of this money reflected the transition funding in 'devolving' the Department). This fell to \$40 million for the new Ministry of Māori Development Te Puni Kokiri (TPK) in 1992 as Vote Māori Affairs became mainstreamed. These reforms ensured TPK's role was limited to policy development and advice, excluding direct service provision that was now mainstreamed. Undoubtedly these monies contributed to government funding for Māori initiatives such as co-ordination of Kohanga Reo and Māori Health providers. However as a population

Māori lost access to cheap mortgages, training and some forms of funded whanau development such as Mātua Whāngai.

These changes were consistent with a prevailing ideology that said that government's role should be to provide the overall economic infrastructure with a range of services provided in a competitive process to maximise efficiency. This thinking also led to targeted social assistance programmes within a residual welfare state. This form of economic rationalism considered the rational pursuit by individuals of their own self-interest as the most efficient way to organise social policy and social institutions (Barker, 1996). To elaborate, "individuals enter relations of mutual advantage, and simultaneously create institutions like markets, firms, families and local communities, including such entities as hospitals, schools, recreation centres, and health farms. By means of these exchanges and associated institutional forms, individuals can increase their full income and as a consequence their well-being, relative to a situation of independent action (Crampton & Howden-Chapman (Eds), 1996, p 66).

The Ministry of Māori Development Act 1992 established Te Puni Kokiri and dis-established the Iwi Transition Agency and the Ministry of Māori Affairs according to policy outlined in Ka Awatea. The succeeding Minister of Māori Affairs changed direction yet again.

Importantly, there appeared to be less focus on iwi as a vehicle for Māori and a stronger emphasis on reducing disparities between Māori and non-Māori, largely through greater government responsibility - a reminder that the market by itself would not deliver for Māori (Durie, 1998b, p 9).

The focus of the new Māori Ministry, Te Puni Kokiri, was policy development and monitoring. Section 4 (1)(a) states that Te Puni Kokiri has responsibility for promoting higher levels of achievement for Māori in:

- education;
- training and employment
- health;
- economic resource development.

Its responsibilities include monitoring and liaising with each department and agency responsible for providing services to Māori to ensure the adequacy of those services (Te Puni Kokiri, 1993b).

The Auckland regional office of Te Puni Kokiri reported in 1993 that, “high Māori unemployment and the desire that iwi are able to participate in the tendering process for health contracts are among the key issues in Auckland” (Te Puni Kokiri, 1993b). A number of health contracts were specified under policy directives from TPK including Whakatohea Iwi Health, Tainui Capitation Model, Smoke Free, Health through the Marae, and Tipu Ora, among others (Te Puni Kokiri, 1993b). Money was transferred from Iwi Transition to mainstream agencies as part of the devolution of TPK. This funding formed the basis for Māori initiatives funding in health and kick-started some of the Māori health initiatives during the 1990s health reforms.

Māori Social Policy

Māori have most often been in the position of having to respond to government initiated agendas although a concerted effort has been made during the decade of Māori development to achieve positive changes by Māori themselves on behalf of Māori (Durie, 1998b). Māori are affected by social policy in two respects, firstly, as New Zealand citizens and secondly, by virtue of their over-representation in low socio-economic groups. As members of the latter group Māori are more susceptible to changes in government programmes partly because they often rely to a greater extent on government assistance. Such reliance has increased during the period of neo-liberal economic reforms and has been stigmatised by Māori and Pakeha alike. For example the ACT political party’s Awatere-Huata argued that Māori parents should,

Stop acting as though a Government is responsible for your children’s education and ultimately their future wealth and choice in life....they should get their financial entitlements from the Government so they can spend it them themselves (Awatere Huata, 1997).

The thrust of public policy reforms was to transform New Zealand from a close economy to a market economy and to encourage economic efficiency. The flow or

effects for social policy would be profound. Most particularly, de-regulation of the labour market and the introduction of laissez faire legislation such as the Employment Contracts Act 1991 would likely affect Māori health. Māori saw the separation of social and economic policies in the agenda of economic efficiency pursued by governments as short-sighted. Durie explains.

The separation of the two (economic and social policies), and a concern to unhook settlements from broader Treaty issues, is consistent with the wider macro-policies of the government and its free market orientation, but makes little sense in Māori communities where economic and social circumstances are inextricably intertwined and where economic goals, including self-sufficiency, are part (only) of tribal concepts of self-determination and autonomy (Durie, 1998b).

Furthermore this linking of Treaty settlements with Māori development (economic and social) was:

A deliberate part of the political strategy of the last 15 years [which] has been to reduce the political risk of Māori inequality. This has been done in two ways; firstly by changing the nature of the debate about the welfare state and market economy. Māori have contributed to this new orthodoxy. Secondly, through the linking of the Treaty settlements process and provision of Māori services to Māori economic independence (Kiro, 1998b).

In contrast to this approach internationally, there is mandatory contracting between Government and First Nation's bands in Canada where government has a statutory responsibility to respond to their needs.

The linking of Treaty settlements with Māori development was driven in New Zealand by the previous Prime Minister, Hon. Geoffrey Palmer, to encourage Māori to use discrete legal identities such as iwi Authorities so the government could have a legal entity with whom could contract and whom they could sue. While iwi, hapū and whanau were traditional Māori structures, they were not legally identifiable and therefore could not be held accountable by government or the judicial system.

Decade of Māori Development

The Hui Taumata and Hui Whakaoranga of 1984 are credited with marking a significant turning point where a 'Māori Development Decade' was initiated (Durie, 1998c). Māori self-sufficiency and Māori control were firmly on the policy agenda. Durie and Cunningham explain how dissatisfaction with the situation led to a re-evaluation of the place of Māori in addressing negative outcomes themselves:

A rise in 'negative spending' for poor Māori outcomes, the emphasis was on reduced reliance on the state and growing confidence in the iwi-delivery model form for some public services for Māori. Central importance was given to the Treaty of Waitangi as the basis of interaction with the Government. The major thrust was on economic initiatives, but several papers on Māori health and unemployment left no doubt of the need for improved social policies to be integral to Māori advancement, with Māori themselves ready to be the major agents of change (Durie, 1999, p 238).

This discussion about an affirmative iwi-centric approach to Māori policy is important because policy has continued to develop along these lines in health, despite an official retraction from this policy in the early 1990s by the National government. In particular, the policies promoting iwi as preferred providers by the Community Funding Authority (of the Department of Social Welfare) and MAPO co-purchasers (by North Health, now the Health Funding Authority) suggest a powerful operational policy of iwi development irrespective of the over-arching policy (Waitangi Tribunal, 1998).

Treaty Settlements In The 1990s

The 1990s have been important for Māori because of the attempts by government to settle Māori grievances relating to land alienation. To some extent this is the result of a Treaty of Waitangi Act process initiated in the 1970s with an expanded jurisdiction from the 1985. The Bolger National government committed itself to settling the large Treaty claims by the year 2000. Of particular importance, because of the size of their claims, were claims from iwi such as Tainui (Raupatu), Ngai Tahu and Taranaki. Part of the

intention was to move Māori from a grievance mode to a more productive mode, with an independent financial basis for further iwi development.

There have obviously been critics of the government's actions. For example Minogue's controversial findings on Treaty settlements argue that the 'culture of grievance' Māori have engaged in has unbalanced relations and stymied Māori focus on the future (Minogue, 1998). He claims that this,

Relegates Māori to the status as miserable victims. It does not justice to their [Māori] evident vitality and resourcefulness, nor to their rich contribution to the history of recent centuries (Minogue, 1998).

He goes on to claim that what happened to Māori in the last century was an inevitable consequence, with no doubt that Māori would have encountered such interlopers to their country at some stage. Furthermore, he claims that war between Māori in the early 1800s demonstrate that Māori were no strangers to military conquest or slavery and that large numbers of Māori living in cities pursue "individual destinies". Social problems experienced by urban Māori are similar to that of the wider society, and are therefore unrelated to the Treaty of Waitangi processes. He relates this search for 'justice' by Māori as a piece of social engineering in which Māori are retribalised, "Such retribalisation helps to make plausible the premise that Māori are a separate people, a premise whose plausibility had been declining decade by decade." These views are not new. Rather they reflect an ongoing belief in the inevitable assimilationist effects of a superior way of life - namely that of western Europeans.

Minogue's observation about our current day understandings of iwi arising largely out of the Waitangi process may have some truth. The debate around iwi Māori may have arisen anyway precisely because of the attempt by government to legitimise particular delivery mechanisms for Māori social services in a climate of constrained government spending.

It is probably more useful to consider the debate about iwi as an inevitable consequence of changing demographics in society wherein Māori are forming a greater proportion of

the population and are therefore a more visible portion of the population. There appears to be a worldwide trend towards greater emphasis on ethnic identity partly as a response to globalisation pressures.

Iwi Versus Māori: Who Has The Right To Represent Māori?

A corollary of a highly targeted approach that requires clear identification of who is entitled to a resource, is who or what are Māori? This question of Māori entitlements, either as consumers or as potential advisors to policy makers, is relevant to this thesis because health policy has been concerned with targeting of scarce health dollars. While research provides evidence of high Māori health need, issues associated with representation of iwi Māori are associated with who gets funded to deliver the Māori specific services. This has been part of the operational health policies of Regional Health Authorities. Court challenges between urban Māori Authorities and Tribal Authorities have focused attention on the definition of iwi and on a reconsideration of the intention of recent legislation (for example legislation relating to the Sealords settlement). An interpretation of the original intentions of the Treaty of Waitangi has been important in considering who gets these resources on behalf of Māori. This debate has been at the heart of Māori development for the past decade.

While whanau, hapū and iwi form the basic structure of Māori society, these have been subject to change and have also been affected by differing perceptions of their role in Māori society. Their commonality is the link by whakapapa (genealogy) usually through a common ancestor, but there is also a turangawaewae (place to stand) where cultural institutions such as marae are visible and where tikanga (cultural practices) and dialectical reo (language) are practiced. The period of Treaty settlements along with changing national policies about Māori Affairs has led to a close scrutiny of the contemporary relevance of historical structures such as iwi.

The literature review summarised key arguments with regard to whanau, hapū and iwi to highlight the extent to which modern understandings of iwi are shaped by historical official perceptions and the extent to which they therefore often serve an agenda outside

that of cultural preservation. For example, there has been vigorous and passionate debate about the application of the 1840s rule that linked iwi to the occupation of certain lands at the time of the signing of the Treaty of Waitangi in 1840. The Crown identified which iwi had 'legitimate' claims in a series of land purchases and Native Land Court decisions in the nineteenth century Crown purchases from this time have reinforced the primacy of their position in 1840 as it was interpreted by the Government and Māori Court. As such, this interpretation has been criticised by some historians and Māori as too rigid an interpretation of iwi which were historically far more dynamic in their relations with each other and their occupation of contiguous territories (Ballara, 1998; Waitangi Tribunal, 1998).

A tendency towards an increasing tribal hegemony results in part from its convenience for government policy officials (Ballara, 1998) rather than from any natural trend. Similarly, the term Māori does not differentiate between those from different tribal areas and was therefore a convenience to policy makers during the period of the welfare state. This term allowed 'Māori' to be treated as a homogenous group without reference to those things that distinguished them from each other. The way that government legitimises certain Māori groups over others therefore has a powerful affect on the way that Māori as Māori also come to interpret ourselves. In part this is because government's views prescribe access to public resources (such as Treaty settlements and ability to contract for services) and access to legislative redress.

Definitions of who Māori are have changed over time which makes some comparisons of social indicators such as health status more difficult. There was little consistency in official statistics used within government Departments, let alone between Departments. Statistics New Zealand's practices provide an example of this problem. The Department has adjusted definitions of Māori in successive censuses ranging from degree of blood (1981) to self-definition as Māori (1991) to self-definition of various iwi affiliations (1996). They did this to try and achieve greater accuracy in their statistics, but it limits any ability to analyse trends. While Statistics New Zealand did develop better definitions

as a result of these amendments, such fundamental changes to the census limits our ability for comparison across the period of greatest change – the 1990s.

Despite these difficulties most researchers agree that some trends appear consistent across time such as the ongoing disparity between Māori and non-Māori. The 1996 census figures are considered more accurate than previous ones (with the possible exception of 1981) and indicate that the mortality gap between Māori and non-Māori is slightly greater (by six months) than previous trends suggest (Reid, interview, 11 August, 1998). This has implications for policy analysts attempting to identify long term trends in Māori mortality and morbidity, Māori identity and other major social indicators. It also shows how ethnicity (or race previously) has come to change so much within New Zealand society over time.

The 1996 census data provides the following information on ethnicity according to various categories of identification for Māori.

Table 6 Rounded Numbers of Māori by Descent, Mixed Or Sole Identified In The 1996 Census

Some Māori descent	500,000	not self-identified
Māori and/or mixed	400,000	morbidity
Sole Māori	300,000	morbidity

Source: Statistics New Zealand 1996 Census

There is an increase in the numbers of people identifying themselves as Māori, however this is problematic since the census data is collected using differing questions over different censuses and using changing denominators. It is possible to see that the number of people self-identifying as Māori has increased. This definitely affects all time-series data because of the changing basis of definition and use of denominator.

According to 1996 Census figures, three-quarters of Māori say they belong to at least one iwi or tribe, say 1996 census figures released yesterday. Nine iwi, each with a membership of 20,000 account for more than half of all responses to the question. South Island based Ngai Tahu had the largest increase between censuses in total membership, at 29,133, and is now the fourth largest iwi.

Antagonism about the iwi versus Māori debate is most accurately seen in the fight of Waipareira against tribes. For example John Tamihere, the CEO of Te Whanau O Waipareira Trust at the time, he disagreed with the iwi-centric focus of North Health.

The Māori purchasing group in North Health are minimising us, as they prefer Ngati Whatua or Tainui for health contracts. But 80 per cent of Māori in this region are not Ngati Whatua or Tainui. We are going to take North Health to court for mental health funding because they won't acknowledge us as an iwi (Tamihere, 1996).

It is not only in health that Waipareira have struggled for equal recognition with iwi. Again, Tamihere explains,

Margaret Bazely won't acknowledge us as an iwi social service agency, so we can't get the same level of access as an iwi. It's just unfair (Tamihere, 1996).

Supporters of an Iwi development approach refer to iwi, hapū and whanau as the traditional structures of Māori society through which economic, social and cultural benefits and responsibilities were enacted. This view is also open to challenge as iwi were not mentioned in the Treaty of Waitangi. Rather it was hapū (sub-tribes) who formed the hub of Māori society and it was their representatives who signed the Treaty of Waitangi in 1840 and the earlier Declaration of Independence in 1835. There are difficulties with accepting prima facie that iwi is a more accurate reflection of what constitutes 'Māori'. There are also difficulties in defining iwi according to the practice of the Crown and Māori Land Court, and latterly by government interpretation in statute and policy. This makes defining iwi Māori more generically as Māori no less problematic. Indeed it may be more so, since it is less specific than hapū and iwi. The main point is to

understand that all of these definitions are problematic and Māori have incorporated aspects of official definition within Māori understanding of such definitions.

Alternatively, those who ignore whakapapa based tribal structures in Māori society go against the tide of history by suggesting that the concept of 'Māori' is itself unproblematic. Māori means 'ordinary' and was used to differentiate ourselves from others arriving during the nineteenth century. The debate is therefore multi-faceted and complex. Simplistic interpretations and unilateral government solutions are likely to be inaccurate in their interpretation of such concepts as iwi.

To some extent Waipareira's desire to be recognised as an iwi demonstrates reflects the kind of contortions which Māori go through in order to become eligible for streams of government funding and reflects the various changing tides of opinion about what to do about Māori development. Centralise - de-centralise - contract - provide broad-based schemes - focus on pan-tribal organisations - focus on iwi organisations. These have all been tried. The 1990s are notable for Māori determination to do things ourselves through a range of different mechanisms (Durie, 1998b; Jefferies, 1998).

Māori In A Globalised Economy And Māori Adaptation

A new debate is emerging around the changing nature of Māori identity in a globalised economy, which has profound ramifications for all Māori and indeed for all New Zealanders. In particular the work of Rata (1998) raises questions about the relationship between contemporary and traditional Māori society.

Rata questioned how contemporary tribes have managed to capture the definition of iwi and accompanying benefits. She believes that the answer lies in its claim to be the legitimate inheritor of the traditional Māori communal society, to speak as representatives of the past, and as the authority for the present and future. Yet, is the contemporary tribe the same social organisation as the traditional tribe in its fundamental defining features?

Rata goes on to argue that:

Two essential defining characteristics are missing from the contemporary organisation despite the appearance of continuity provided by real things such as lands, waters, taonga, genealogical links, knowledge and customs. Firstly the traditional tribe was a communal social organisation, albeit hierarchical. In contrast, the contemporary tribe is characterised by a class structure which divides those with control over material resources from two other groups: tribal workers and the detribalised and dispossessed Māori. Already this group is emerging as a relatively privileged tribal middle class. Secondly, while the lands, waters and knowledge are the same real things as in the past, the meaning of these things is fundamentally different. Land, waters and knowledge used as capital for the production of commodities and the creation of wealth is not the economy of a traditional communal society. Such an economy changes the relations between people and destroys a society based upon communal access to resources (Rata, 1998).

She argues that this link between, “capitalised resources, commodity production and class emergence - break that continuity” between traditional and contemporary tribes. Such a fundamental shift in the nature of this relationship changes the nature of the claim between iwi and dispossessed Māori.

This analysis reflects the emergence of a more articulate questioning of the underlying assumptions in the Treaty settlements process and also the emergence of class as a significant difference emerged between Māori under New Right social policies. The commodification of land, fisheries and forestries that were gained because of an assumed spiritual relationship of iwi, raises serious questions about the way in which these settlements are linked to other policy solutions.

In particular, successive governments during the 1990s have linked Treaty settlements to economic self-sufficiency of those iwi who receive settlements (iwi themselves have contended this, for example Tainui do not believe that their entitlements as citizens are

eradicated by the Raupatu settlements with the Crown). Furthermore, the judgments of the Waitangi Tribunal, and government enactment of many of these, have been translated into legitimacy for service provision of by these same iwi. This therefore reflects dominant views about the responsibilities of families and communities to care for those in difficulty, in the face of government retreat from provision of services and entitlements of citizens to benefits as of right. The direction of changes is towards ethnically specific policies by government which have implications for Māori because they relate more to Article II Treaty rights rather than Article III Treaty rights relating to citizenship and which are therefore subject to Pakeha veto (Cheyne et al., 1997).

While Māori have the potential to be serious players in the New Zealand economy with an estimated \$10 billion of capital in Māori private, tribal or corporate hands (NZPA, 1998), Māori also remain socio-economically vulnerable and therefore have fewer protections against the vagaries of the global marketplace. One consequence for Māori of a globalised market place is that they need to deal with institutions and markets that are faceless and require large amounts of capital to influence. There is also a tendency to aggregate resources and no obvious morality associated with this accumulation. Such global influences represent a third wave of colonisation for Māori since the effect of these faceless institutions on the daily lives of Māori, is profound.

The evidence of growing income and wealth inequality globally and nationally cannot be ignored. As noted earlier, in 1994, *The Economist* described the market economy as having, “no moral sensibility: income inequalities arise from the independent actions of individuals with different skills and assets who are rewarded according to what consumers and producers are prepared to pay” (Anonymous, 1994). America and Britain income inequalities are larger than at any other time since the 1930s, as they are in countries such as Australia and New Zealand.

After America in the inequality league-table come Australia, New Zealand, and Switzerland. In all four countries the ratio of the income of the richest 20% to the poorest 20% is between 8.5 and 11. Japan and Germany are among the most equal societies, with ratios of 4 to 5.5.

Britain, Canada and France fall somewhere in between (Anonymous, The Economist, 1994, p 20).

Such a growth in inequalities is a direct reflection of the redistributive decisions of governments in these countries, as well as the degree to which markets correct for such inequality. The extent and nature of this trade-off between equality and economic efficiency is a political decision. In New Zealand the decision has been made to reward economic efficiency and to forgo equality. This means that as a society Māori are prepared to tolerate higher levels of unemployment, homelessness, income and wealth inequality than during the years of the welfare state. However this social despair is not evenly spread across the whole population. Māori are more likely to experience this because of structural features of the Māori population.

Māori and the Market-place

Māori fared badly as a population under more market policies of Governments between 1984 and 1999. The disparity between Māori and non-Māori was particularly telling, but so also was the difference between wealthy and poor Māori. This disparity was an inherent component of the market oriented policies. An Economist article explains,

The extent that greater inequality is linked to fundamental changes in technology and global competition, the gap between skilled workers and unskilled workers is likely to continue to increase, all other things being equal (Anonymous, The Economist, 1994, p 20).

Māori have come to believe in the rhetoric of Māori dependency and Māori reflect some of the same punitive values encouraged by neo-liberal policies in our dealings with each other at an institutional and personal level. Increases in benefit dependency are ascribed to an unwillingness to work rather than to the changes to the labour market and withdrawal of government assistance in provision of cheap housing, apprenticeships, adequate childcare and similar services, which are the more likely causes. It is ironic that the welfare state with its commitment to full employment (including subsidised work) created less dependency across the whole population than the more market-oriented government policies that have led to massive increases in government dependence. As at 30 June 1996, 30% of those going on the Domestic Purposes Benefit

(DPB) were Māori according to Department of Social Welfare Briefing Papers to the Government in 1996. During the period of market-oriented economic and social policies Māori benefit dependence actually increased. Furthermore this rhetoric belies the reality of increased Māori participation in the workforce from 15% in 1991 to 25% in 1996, although for those on the DPB this increase was largely due to the take-up of part-time positions (Department of Social Welfare Briefing Papers to the Government in 1996).

There is an assumption now made with respect to Māori and the Crown that sees Treaty settlements as an opportunity for Māori autonomous economic, social and cultural development. These aims are consistent with Māori desires for tino rangatiratanga, but Māori should be wary of an attempt to devolve responsibility for the current parlous state of Māori well-being from the government to iwi authorities or Māori organisations. Treaty settlements can only provide a limited opportunity for improvement to Māori well-being. Māori cannot possibly meet all of the social ills from Treaty settlements of taonga such as land or money. These are too inadequate a resource to overturn the massive effects of cultural, social and economic dislocation caused by colonisation.

Furthermore, a commitment to iwi as the conduit for economic and social development for Māori fails to account for the significance of new Māori structures. These new structures were created by Māori (and often by government) as a means of meeting new demands in cities and towns around the country as Māori became urbanised. They created new communities of Māori - some of whom were linked by whakapapa (such as Taura Here) and some of who were not (such as District Māori Councils). These innovations occurred to provide advocacy, support and a Māori vision, within alien urban environments. It is possible to support historical settlements for Hapū and iwi while also supporting the need for ongoing developmental support from the government for a range of Māori organisations.

In reality, however, Māori relations with both the welfare state and the new market economy are less didactic than argued above. Māori have benefited from both the welfare state and market economy activities, although not in the same way. To explain,

Māori have benefited as a population from the welfare state with its focus on universal entitlement, commitment to decent family wages (linked to men's earning capacity) and full employment. In comparison, some iwi and Māori organisations have benefited from the market economy while overall indicators of well-being have fallen or remained static. These iwi Māori beneficiaries fall into two main groupings, those iwi who finally secured Treaty settlements for long standing grievances for loss of land and other taonga, and those iwi and Māori organisations (such as Urban Māori Authorities), who have positioned themselves entrepreneurially to take up the privatised functions of the state and Territorial Local Authorities.

The adaptability with which Māori have attempted to shape government agendas in their own interests is a recurring theme in Māori development. During the period of neo-liberal economic reforms some iwi have seen their interests as more aligned with government desire for devolution of risk and responsibility. The reason for this is because this approach has allowed more space for iwi and Māori organisations to exercise tino rangatiratanga than had hitherto been the case with a centrally planned economy and social services. This relationship is explained as follows.

The shift from centralised provision to decentralised service delivery and group-targeted services, especially since 1991, has focused on Māori 'problems', rather than on the non-culturally specific improvement in Māori social conditions resulting from universally provided benefits and mainstreaming. The family benefit, for instance, dramatically increased family incomes for larger Māori families in the 1940s. It did so without overly drawing attention to Māori entitlement, since it was provided to all citizens (Cheyne et al., 1997, pp 154-155).

They go on to argue that,

Group targeting - the result of mainstreaming health and education services also with services once provided by the Department of Māori Affairs - makes welfare provision much more culturally specific. This allows services to be tuned to tangata whenua needs in a way that could be seen to be more responsive to the Crown's Treaty obligations, but it also

makes any attempts to transfer resources to Māori subject to Pakeha cries of separatism. Article II rights to redress economic impoverishment are more subject to a cultural veto by Pakeha, than Article III rights, which stress common citizenship (Cheyne et al., 1997, p 155).

And further,

Both Māori and government have, since the 1970s, given more attention to a shift from the social rights of citizenship to those of a culturally defined group. Māori political activism has taken place in an increasingly pluralist environment since the 1950s. Māori have demanded recognition for a special kind of difference, one based on indigeneness. An acceptance, even a tolerance of diversity cannot be confused with a transfer of economic or political power The humanitarian rhetoric of the 1840s has become the biculturalism, partnership, pluralism, or postmodernism of the 1980s and 1990s. The rhetoric draws Māori into the discourse, but in practice little else has changed (Cheyne et al., 1997, p 155).

Such considerations have important implications for Māori who have struggled to expand their share of government resources during a period of retraction by the State, and also when faced with an increasingly disgruntled taxpayer. Such taxpayers may be less inclined to support Treaty settlements and government assistance to the poor – both of which will have a significant effect on Māori families.

Māori and Neo-liberalism

The congruence between Māori desire for autonomy and neo-liberal support for a residual state has the appearance of being Māori-friendly, but lacks substance. As Manuka Henare said,

In Aotearoa, New Zealand the free market is not culture-free, and is therefore not values-neutral. Contemporary social and economic policies are imbued with ethical and moral codes, and their delivery involves forms of behaviour that are often at variance or in direct conflict with those of Māori and other Polynesian peoples (Henare, 1999).

Successive governments from 1984 have been concerned to locate responsibility for welfare back within the communities within which these social needs arise under the guise of devolution. Devolution allows two things to be dealt with at the same time, community desire for control (in this case the Māori community desire for tino rangatiratanga) and government desire to exit welfare provision as non-core 'government business'.

Although neo-liberalism has a strongly applied normative framework which reflects a highly Eurocentric (especially American) cultural bias (Hazeldine, 1998, p 10), there have been Māori advocates for neo-liberalism precisely because it promotes individual endeavour and an implied economic meritocracy which rewards those who work hard and take clever risks. Such a view enables a separation of culture from economic reward sufficiently to see those Māori who are financially successful as beyond reproach by society. They have not been given the money, but have played cleverly in the global marketplace to create their wealth and what they do with it is therefore their business.

In addition to this, neo-liberal government policies encourage the devolution of resources and services to those communities closest to the 'problems'. Such proximity means that they are better able to understand these 'problems' and better able to provide solutions to them. However, such a view is open to criticism since it locates the 'problem' at the level of the community or individual experiencing the problem and therefore minimises or disguises a more structural and broader analysis. Such an approach reveals a pathological orientation that cannot lead to the desired results. It is impossible for the communities within which these very things are manifest to develop a more comprehensive response which can address problems rooted in wider structural contexts.. Such an approach only allows the staunching of blood from communities which are really in serious need of a transfusion. It may therefore reflect the wrong treatment for the wrong cause.

Neo-liberal policies also appear less attractive when consideration is given to how those who are socio-economically disadvantaged are treated by the global marketplace.

Income differentials appear to increase, and this has certainly been the case in New Zealand since the market reforms (Chatterjee & Podder, 1998; Statistics New Zealand, 1999). It is clear that Māori are socio-economically disadvantaged when compared to the rest of the New Zealand population.

This devolution of responsibility has been a deliberate political strategy by governments over the last 15 years to reduce the political risks associated with Māori inequality. This has been achieved in two ways, first, by changing the nature of the debate from welfare to 'workfare', and secondly, by linking Treaty of Waitangi settlements to Māori economic development. Structural features that contribute to Māori unemployment remain unaddressed. Now the pathology is also reflected in iwi and hapū ability to meet (or not) the needs of their people and it coincides with the structural unemployment evident in the New Zealand economy.

Ironically part of the momentum for neo-liberal change was generated by those frustrated with their perception of an evolving elitism of the Treaty settlements process. The 1990s have witnessed a growth in the number of 'corporate Māori'. Donna Awatere-Huata claims that,

In fact the average Māori will not see a cent of any Treaty settlement. Rather, a new breed of tribal, urban Māori middle-class bureaucrats will massage treaty spoils into a larger resource with little consideration for those whom they are supposed to represent. Take the fisheries. The only ones to benefit will be either tribal or urban bureaucracies plus their assorted lawyers. After millions of Māori dollars have swilled about in the legal and bureaucratic troughs, it will not matter which side wins. The average Māori, to whom the fisheries ultimately belong, will have nothing (Awatere-Huata, Treaty issues: don't leave them to the bureaucrats, NZ Herald, February 6, 1997).

Similar views are expressed by Tamihere when he claims that he wants to stop the 'feeding frenzy' on Māori plight and that there is,

A huge vacuum between government policies and what happens on the ground and I can do more here We are in a race against time. The people round these wealthy iwi organisations will do all right, but too many of our people will end up on the gutter (McLoughlin, 1998).

Awatere-Huata's prescription for rangatiratanga is the return of these responsibilities to individual Māori and to iwi through their entitlements via a personal allocation to a defined population of government resources. In this prescription, the state is removed almost entirely and as such this becomes the ultimate expression of neo-liberalism. Thus Māori can see that a radical Māori agenda of self-determination can be consistent with neo-liberal arguments about the necessity of removing the state from social interactions. The reasons for wanting this differ. For government it is seen as a means of limiting distortions within the market place. For Māori it is seen as a means of exercising authority without interference from a colonial government.

Unfortunately Ms Awatere-Huata's proposed solution may actually exacerbate the problem since it ignores the effects of relativity and social exclusion which Māori experience as a population. The assumption that Māori enjoy the same degree of choice as non-Māori is debatable. In particular it ignores the infrastructure necessary for Māori education, health and welfare and the extent to which this infrastructures requires a co-ordinated national strategy and a central government.

Tamihere is also considered an outspoken critic of a tribal elitism - something he refers to as the 'brown table' and therefore synonymous with the privilege associated with the Business Round Table. As a January 1998 North South article identified,

he has no patience with those who would have Māoridom revert to its tribal roots in a fast-changing world, or with the elders of the "brown table"... who have presided over the tribally based Treaty settlements for the past few years (McLoughlin, 1998).

It is possible to see the benefits accruing to particular tribes as evidence of the worthiness of those tribes to receive those benefits, either through the efforts of their negotiators to obtain redress for past injustices or through some other mechanism. Tamihere, however,

argues that tribalism is an outdated way of thinking about ourselves as Māori in the modern world. Like Awatere-Huata he doesn't agree with Māori dependency on government handouts, claiming, "numerous government agencies and welfare organisations live off Māori dependency but achieve little" (McLoughlin, 1998).

Waipareira Trust has fought legal battles against the Treaty of Waitangi Fisheries Commission and has made a successful Treaty claim to the Waitangi Tribunal about the Community Funding Agency in a bid to secure more equitable funding on a par with iwi Authorities. In a North South magazine article, Tamihere explains what drives this momentum among urban Māori authorities.

80 percent of Māori are urban now and live far beyond their rural iwi boundaries. Many do not even know their iwi affiliation. They should get their fair share of Treaty settlement proceeds and state funding in health, education and training programmes. Instead, he argues, Treaty settlements and state funding is going largely to iwi authorities which are becoming wealthy at the expense of the majority of Māori (McLoughlin, 1998).

Iwi Authorities, however, have been keen to promote education within their iwi and have proactively contracted with government departments along with Māori urban authorities for services in health, education, and justice. For example Tainui and Ngai Tahu have both developed extensive scholarship schemes to support further education among their own people as part of a planned commitment to ongoing iwi development.

New Māori Orthodoxy: Transformation From Structural Analysis To Individual Freedom And Choice

A new Māori orthodoxy has emerged during the 1990s which has taken Māori far from the debates of the 1970s. The transformation of Awatere-Huata from Māori radical to free market advocate is the embodiment of this change. The 1970s were epitomised by the use of structural analysis to explain Māori disparity. Māori were seen as the victims of processes of colonisation that ensured economic subjugation in successive generations of Māori. Low educational achievements were the result of a self-reinforcing cycle of deprivation, with few employment opportunities (low incomes were guaranteed), poor

housing, and poor living standards. In this respect, Māori became defined by our deficits rather than our strengths. This has been altered to a more pathological explanation where a person's individual failings explain their 'failure' in society.

Awatere-Huata claims that,

More important than all the Treaty settlements, all the land, fisheries, tribal radio, cash and property, mana and apologies is the education of each Māori child. The great social division today is not between rich and the poor; it is between those who have education and those who do not (Awatere Huata, 1997).

The 1980s witnessed a change in this deprivation thinking with a growing critique of Māori inadequacy and a view of Māori as the passive recipients of welfare or aid. The mood during the Decade of Māori Development was to ensure that Māori came to control their own destiny. However this was coupled with a measure of self-interest from particular iwi and tribal leaders, and an increasingly hostile social environment. Recipients of public welfare were labeled 'bludgers' because they were dependent on the state. Such attacks were not new to New Zealand. They reflected a return to welfare approaches reminiscent of nineteenth century responses to the same questions around need and public provision (Thomson, 1998).

The core elements of these policies are dealt with elsewhere in the research, however their impact on Māori, an already vulnerable population in New Zealand, has been profound. Even so, there have been too few voices raised among the Māori leadership to draw attention to the underlying reasons for this. Noticeably it has been Māori urban organisations and Māori activists who have maintained some semblance of a broader analysis of the international situation and its detrimental effect on Māori. Examples of such activists include Annette Sykes, Mike Smith, Moana Maniapoto Jackson and John Tamihere.

That this occurs during a time of Treaty settlements, which themselves are constrained by the Crown as a kind of massive risk management strategy, is no accident. International

capital is extremely fluid, constantly seeking higher returns for particular levels of risk. Suggestions of massive claims by indigenous peoples against strategic assets make them nervous. Such potential had to be managed before New Zealand could seriously take itself into the international marketplace.

A review of the evidence shows that Māori secured major gains in health outcomes such as life expectancy, home ownership, labour force participation and the establishment of Māori initiatives such as Kohanga Reo in education during the period 1950 - 1980. Such gains were greater than had been achieved at any other time in our history. However this is conveniently forgotten in the rush to remonstrate about the failings of the Welfare State.

There is no doubt that the welfare state was a two-edged sword for Māori and that the nature of the social contract between citizens and government would inevitably alter, but little thought has been given to what Māori have been expected to give up, and what was exchanged. Early promise of benefits, such as those arising from the Treaty settlements, remain to be seen by most Māori.

More importantly there is evidence of major structural rifts developing within the Māori population which must be cause for alarm if Māori are to avoid further fracturing in the future. In particular increased polarization in income, education and other social indicators is significant. With the closing down of Māori Affairs and the mainstreaming of Vote Māori Affairs monies there are no cheap housing loans and no trade training schemes available for the unique characteristics of Māori. While these were open to criticism (such as creating ghettos for Māori), they were more than Māori have now. The current system has not encouraged Māori into the workforce and has ignored fundamental restructuring of the labour market in ways which continue to ensure Māori remain an under-class relatively worse off than their immediate forebears.

Māori Middle-Class

One assumption of this research was that Māori would exhibit the same features of middle-class capture as has occurred in the general population as a result of pressure on welfare during periods of economic stagnation. As incomes of the middle class decline and social services become more targeted, it is the middle-class who are able to access the scarcer welfare services, rather than the poor who are ostensibly the major beneficiaries of welfare (Catholic Caring Founding, Father Fred Canon, Morning Report, March 23 1999). The middle class is itself the product of the benefits of welfarism: benefits which accrued during the period of the welfare state and which are now under threat (Thomson, 1996). This compares historically with notions of private charity that drove much of what was considered welfare in nineteenth century New Zealand (Thompson, 1998).

Neo-liberal arguments about the capacity of private giving to assist those who are unable to meet their own needs do not bear scrutiny. It is simply not possible for churches and charities to pick up the slack of government exit from public welfare through private charity. This capacity for private giving assumes that agreed notions of good arise from such philanthropy and that a civil society infrastructure capable of supporting private charitable work exists, including an army of volunteers. None of these things exist in New Zealand. Our charitable capacity is severely limited and would be unable to meet government's exit from social services provision; our social cohesion and commitment to public philanthropy appears strained; our civil society is weakened; and our voluntary capacity is diminished.

Welfare has come to have different connotations at various points in our history;

'Welfare', 'social welfare' and 'welfare state' are slippery terms, meaning different things to people at different times and in different places. In mid-twentieth century New Zealand 'welfare' had rich and generally positive associations, encompassing all public activities which improved citizens' material and psychological circumstances, including education, health, housing, job protection, infrastructure investment, the management

of savings, and a great deal more. Of late it has narrowed and taken on a more pejorative edge, referring to income support by government, and even just to cash to the non-elderly (Thomson, 1998, p 3).

This trend is identifiable also within Māori initiatives such as Kohanga Reo and Kura Kaupapa - both initiatives that owe their existence largely to a Māori middle-class who provided the intellectual and practical support for the initiatives to survive and develop. The growth of a Māori middle-class (which has paralleled a growing Pakeha middle-class) during the period of the welfare state has to some extent skewed outcomes under a targeted government assistance regime because of their greater ability to access resources. An example is preliminary research by the Ministry of Health around the effects of increased use of General Practitioners for children aged 'under six years old' – a policy introduced in 1997 by the National led Coalition government with New Zealand First, reinstating earlier provisions for this group of children abandoned during the period of reform.

Māori have never been so well educated nor so poorly educated. The middle-class are able to exercise choices while the poor appear locked into a pattern of continuing deprivation.

Chris Trotter, in a speech to the Massey University Staff Club on 30 March, 1998, explained his view that Māori need to address the context of Māori development where issues of gender and class remain to be explained.

The articulation of group needs by the middle-class means that the policy process is often captured by them (as the initiatives also are). Policy-makers are atypical and do not usually reflect the general Māori population.

Powerful iwi have benefited from the reforms for a number of reasons - they are well organised and have responded quickly and convincingly to government initiatives. An example would be Tainui's development of a Health Care Plan in the late 1980s, while

other iwi and Māori organisations were still trying to grapple with what Health Care Plans were and what opportunities existed in changing government health policy.

Ngai Tahu, Tainui, Te Arawa and Tuwharetoa have been able to mobilise leadership to access government resources. The latter two have effectively been in this position since the 1920s because of earlier settlements and this has given them greater ability than other iwi to enter a new market in, for example, healthcare.

Middle-class Māori children are more likely to attend pre-school, including Kohanga Reo, more likely to participate in cultural institutions and events (Te Hoe Nuku Roa) and more likely to attend GPs earlier than poorer Māori.

Government solutions to these problems of ensuring access for low income families includes home visiting (for example Family Start) but these may also impose authoritarian and normative prescriptions on already stressed families struggling for daily survival. Such proactive approaches may however improve compliance and increase immunisation rates (such as with a mobile clinics).

Māori concern about data capture by government agencies and subsequent data matching is a result of this perceived harsher environment. They have developed a range of techniques to address this concern by minimising wherever possible the government 'face' in their services. For example, Te Paea Marae and the Tipu Ora Programme (run on Te Arawa marae), try to accommodate this in their services by adopting strategies such as meeting whanau at an independent place. However, in this case these workers were their 'nannies', tribal kuia (older women of status) - so it was much easier to create a safe environment for these 'at risk whanau'. These whanau experience things such as high housing density, little housing security (for example in rented accommodation) which both perpetuate and exacerbate the negative experiences of low income Māori (Milne, 1998). In this example, the Plunket model was viewed as an inappropriate way to rear impoverished Māori children because of its historical association with Truby King's strongly prescriptive and authoritarian legacy. However, in comparison it does appear

that there is a high Māori acceptance of Public Health nurses - particularly in rural communities. Possibly their approach was more pragmatic and located more within the experiences of these clients.

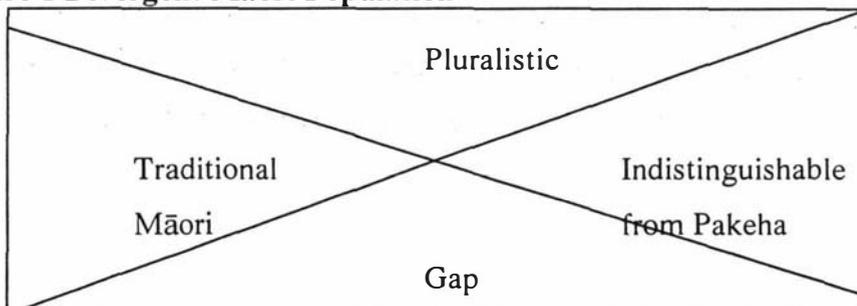
Māori are not a homogeneous population. Like Pakeha, Māori have a range of political views, with a growing middle class who aspire to many of the same things as non-Māori. These aspirations are very much defined by where in the country you come from. Māori, particularly in rural communities retain more modest aspirations in respect of what type of health services should be available in their area than their city cousins (Cunningham, 1997). In such communities, being seen by a doctor is what they want. Being seen by a Māori doctor surrounded by a multi-disciplinary team would be beyond their expectations.

What constitutes an adequate health service depends to a large extent on your educational background and socio-economic status. Māori policy makers may reflect a 'false consciousness' wherein largely Māori middle-class concerns are projected onto the whole Māori population.

Divergent Māori Population

This analysis about the divergent nature of the Māori population is best explained by Chris Cunningham's model of the Māori population that identifies four main groups. These are identified in Figure below.

Figure 1 Divergent Māori Population



Source: Chris Cunningham, Te Pumanawa Hauora, Massey University, 1998

This typology suggests that there are essentially four population groupings among Māori, each with a unique profile. These are pluralistic, traditional, Pakeha and gap Māori. Traditional Māori are those who remain in traditional environments and who experience close relationships with turangawaewae and strong iwi/ Hapū and whanau identity. They are able to speak te reo and practice tikanga regularly in their daily lives, including involvement with their marae. Pakeha Māori are those who live their lives in an almost identical way to Pakeha. They do not speak Māori regularly, do not necessarily identify as Māori (although they may), do not participate regularly in tribal activities and do not have regular contact with their marae or turangawaewae. They aspire to exactly the same things as mainstream New Zealand. Pluarlistic Māori are those who step between traditional and Pakeha worlds, reflecting elements of both. They may speak some Māori, are often better educated than any of the other groups, have regular contact with their marae and possibly involve themselves on the periphery with iwi, hapū and whanau concerns and activities. Gap Māori are those who do not identify as traditional Māori, or as Pakeha Māori. They are most likely to be socially isolated or vulnerable and most likely to be uneducated. They may participate in another type of sub-culture such as gangs, or sole parent associated poverty.

These groups are therefore related to particular features include educational status, income levels, employment associations, rural and urban living environments and cultural identity. The latter includes two dimensions: access to and participation in Māori culture and institutions, and security of identity.

Cunningham points out that the benefits of the last decade have been disproportionately enjoyed by pluralistic and traditional Māori, with an attempt in health to find a “kohanga reo” solution adapted from education to other social services (Cunningham, interview, 1998).

Conclusion

The 1980s were seen as the decade of Māori development, with results delivered in a series of decisions such as the Treaty settlements and various legislation such as the

Māori Fisheries Act 1989 and Treaty of Waitangi (Fisheries Claims) Settlement Act 1992. There is a perception that there have been gains in service delivery with for Māori by Māori service providers, particularly in health.

This analysis raises questions about the degree that Māori and their leaders have colluded with a neo-liberal agenda during the period of these reforms. The use of national Māori organisations to act as spokespeople for Māori has been replaced by a re-emergence of tribal leadership. This is a direct result of the Treaty settlements process which has legitimated and rewarded particular iwi based upon rigorous research presented to the Waitangi Tribunal. However the re-emergence of tribal parochialism is to be expected and reflects a continuation, rather than a break with tradition. Belich (1996) explains how the current situation has parallels in our history from last century.

Tribalism remained immensely important, sometimes compatible with pan-tribalism, sometimes competing with it. Yet pan-tribalism did rise from the 1850s, and it has been downplayed in retrospect, partly because of the myths of empire and their historiographical residues. There is also some tendency among Māori to rank the tribe above all else, and to see Māori unity as a Pakeha invention. That, too, seems to be a retrospective gloss on history. Te Ua Haumene, prophet of Pai Marire, instructed his lieutenants: 'Do not be concerned for your own village. No, be concerned for the whole land'⁶ (Belich, 1996, p 234).

Simplistic understandings of the relationship between Māori and Crown do Māori no favour. Māori were not simply pawns in the hands of an indifferent Crown, but were also active shapers of our destiny. Chiefly interests and tribal interests through the restoration of mana were sometimes primary concerns for actions with the Crown against other Māori, or against other Māori irrespective of Crown preferences. Again, Belich casts light on this.

At the broadest level, it was a partnership between two autonomous spheres, one ruled by governors and governments, the other by chiefs and

⁶ 'Te Ua Gospel', translated in Head, 'Te Ua', 63

tribes, jointly policing the interface. At the local level, the nature of particular partnerships varied, from very close to very distant, and from Pakeha seniority in the relationship to Māori seniority (Belich, 1996 p 228).

The degree to which Māori see collaboration between themselves as beneficial to their individual iwi interests will determine future improvements in health, many of which will need to be addressed through a cohesive and united approach.

The restoration of lands, monies or other taonga, has been important for establishing an independent economic productive base as well as a location for the continuation of our culture. As Durie points out, land is a necessity for spiritual growth and economic survival (Durie, 1998c, p 115).

Māori are at an historically important cross-roads with divergent paths for future development open to us. One path is the global economy with investment in fisheries, forestries, land development and new companies including innovations in eco-tourism, and consultancy services. The other path is uncertain and unclear but may include a more localised investment pattern such as the small-scale banks being trialed in Scotland and Asia.

Questions of class arise given the increase in disparity within Māori society, as well as between Māori and non-Māori over the past decade. While ethnicity is often treated as a proxy for social class, this is misleading and simplistic according to Smaje, 1995. Theoretically class and ethnicity are two distinctive and different phenomena, each with their own outcomes in health (Smaje, 1995). However, Māori are affected in New Zealand by institutions that are at times fundamentally opposed to their interests as a people and there is evidence to suggest that class and ethnicity act together to multiply the experience of disadvantage.

The challenge for Māori in the next decade is the creation of a more diversely skilled and well-educated work force, greater asset ownership (including affordable housing), and

improvements in key areas of health, all of which require co-ordinated strategies in conjunction with government. Māori must see our interests in common if Māori are to address the effects of our circumstances and Māori must reject the winners and losers psyche which underpins new right policies. A concerted and co-ordinated national strategy is required that includes iwi and urban Māori in political pressure to address these inequalities in employment and education, housing and cultural independence. Māori do not fit one mould and therefore, there will not be one solution.

CHAPTER 5

Health Reforms: 'Whaia Te Ora Mo Te Iwi'

Introduction

New Zealand's health system can be characterised as involving reform and conflict over the allocation of responsibility for provision from the time of British colonisation to the present (Cheyne et al., 1997, p 221). Central government assumed an increasingly important role from last century, culminating in near universal provision from the time of the Social Security Act 1938.

The 1990s health reforms formed a visible part of the platform of public policy reforms in New Zealand from 1984. The reforms affected many New Zealanders and evoked strong responses from the public. While the reforms under the Labour government in the 1980s could be characterised as more managerial than market, the 1990s reforms introduced a health market. Questions about a residual state, the need for rationing of public resources, efficiency and better management all found expression within the health sector.

Problems with cost containment, an aging population, changing consumer expectations and pressures of technology forced a rethink in the 1960s and 1970s (Cheyne et al., 1997; Dow, 1995). The Area Health Boards Act 1983 was introduced to facilitate the integrated planning for primary and secondary health care. The approach signaled by this Act was changed markedly with the introduction of a market-oriented approach adopted by successive National governments during the 1990s.

A series of reports from the late 1980s promoted a range of options for healthcare for New Zealand. Some of the assumptions of these reports are questionable such as the amount of savings predicted within the health sector in the Hospital and Related Services Taskforce (known as the Gibbs Report) 1988. All of these contributed to a climate of

debate for more substantial change that filtered through government and all were subsequently used to justify substantial changes brought in by the National Government elected in 1990.

Further changes occurred during the whole of the 1990s, particularly in the structure of the health sector. The purchaser became a funder, the new Public Health purchaser was dismantled, new Māori providers emerged and new organisations such as Independent Practitioner Associations (IPAs) were established.

The health reforms are examined in detail in this chapter as they provided the impetus for the emergence of Māori health providers. The legacy of the 1990s health reforms are also likely to live on for decades to come, affecting the future of Māori health providers.

The New Zealand Health System

An ad-hoc health system developed in New Zealand during the nineteenth century initially in response to the threat of infectious disease and early public health concerns with sanitation and water supply, along with practices such as quarantine and vaccination (Dow, 1995). The colonial system of hospitals and health officers would come to supplement then supplant Māori tohunga and traditional practices. These included a range of practices including rongoa, mirimiri and karakia as treatment for ailments. The Tohunga Suppression Act 1907 prohibited such traditional treatments until it was repealed in 1964.

Despite widespread concern about epidemics, provincial centres continued to argue about who would be responsible for public health interventions.

Throughout New Zealand there was an apparent lack of effort to tackle the situation. Almost a decade would pass before central government demonstrated a willingness to accept some responsibility for public health (Dow, 1995, p 21).

New Zealand's early public health legislation arose from the combination of the threat of epidemics and a degree of informed support from within the community (Dow, 1995, p

21). The purpose of the Public Health Act 1872 was to prevent disease from foreign seas, suppress it when it occurred and to provide for vaccination (Dow, 1995, p 23). Despite the passing of the Act provincial governments continued to be reluctant to spend money on public health. However, provision of health services was seen as a 'paramount duty' of the superior civilisation for those of a more primitive civilisation. This duty extended beyond vaccination to include providing Māori with access to hospitals and other medications. Dow has observed that self-interest 'as a spur to action was a recurring motif of public health activity on behalf of the Māori' (Dow, 1995, p 31).

Hospitals in Auckland (1847), New Plymouth (1847), Wellington (1847), Wanganui (1851) and Dunedin (1852) were intended, 'primarily for Māori needs' and were supported by the government in Britain (Dow, 1995, p 31). These hospitals provided treatment and dispensed medicines, subsidised by colonial New Zealand government in negotiation with their medical officers (Dow, 1995, p 31). Historical accounts suggest that Māori regularly used these hospitals. The hospitals were also used to provide outreach to Māori communities. Māori were more literate than non-Māori at the time and health education included publications on matters such as smallpox, burial practices, vaccination and sanitation (Dow, 1995). Native medical attendants were appointed to each of the principal Māori settlements by 1865, although some were not medically qualified and some were obviously unsuitable (Dow, 1995, p 32).

Māori use of hospitals waned following the land wars of the 1860s. Concern about Māori delay in seeking treatment at hospitals had emerged by 1874 when Hopkins Clarke, Officer in Charge of Natives at Tauranga, said,

It is often the case that the sick do not get proper medical treatment until the M•ori doctor has exhausted his skill, and naturally enough, when brought to the hospital [they] are beyond all hope (Dow, 1995, p 32).

In 1885 the Hospitals and Charitable Institutions Act established Hospital Boards governed by elected members. These Boards remained relatively unchanged until the Area Health Board Act 1983. Hospital Boards were a reflection of the 'parish-pump politics' which dominated provincial New Zealand. Prior to the Social Security Act 1938

Hospital Boards were responsible for raising funds for hospitals from local rates, fees and central government contributions. However, central government was increasingly looked to for funding of health services and for central co-ordination and planning in health care. Following the 1938 Act, most health services for both GP and hospital services were publicly funded by central government.

By 1900 pressure had mounted for a more professional approach to public health than was the case under the management of provincial government leaders. The growing control of medically qualified staff was reflected in the creation of the Department of Public Health through the Public Health Act 1900. The Department of Health was evidence of an acceptance that a population level approach was needed in health, rather than one which continued to focus on individual pathology (Cheyne et al., 1997; Dow, 1995, p 221). The new Public Health Act 1920 is credited with the evolution of an integrated health system that built on the original hospital and medical services (Dow, 1995).

New Zealand's experience of the Great Depression led to 'universal access to health care as part of a package of social-security measures' (Dow, 1995, p 221). The intention of the Social Security Act 1938 was that 'general practitioner, hospital, pharmaceutical and maternity services were intended to be free and universal' (Cheyne et al., 1997; Dow, 1995, 122). Although the level of subsidy would deteriorate over the years, this commitment to universal access to health services on the basis of need rather than ability to pay, remained in place until the 1990s health reforms when greater emphasis was placed on the latter. However, New Zealand continued to operate a free and universal system for all citizens even during this 1990s period.

As the first universal, free health system in the world, New Zealand came closest to the Beveridgian ideal in health services. Other countries whose systems reflected this model to some extent include the United Kingdom and Canada. However, other models were also on offer and these would come to dominate other health systems. Two other models in particular deserve a mention, the social insurance model and the private market model.

The social insurance model is premised on a contribution paid by individuals to a central pool, which is then topped up by taxation and paid when health care is needed. Most countries have adopted elements of all of these models. The private market model is where individuals meet their own health needs either through private health insurance or by paying out of pocket. The United States is often cited as an example of this model, although it also operates a very expensive and extensive public hospital system with access to Medicare and Medicaid for those citizens on pensions or low incomes. They also operate an extensive Veterans hospital system for those who have served in the defence forces.

Auckland's Traumatic Changes

The Auckland Area Health Board, and the Auckland Hospital Board that preceded it, complained continually of chronic under-funding for Auckland. As the fastest growing population centre it had fallen behind other centres in funding. This under-funding problem and lack of population funding equity was not solved by the health reforms. Rather they masked the real problem through a series of transfers from existing commitments to hospital services to other services, in particular through the creation of independent health providers funded from the public purse.

A review of Auckland's health and hospital services in 1987 identified a role in purchasing and providing for all the major stakeholders in Māori health through the development of a purchasing strategy (Committee to Review the Organisation of Health and Hospital Services in Auckland, 1987). This report included a Māori proposal for a regional Auckland Māori Health Council, with representation on the Auckland Regional Health Board, Executive Committee and each District Health Authority. These structures were a refinement of the Area Health Board model that has been reflected in aspects of the District Health Board reforms announced in 1999. The addition of a Māori Health Council would have enabled Māori to have a role in planning both specialist Māori services and mainstream services. This would have guaranteed Māori representation at all levels, and also guaranteed a Māori, regionally focused health authority. The report proposed that,

a M•ori Health Council be established to undertake responsibility for matters of M•ori Health from a M•ori perspective with the support of the Auckland Hospital Board. The Council to be constituted by the five Tribal and Regional M•ori Authorities in Tamaki-Makau-Rau (Committee to Review the Organisation of Health and Hospital Services in Auckland, 1987, Appendix D).

The report's authors claimed to have consulted and received support from Tainui Trust, Ngati-Whatua Trust, Te Whanau O Waipareira Trust, Auckland District Māori Council and the Māori Women's Welfare League.

This recommendation from the Committee was never implemented as the Auckland Hospital Board - transformed into the Auckland Area Health Board in 1989 - was sacked, then re-appointed later that year. In July 1991 all Area Health Boards were summarily dismissed by the then Minister of Health, Simon Upton. Harold Titter was appointed as Commissioner when the Area Health Boards were dismissed. He was subsequently appointed Chair of the newly formed Regional Health Authority, North Health, when it came into existence on 1 July 1993.

These constant changes demonstrate the impact of the tumultuous nature of the health reforms on Auckland. The Auckland Hospital Board and Auckland Area Health Board controlled enormous capital and income. They were the largest employers in the Auckland region. In 1990 there were around 14,000 staff who provided services to 33% of the New Zealand population. Relations between Wellington and Auckland were at times tense given that each tried to enforce their will on the other. Auckland was a runaway train carriage, in danger of taking the rest of the train with it.

Other areas covered in the report were how to improve intersectoral collaboration and coordination, inviting local representation through district health committees and the establishment of a regional health board. The objectives for the Auckland Regional Health Board System were as follows; maximisation of health, coordination and cooperation, equity, communication and influence, acceptability to users, sensitivity,

Māori health initiatives, information, education and research, staff morale, effective management and accountability (Committee to Review the Organisation of Health and Hospital Services in Auckland, 1987, p12-13).

Their stated Māori health objective was; “to foster Māori initiatives to provide culturally appropriate services and care” (Committee to Review the Organisation of Health and Hospital Services in Auckland, 1987, p13). The report concluded that there was a need for more structures to ensure that there was greater community accountability and input into health decision making. This would necessitate both regional and district structures. There was also an explicit acknowledgement that while there were too many structures nationally, in Auckland the reverse might well be true (Committee to Review the Organisation of Health and Hospital Services in Auckland, 1987, p7). The debates circulating within the health sector increased in tempo with a number of reports such as Choices for Healthcare (Taskforce, 1986) and Hospital and Related Services Taskforce (Hospital and Related Services Taskforce, 1988).

The 1990s health reforms were a response to a series of perceived problems within the health sector. A Health Boards New Zealand study tour found that New Zealand’s health system compared favorably with those of the United States, Canada, United Kingdom, Netherlands and Germany (Ashton, Beasley, Alley, & Taylor, 1991), but this did nothing to stem the tide of reforms introduced under the Minister of Health Simon Upton between 1991 and 1993.

The authors made the following observations: that reform should seek to improve the obvious weaknesses of the system without also undermining its strengths; that there were lessons to be learned from the experiences of other countries; that there were special cultural and social characteristics of New Zealand that must be taken into account; that the government should remain the dominant funder; that access to publicly funded health services in New Zealand should remain universal; that the state should explicitly state what services will be available for everybody; that responsibility for the funding of both primary and secondary care must be given to a single funding agency; that an across-the-

board funder / provider split could not be recommended at this time because of a number of factors such as additional administrative costs; uncertainties surrounding potential efficiency gains; and that there were implications arising from the embryonic state of general management for integrated service planning.

The authors also supported limited competition. They suggested allowing 'individual areas' to be free to tender for services from both public and private providers and argued that efficiency gains could be achieved through service based general management, although they recognized that this model of practice was still in its infancy. They also observed that the timetable for such reforms was unrealistically short (Ashton et al., 1991, pp 53-54).

The health reforms therefore attempted to open debate about an appropriate model of care. This included a shift towards a private market model, although there was also some discussion about whether New Zealand should adopt a social insurance model.

The 1990 health reforms consisted of a series of significant policy and structural changes to the health sector aimed at eliminating problems identified with the 'old system'. However, there were a number of reforms prior to 1991 when the Bolger National government began the most significant changes to the New Zealand health system to occur in over 50 years.

Two periods deserve special mention, the period where a comprehensive public health system was established in the late 1930s, and the period where Area Health Boards were introduced incrementally in the 1980s. Increased government expenditure in a period of constrained income during the 1970s in New Zealand, led to an undermining of the consensus that had driven the New Zealand health system from the 1938 legislation. This undermining of the previous welfare state based consensus was attributed in part to the declining value of the General Medical Subsidy (Cheyne et al., 1997, p 222). This subsidy was paid to General Practitioners for patient consultations. Other problems common to other OECD countries that led to the undermining of this consensus include

the increased 'demand for health services, an aging population, new technologies and higher consumer expectations' within New Zealand society (Dow, 1995, p 242). New Zealand shared these trends with other developed countries. These, coupled with a sense that the system was failing to produce equity, all contributed to pressure for reform within the health sector.

What were the Reforms Trying to Fix?

There were a number of perceived problems with the 'old' health system which the 1990s reforms were intended to address. A major problem was the increasing cost of providing health care to an aging population. In addition, New Zealanders had increased expectations of what the health system should and could do for them, including having access to an increased range of expensive technologies. Furthermore, politicians and the public had come to believe that the system needed fixing. All of these contributed to a discourse of necessity for major change that permeated politics in New Zealand during the 1980s and 1990s.

In July 1991 the Green and White Paper, *Your Health & the Public Health*, laid out the policy blueprint for the coming months. The report included a rationale for changes to the health sector. It stated that New Zealand 'lagged well behind the rest of the world in the provision of day surgery, shorter hospital stays and community-based treatment options outside the hospital setting' (Dow, 1995, p 241). The report claimed that costs of health care outstripped the increase in consumer prices by some 26 per cent between 1980 and 1991.

This view was contested by Michael Cooper who argued that the, "real cost increase in New Zealand's health services between 1980 and 1988 was 14 percent" (Dow, 1995, p 242). This was accompanied by increases in hospital admissions of 12 percent, outpatient admissions of 16 percent and day services of 150 percent during the same period (Dow, 1995, p 242).

The health reforms were also underpinned by a critique of the health system which considered that there had been cost-shifting, inefficiency, a lack of information, poor accountability and poor integration of primary and secondary care (Ashton, 1999). There were sharply divided views about the effectiveness and efficiency of the New Zealand health system at the time of the reforms, and there was little enthusiasm outside the government's inner circle of Treasury, Health Services Taskforce, Business Roundtable and cabinet for such major reforms.

Brian Easton has claimed that one of the reasons for the radical nature of the health reforms was the unexpected appointment of Simon Upton as Minister of Health (Easton, 1997a, p 151). Upton had a vision for health, which tended toward compulsory insurance for those individuals who could not provide for themselves.⁷

The extent, to which the health reforms reflected an ideological agenda consistent with changes in other public sector changes can be seen from the repetition of 'more market' as the solution to diverse problems. Public skepticism about the health sector had grown in part because of the greater public accountability brought about by democratically elected Hospital and Area Health Boards with extensive media interest in their activities. While there was widespread concern about the health sector, it was more in style than substance (Easton, 1997a, p 151). Furthermore, this concern was shared by many other OECD countries, with 18 out of 24 planning or implementing major changes to their health services by 1991 (Dow, 1995, p 242).

⁷ This view is spelt out in his Mont Pelerin Society prize-winning essay quoted in Easton (1997, p 151) as follows; "...there are the vicissitudes of ill-health and old age, which no one can hope to avoid. These should, whenever possible, be the responsibility of individuals. It may well be desirable to require some form of compulsory insurance to cope with those who would otherwise make no provision and then become a burden at a later stage...because a service is funded out of taxation, it does not mean that the government should actually provide the service itself. In many cases it will be possible to have the work put up for competitive tender by the private sector (S. Upton, 1987, pp 24, 26)."

Stated objectives of the reforms

The objectives of the new health sector between 1992 and 1993 were summarised in a report by Manatu Māori in 1992. These were;

- improve cost efficiency within health services
- reward the most effective health care providers
- improve choice and responsiveness: i) between public, private and voluntary providers, and ii) through finding more innovative ways of delivering health care (Manatu Māori, 1992, p 6).

In this report, Māori were exhorted to participate in the reforms proactively, but were also warned about the scale of the some of the changes and likely implications for population sizes based on overseas experience (Manatu Māori, 1992).

According to Ashton, the objectives of the health reforms were further extended to include the following (Ashton, 1999, p 135);

- to encourage efficiency and flexibility in service delivery
- to improve access to a system that is fair and affordable
- to reduce waiting times
- to widen consumer choice
- to enhance the working environment for health professionals
- to recognise the importance of public health

To these can be added:

- containment of public expenditure particularly in primary care
- purchaser provider split
- combining of funding for primary and secondary care
- reducing the power of health professionals
- increasing the power of health managers
- devolving responsibility away from the centre (central government)

The emphasis on containment of public expenditure arose from the neo-liberal emphasis on fiscal responsibility and minimising the role of government, particularly in service delivery. Government's role was limited to providing the overall policy framework within which these services would be contracted to various providers of services. Government was also to have a role in New Zealand in ensuring a 'safety net' for those unable to access services privately. While the New Zealand health system always retained a significant public provision in health services, this was driven by public reaction against the 1992/1993 reforms, rather than a belief by the then Minister of Health, Simon Upton, in the inherent rightness of such an approach.

Concern by governments about increased demand for health services and the escalating costs of such care was shared by other OECD countries (Van de Ven, 1996).

The split of a purchasing role from a providing role was premised on the perceived efficiencies that would eventuate from competition. This was linked to a belief in the inherent superiority of a market to deliver better health outcomes by forcing providers to become more accountable to purchasers and patients.

Interest in the integration of primary and secondary care came from two trends simultaneously, the drive for cost saving and the drive for greater consumer responsiveness which pre-dated the 1993 legislation. Greater consumer responsiveness challenged the health system to respond to episodes of patient care in a more continuous manner under the new reforms. This meant that there should be seamless care across public and private health agencies when managing the health of individual patients.

This interest in primary and secondary integration also came from a review of the hospital admissions that suggested that intervention at earlier stages to prevent acute episodes were beneficial for patients and for cost.

The health reforms originating in the National Health Service in the United Kingdom during the late 1980s were a precursor to the reforms in New Zealand. Decisions by

clinicians have different drivers than those of managers. The latter have primary accountability to the organisation for financial control and 'output' reporting. Clinicians experience different 'drivers' when confronted with patients or other medical colleagues: they were less concerned with cost than with ensuring clinical interventions for individual patients. Governments believed that these clinical drivers had contributed to escalating health costs and therefore controls were needed to change these. Managers became responsible for this control and effectively replaced clinicians in decision making roles in the health sector (Pollitt, 1994).

Successive Governments during the 1990s pushed for 'local solutions to local problems' as part of a devolution of government functions to other sectors. They encouraged this also in part because of a belief that local solutions would be more innovative and would respond to real life situations managed by those actually working with these communities. This suited some of the new initiatives such as Māori providers and IPAs because it allowed them greater autonomy from government and increased their sense of control over their own destinies based on their efforts.

This was a successful compromise by government because it generated goodwill while implementing their vision of a smaller central government role. In reality however, funding constraints and inequitable contracts between Regional Health Authorities and Māori providers and IPAs around the country hampered this promise of autonomy.

The overall intention of the Government was to address what were seen as inefficiencies in the health sector created by self-interest. They did this with little understanding of the health sector and relied heavily on reports from consultants, such as Alan Gibbs, who were also ignorant of the health sector. Alternative advice came from within the sector about how to address Government's concerns (Ashton et al., 1991). The Government, however, preferred to rely upon Gibbs' 1988 report which argued that savings could be made in the health sector through a different management regime, and that the health sector should be opened to the market to improve efficiency (Hospital and Related Services Taskforce, 1988).

Simon Upton, the then Minister of Health, pushed ahead with dramatic reforms which curtailed the growing impetus of Area Health Boards and refocused the health sector on a more mechanistic response to health need. The emphasis on contracting fitted the more-business-like approach of the newly reformed health sector. However, this approach to contracting would also lead to inherent inefficiencies, particularly among those providers working in less clearly defined areas such as community care and mental health (Ashton, 1998).

The findings of the Health Board's New Zealand study tour, published in 1991, advised the Minister against such dramatic reforms claiming that New Zealand's health system compared favorably with other similar OECD countries (Ashton et al., 1991). Rather than overturning the whole system, they recommended that reform concentrate on what was wrong with the system because of fears that strengths would also be lost in the overthrow. They also recommended that New Zealand's response be a specific to our needs as a country.

The Health Board cautioned that government should remain the dominant purchaser in health care and that access to health should remain based on universal provision for those services specifically identified by the government for funding. They went on to argue for a single funding agency for primary and secondary care and warned against revolutionary change because of the infancy of 'service based general management' (Ashton et al., 1991, p 53). Although supporting the idea of free tender by 'services from both public and private providers' (Ashton et al., 1991, p 54), they ultimately warned against the unrealistic timeframe for implementation of the extensive reforms proposed by Upton and his taskforce and spelt out in his paper, *Your Health and the Public Health*. Almost all of this advice was ignored.

The Hospital and Related Services Taskforce said there was a 30% potential for savings in the health sector if efficiencies could be implemented. This was based on the Chicago accounting firm Arthur Anderson's analysis. Easton has criticised this as it was:

based as much on wishful thinking and assumption as rigorous analysis. Much of its claimed potential 'productivity' amounted to cost-shifting; that is, switching costs from the public sector to the individual patient, family and community (Easton, 1997a, p 152).

In fact such cost shifting has been a key feature of the health sector during the 1990s with increased expenditure from private individuals, from ACC and from other government transfers (Ministry of Health, 1996).

Easton goes on to explain that the implementation of a radical reform agenda was likely to have been driven by the then Minister of Finance Ruth Richardson based on her own ideological commitment to New Right policies and faulty Treasury figures.

Public spending on health, at 14.0 percent of net financial expenditure in 1993/94, is a significant part of fiscal outlays. It was claimed, wrongly, that the volume of spending on public health was rising. The mistake arose in a Treasury paper which deflated the nominal spending with the wrong price index, failing to compare apples with apples, and then using a period which maximized the size of the error. The faulty Treasury figures had misled Labour ministers into accepting cuts in public spending. Upton quoted the incorrect figures frequently, both in opposition and in government. They were used to reinforce the thesis that the health sector was inefficient, since it appeared that although resources had been poured into the sector, outcomes had not markedly improved (Easton, 1997a, p 153).

The creation of quasi markets was seen as a means of improving efficiency and ensuring that distortions arising from agents intervening on behalf of consumers were minimised, maximising their utility as consumers in a marketplace. Contracting was the mechanism that enabled these markets to transact their business. Contracting therefore became increasingly sophisticated during the 1990s, specifying outputs from providers in greater detail and linking these to prices. While early contracting was very mechanistic, relational contracting was emphasised by the purchaser by the end of the 1990s.

The 1993 Health Reforms

The objectives of the health reforms were to be implemented through a number of strategies. Efficiency stemmed from competition, which created pressure to achieve efficiencies within the sector. It was also believed that competitive tendering would lead to greater transparency and would continue to drive down costs, which would then be reflected in the price paid by government for the same services. The source of service delivery became much less important than delivery of services to contracted specifications. Thus private providers were just as valuable as public providers as long as they could meet the quality standards and provide the services within the specified price.

The 1993 health reforms objectives were never fully implemented. However, key aspects of the reforms were, such as the purchaser provider split. Many of these strategies related to government's belief in the superiority of the marketplace to deliver quality within the health sector for a reduced price. The first sign of this in official documentation is in the Gibbs Report of 1988. In this report Gibbs claimed that the hospital sector could save a significant amount of money each year through efficiencies. The assumption was that effective management of this sector and business-like behaviour would generate these savings. This was an especially attractive message to a government under pressure to finance increasing expenditure in health.

Those aspects of the reforms that were introduced are summarised in Table below.

Table 7 Summary Of 1993 Health Reforms

Reforms Implemented
<ul style="list-style-type: none">• Separation of purchaser and provider• Establishment of 4 regional purchasers (Regional Health Authorities)• Integrate primary and secondary funds into Regional Health Authorities budgets• Restructure hospitals as independent businesses• Reconfigure 14 Area Health Boards into 23 Crown Health

Enterprises

- Establish Public Health Commission
-

The original proposals in the Green and White Paper in 1991 were changed to reflect no competition between purchasers, no definition of 'core' services, no transfer of funds for accidents to RHAs and no separate purchasers or providers of public health services (Ashton, 1999).

Rapid and extensive changes in the health sector during the 1990s meant different agencies were responsible for various roles. Purchasing organisations have changed six times between the announcement of the reforms in July 1991 and 2000 when the Public Health Services Act will demolish the Health Funding Authority. Between 1993 and 1997 there would be three changes to the purchaser, with two of those changes occurring in a six month period alone. This research is primarily concerned with the period where the Regional Health Authorities (RHAs) existed, it is also important to understand that these RHAs existed for a relatively brief period and were preceded and succeeded by other government funding bodies that also experienced considerable change.

Table 8 Chronology Of Events Health Reforms

November 1990	National Government elected
February 1991	Taskforce for Green and White paper under Upton
July 1991	Reforms announced, Area Health Boards abolished, Commissioners appointed by Minister of Health
February 1992	New user charge regime introduced
April 1993	Hospital charges abolished
July 1993	New structures introduced (RHAs, CHEs, PHC)
July 1995	Public Health Commission abolished and responsibility for public health purchasing shifted to RHAs
December 1996	Coalition Government changes CHEs name to HHSs (Health and Hospital Services) announced in Treasurers pre-budget statement
July 1997	RHAs abolished and Transitional Health Authority established

January 1998	Transitional Health Authority abolished and Health Funding Authority established
February	Health Funding Authority Interim Board to dis-establish HFA, merger
November 2000	with Ministry of Health and establishment of District Health Boards

While contracts became the major mechanism for organising work between government and providers, they were affected by a number of management positions that were crucial to the implementation of these health sector objectives. Many of these managers were recruited from the private sector or from key government agencies such as Treasury.

From the 1980s the health sector pursued,

the appointment of managers or the adoption of private sector management discourses and techniques. What is taking place ... is a deeper ideological process of managerialisation which is transforming relationships of power, culture, control and accountability (Cheyne et al., 1997, p 237).

Changes to the Reforms

A number of changes were made to the 1993 health reforms, these came about because of the experience of health professionals and managers in working with the reforms, and from the strong public backlash that occurred over aspects of the reforms such as the user pays philosophy.

There were other parts of the reforms that were never implemented or were abandoned. These included the removal of competing purchasers when Regional Health Authorities were merged into a single funder in 1997. The Bolger government also failed in its attempt to define 'core' health services with the committee responsible for this consultation giving up on any attempt. Funding for accidents was never transferred to Regional Health Authorities as intended under the reforms, with the difficulties around accident compensation proving far more complicated than originally envisaged. Lastly,

there would be no separate funder for public health with the early dis-establishment of the Public Health Commission in 1995.

The promised reform of managed care also never eventuated, although IPAs and some Māori providers were able to move towards this in a limited way by taking up budget holding or capitation.

The Ministry of Health acknowledged in its 1996 Briefing papers to the incoming government, that the health reforms had not delivered promised benefits;

Health sector performance over the last three years has been disappointing in a number of areas; costs have not been constrained in line with planned funding growth; both CHEs and RHAs have experienced deficits; although total output has increased, access to some services appears to have reduced; and only 35 percent of public health targets are expected to be achieved. There is widespread lack of confidence in the ability of the sector to meet performance expectations and in the credibility of policy settings (Ministry of Health, 1996).

Government Expenditure on Health During the Reforms

Total contributions by government increased in health, government's per capita contribution declined between 1990 and 1996 (Ministry of Health, 1996, p 48), although governments did increase the total amount of money for health . Increases in total expenditure in health have continued to climb in real and on a per capita basis, but the increase has largely been funded by a significantly larger private contribution to health expenditure (Ministry of Health, 1996, p 48). In addition there have been transfers from other organisations, such as the Accident Compensation Corporation (ACC), who have contributed an increasing amount to real health expenditure (Ministry of Health, 1996).

Ashton (1999) explains that the increase in total per capita expenditure on health was,

due entirely to increased private spending on health services (that is, personal expenditure, private health insurance, and charitable donations), which doubled in real terms since 1987 (Ashton, 1999, p 140).

Despite growth in real expenditure in health, the per capita expenditure was 4 per cent lower in 1996 than it had been in 1989 (Ashton, 1999, p 141).

In 1994 RHAs had sustainable funding paths that allowed them to increase funding in line with population, but not with inflation (Ashton, 1999, p 141). Further injections of around \$1 billion were made in the three years from 1993 to 1996, resulting in a turnaround in the period following the reforms in 1993, “from an average annual decline of 1.7 per cent in the four years from 1989 to 1993 to average annual increases of 1.1 per cent in the three years following the reforms” (Ashton, 1999, p 140).

The Ministry of Health 1996 briefing papers also pointed out that demographic growth alone would not allow RHAs to meet rising expectations or other pressures ‘outside RHAs’ control in the medium term’ (Ministry of Health, 1996, p 49). The Ministry saw that the danger was purchasers would look to cut those things which were easiest to cut such as elective surgery as CHEs sought to live within their budgets. It was thought that this might not produce the correct mix of services (Ministry of Health, 1996, p 49). In particular, pharmaceuticals spend continued to be a significant portion of the expenditure in Vote Health.

Hospital Boards and Area Health Boards had been plagued by lack of investment in assets and it appears that little changed during the period of the 1990s reforms. Responsibility for funding depreciation on assets and improvements to assets fell to individual CHEs to meet through the creation of efficiencies, sale of assets or private financing as part of their overall debt structuring. The increasing level of CHE debt became a concern for government who subsequently restructured the debt to produce more favorable balance sheets in the late 1990s (Hudson, interview, 12 November 1998).

Iwi Health Care Plans

Health Care Plans were a promised result of the health reforms. These were plans for health strategies for specific populations with agreed budgets.

During the late 1980s some iwi had already begun developing iwi health care plans which reflected their interest in an integrated iwi development approach. Iwi health care plans were clearly brought on the agenda during the period of moving to Area Health Boards of the late 1980s. They provided an alternative to regional health authorities (Durie, 1998c, p158), and they represented part of the spirit of the Hui Taumata's call for Māori development. Durie has described the 'selling' of these alternate health plans at various hui around the country following the 1990 budget.

There was enthusiastic support by the Task Force on Funding and Provision of Health Services for the Plans because they were seen as "supporting the empowerment of Māori people" and giving expression to "tino rangatiratanga" (Task Force on Funding and Provision of Health Services, 1991, p 158). This support was initially linked to discussion about social insurance:

Plans to privatise the demand (or purchaser) side were less elaborate. User charges for health care had been introduced and increased. The issue of the major source of funding was to be left to public discussion (with the Orwellian use of the term 'social insurance' to mean private insurance). There were to be 'health care plans' which were to allow a group to take its share of government funding and manage it separately, with the possibility of adding privately to the funds, which could ultimately lead to some sort of 'social' insurance. This proposal may have been the result of a compromise in the ministerial committee, arising from a refusal to commit the government to the more radical option of private funding. Certainly it appears ill thought through. Not surprisingly the health care plan proposals were later dropped as unworkable, although there remains a residual provision in the legislation (Easton, 1997a, p 157).

Easton claimed the discussion around social insurance was linked to Treasury and government intent to privatise the health sector and shift the cost from government to individuals (Easton, 1997a, pp 151-158). Māori were initially interested in the possibility of controlling monies on behalf of their own populations, but they remained wary of government's intentions with respect to iwi Māori health. The plans had been promoted

to Māori by the Task Force on Funding and Provision of Health Services as a means of Māori achieving 'tino rangatiratanga' (Durie, 1998c, p 155). While Health Care Plans were attractive, appealing to those populations who believed the existing health system lacked the "finesse or individual sensitivity" required, there were still problems to overcome.

Certainly there was Māori interest, though tempered somewhat by warnings that the development and management of health care plans would be a 'complex issue' and that financial viability would require a minimum of 25,000 members (or 50,000-60,000 if a plan were to employ its own medical and specialist staff). There was, of course, concern about other issues, including the unfair competition that could be expected between Iwi health care plans and RHAs, and the linking of health care plans with what would amount to a private health service for which the State might assume progressively less responsibility. The last thing that was needed was a health care system which was less accessible than the mainstream service or which, for financial or management reasons, was forced into delivering a substandard level of care.

Very quickly the availability of funds for Iwi to operate their own health care plans became a major concern. The Task Force had anticipated (though without any serious consultation) that Māori authorities would make substantial 'top-up' contributions which would supplement State funding. However, few Iwi had budgeted along those lines; nor was it likely that individual members, particularly those targeted because they were at risk, would be in a position to pay an annual subscription or membership fee, or that there would be a risk-adjusted entitlement from the government. Major outside funding would be necessary to inject a measure of reality into Iwi plans. Without it, collapse of a health care plan would be difficult to avoid (Durie, 1998c, pp 156-157).

The health care plans were attractive to other Māori organisations as well as to Iwi. Te Whanau O Waipareira Trust were early innovators of the capitation scheme offered during the 1980s. They were also quick to see the potential benefits of Māori health care

plans. Māori would be responsible for all aspects of service planning, purchasing and provision.

Many of these ideas were merged in later models promoted in the late 1990s, such as co-ordinated care and primary health care General Practice capitation. The attraction for health professionals and Māori was the greater control over services with a guaranteed level of funding and emphasis on promoting a healthy population. The thinking behind this model is that current systems skew patient and practitioner behaviour and that appropriate incentives to keep patients well were needed. Profitability, it was argued, comes from keeping patients healthy and out of the service, rather than by processing them through the service. Māori had a vested interest in keeping their populations healthy.

This view was reflected in subsequent policy approaches with regard to Māori, namely that benefits to Māori were to be sold on the alignment of health development with iwi development. Furthermore, an assumption that greater personal choice would guarantee better health outcomes was a recurring idea promoted under the New Right agenda. While control of health resources by Iwi may well deliver improvements in some key areas such as primary and preventative health strategies through education in areas such as immunisation and nutrition, there is no clear solution to the ongoing need for secondary and tertiary care.

Evidence that Māori health would be improved by 'opting out' of mainstreaming was found in negative statistics which showed that despite considerable utilisation by Māori of mainstream services Māori health status remained poorer than that of non-Māori (Pomare et al., 1995). There was, however, no available evidence to support the attraction of this model in place of the existing system, despite the fact that, "Health care plans were promoted as alternatives to the public system" (Durie, 1998c, p 159).

The attraction for iwi Māori of anything that promoted autonomy from the state while allowing them to control significant resources, continued during the 1990s. It appeared that health care plans and managed care offered this opportunity.

There were important concerns about these plans, such as the possibility that these, “could amount to a private health service for which the State might assume progressively less responsibility. The last thing that was needed was a health care system which was less accessible than the mainstream service or which, for financial or management reasons, was forced into delivering a substandard level of care” (Durie, 1998a).

The momentum for introducing health care plans slackened in the face of the government’s agenda to implement other major changes to the health system, in particular the establishment of RHAs in 1993. As Durie observed, “By February 1992 Māori attention had turned to other aspects of the reforms and particularly to the provision of health services by Māori providers” (Durie, 1998c, p 160).

Iwi health care plans were shaped to meet the new environment as Māori could see opportunities for participating in this reformed health sector. They were strongly encouraged in this by numerous government agencies, including Manatu Māori⁸ who wrote.

The report [Ka Awatea] suggested that the present system has failed to respond adequately to Māori needs. It stressed the need for Māori to participate fully in and contribute to the development of New Zealand. The good health of Māori is recognised as particularly important for this. Positive incentives must be given to Māori as individuals and as members of whanau, hapū and iwi and other community groups to take responsibility for their own health. The proposed health reforms provide some opportunities for Māori to be involved particularly in health care

⁸ Manatu Māori were the transition Ministry of Māori policy agency during the changeover from the Department of Māori Affairs to the Ministry for Māori Development (known as Te Puni Kokiri).

plans. Although these plans have the potential to influence the way health services are delivered and to address the health status of Māori, there is still a considerable amount of research and work that needs to be undertaken (Manatu Māori, 1992, p 24).

Tainui Health Plan

Tainui was one of the few Iwi who had a plan for their development, which included health services. As Durie (1994) has pointed out, “ The Tainui confederation of tribes ... had been interested in delivering their own health services in their own style since the time of Te Puea Herangi” (Durie, 1998c, p 164). Tainui have had a medical clinic in Ngaruawahia and Huntly from 1943, which was linked to a wider plan for socio-economic development, and they opened the Waahi Clinic at Huntly in 1983. These were, “not so much a health clinic as an arm of the Tainui development plan linked to other Iwi programmes and dedicated to positive and integrated development at historical, environmental, social and economic levels” (Durie, 1998c, p164).

Tainui published a comprehensive plan in June 1990. The plan took a community development approach and laid out a convincing argument regarding the need for iwi to control their own health services for their people. A series of hui with the Health Task Force were subsequently held. Prior to the publishing of the plan, a survey of the health needs of Tainui people found that Tainui people suffered from high rates of ill health, high rates of unemployment and low levels of formal education (Florin, 1990).

The report and research aligned health development as part of an overall strategy for tribal development, “The Tainui Health Plan is one of those policy statements which, with others, comprise an overall plan for tribal development” (Florin, 1990). Furthermore, the survey process found that Management Committees of local beneficial marae had prepared healthcare plans.

The existence of plans reflected the particular iwi dynamics of Tainui, with recognised Tainui marae and an Iwi organisational structure, which had developed from a history of land claims, whakapapa and support for te Kingitanga. Furthermore they had a long

history in health services from Princess Te Puea's time. Te Raukura Hauora O Tainui is responsible for Māori providers within the Tainui rohe. This preceded Tainui MAPO who became the Tainui purchaser under North Health's Treaty relationship policy during the mid-1990s. Wayne McLean has explained this history as follows:

The conception of Raukura Hauora O Tainui aims extend as far back as the 1930s, a period of high Māori mortality, when Princess Te Puea was instrumental in the construction of a hospital for Māori The next major step in health development occurred in 1983 when community health workers were established at Wāhi marae. This was built on the concept of the "barefoot doctor". In 1991 Raukura opened its first primary medical clinic. The organisation has now grown to 42 people employing medical practitioners, nurses, community workers, and alcohol and drug service personnel (McLean, 1997, p1).

On 15 December 1995 Raukura Hauora signed a Memorandum of Understanding with North Health as part of a complex series of mechanisms designed by North Health to include Māori co-purchasing within its purchasing function. Similar Memoranda were also signed with Ngati Whatua MAPO and Te Tai Tokerau MAPO (Māori Health Development Division, 1995, p2).

Conclusion

The National government's health reforms were concerned with extending the managerialist interventions of the previous Labour government in the health sector. These managerial reforms created some benefits, such as improvements in the quality of information available to make health-rationing decisions. New opportunities were also created that engaged key stakeholders such as Māori, Pacific peoples and General Practitioners in new healthcare arrangements with the potential to lead to improvements among crucial populations. However, the extent to which the reforms were successful is debatable, especially when put in the context of the total cost of successive reforms and the impact on the morale of those working in the health sector. Despite some improvements, serious questions remain about the overall cost of such changes and about whether such traumatic reforms were necessary to achieve the same performance.

Reservations expressed in the Health Boards New Zealand study tour report of 1991 were to prove prophetic. By 1996, even the Crown Company Monitoring and Advisory Unit (CCMAU) expressed the view that,

the health reforms have yet to yield the original expectations. By a range of measures (e.g. average length of stay, personnel costs, bed numbers) the pace of performance seems, if anything, to have weakened since the advent of the reforms (Crown Company Monitoring and Advisory Unit, 1996, p 21).

While the reforms changed the fundamental nature of the contract between the state and government, Māori viewed them more positively than other groups. The reason is that the health reforms have allowed two things to happen that have been important for Māori. The first is that it allowed Māori control and ownership over Māori health providers who have taken up the opportunities created by the new purchasing decisions.

The prospect of greater Māori control over health services was taken as evidence of a greater willingness by government to address Māori health. This was understandable given Māori desire for empowerment and autonomy, but in the context of other public policy changes impacting on Māori as a population, this was perhaps too generous a view. There was hope that control over some health services and improvement of access would address the key problems impacting on Māori health. However evidence showing a link between improved access is absent, especially improved access at the low level which exists even after the reforms and after the establishment of many more Māori health providers. Yet these two assumptions about the importance of Māori control of health providers and improvement of access as the key to improving Māori health drove the reforms.

There was widespread and almost unanimous Māori support for Māori ownership of Māori health providers and a belief that improved access to primary health care was an essential strategy for improving Māori health status. Such a high degree of consensus

within the Māori community has contributed to the perceived success of the health reforms for Māori.

There was also widespread support from other mainstream providers in both secondary and hospital care sectors. This level of mainstream support has been essential for the survival of these Māori providers. The political support that established Māori health providers may well dissipate over the next few years as the realities of the full cost of providing comprehensive primary health care to Māori clients becomes clearer. At the moment Māori health providers are funded for their capital costs through various ad hoc funds such as Māori Provider Development Subsidy (MPDS) and Transitional Assistance Grants (TAGs). These are short-term, high capital costs that are useful for establishment of providers but their operational contracts do not reflect these costs. This suggests that there will be difficulties for Māori providers in the years ahead in terms of meeting these 'hidden' costs.

CHAPTER 6

Social, Economic And Cultural Determinants And Health: Theorising The Evidence

Introduction

There are a number of ways of explaining who gets ill and who stays well. These explanations are of interest to policy makers because they inform interventions and influence decision-making. How these ways of explaining health come to dominate public policy is of as much interest as how effective they are (based on the evidence of success through intervention). These ways of explaining illness include germ theory, lifestyle theory and structuralist theories (Fougere, 1990, pp 149-150). More recently two alternative theories have grown in influence: gene theory, which has grown from biomedical interest in the influence of genes, and socio-economic determinants theory, which has grown from a broad public health analysis. Each of these theories of causation has implications for strategies used to address these illnesses (Fougere, 1990, p 149). More recently in New Zealand debates about socio-economic determinants have been extended to incorporate cultural determinants - which have been explicitly identified, having previously been subsumed as socio-cultural or psycho-cultural determinants - as a refinement for explaining disparities between Māori and non-Māori health (National Health Committee, 1998). For the purposes of this analysis culture can be defined as the 'symbolic systems of a people'. These symbolic systems are reflected in people's social and cognitive behaviour and therefore shape a distinctive mode of life for a particular group (Fabrega, 1979, p 29).

Historical concerns about public health have focused on the impact of external physical factors on the health of populations with issues such as sanitation, clean water and safe housing as examples. These environmental factors extended to concern about pollutants, ozone depletion and similar 'external' factors. This compares to more biomedical

concerns where 'internal' influences are emphasised, including things such as the germ, the gene and individual pathology and how these are then expressed in health outcomes. More recently public health has become increasingly interested in socio-economic determinants as a means of explaining why illness strikes some populations more than others. This interest arises from a growing body of evidence that shows that socio-economic status and ethnicity act as determinants for health outcomes in populations (Brown, 1998; Brown, 1999; Brunner, 1997; National Health Committee, 1998; Howden-Chapman, 1998; Davis, 1998; Black, 1992; Fougere, 1990; Jackson, 1998; Gori, 1998; Kawachi et al., 1997; Wilson, 1997; Macdonald, 1982; Lillie-Blanton, 1996; McKeown, 1976; Navarro, 1990; Pearce et al., 1984; Crampton, 1996; Beaglehole, 1997; Wilkinson, 1996). Differences in rates of mortality and morbidity also reflect patterns of social inequality within and between populations (Fougere, 1990, p 149) and this basic social inequality may itself materially affect these rates (Wilkinson, 1996; Wilkinson, 1997).

The discussion about socio-economic determinants has arisen from within the public health sector. However, public health explanations of well-being have not been accorded a high status internationally. This low status has been attributed to a political and economic preoccupation with market forces and individualism (Beaglehole & Bonita, 1997, pp xiii-xvi). The professional power of the medical profession has been subsumed within political and economic concerns wherein the pathological is elevated as the pre-eminent explanation. Such an approach allows Māori to conceptualise sickness as being solved by biomedical science and results in the view that health is "a personal and technical problem rather than a political one" (Tesh, 1988). How Māori come to conceptualise health is therefore dependent in part not just on the progression of knowledge in the Popperian scientific tradition but is also a response to a wider environment where powerful professional, political and other actors legitimise particular modes of enquiry (Fougere, 1990).

Put differently, some epidemiologists have been concerned with 'decontextualised individual risk factors' instead of 'upstream' causes such as poverty (Pearce, 1996). Rothman has argued that epidemiologists have

abandoned their public-health mission of being “physician-scientist” to society in favour of studying the scientific arcana of disease causation (Rothman et al., 1998, p 810).

Critics have responded to this argument by drawing attention to the multiple problems associated with trying to solve such big problems as poverty. In particular they point to the ‘less secure inferences about the causal path’ of disease as they move towards root causes, making the link between effective intervention less certain rather than necessarily more effective. The link between many policy level interventions and health outcomes remains unproven and therefore particular types of intervention at this macro level may, or may not affect the particular health outcomes sought (Rothman et al., 1998, p 811).

Hauora Māori has not been premised historically on scientific explanations, rather it has been based on supernatural explanations where illness resulted from disruptions in the balance of relationships between humans and the ‘natural order’. Underlying this view are notions of reciprocity, tapu, noa, mana, wehi, ihi and mauri. A number of models have been developed to explain how Māori health is conceptualised, each reflecting an interest in more holistic explanations (Durie, 1998c, p 69). The Whare Tapa Wha model for example, incorporates taha wairua (spiritual), taha hinengaro (mental), taha tinana (physical) and taha whanau (extended family) where ‘health is viewed as an interrelated phenomenon rather than an intra-personal one’ (Durie, 1998c, p 71). Arguably the more contextualised explanations of health are more consistent with traditional Māori explanations, although it is likely that all explanations offer some promise to Māori for health improvements.

Explanations of Illness

There are a number of different ways of explaining illness as well as health. Māori explanations of illness identified four main causes: mana atua, mana tangata, mana whenua and mana Māori (Durie, 1998c, p 27). Mana atua came from the divine intervention of supernatural godlike beings (ibid). These interventions were ascribed to some failure in obligation by a person or persons to maintain balance within the ‘natural order’, for example, by breaching tapu or a rahui. Durie identifies epidemics and new

infectious diseases as examples of this explanation. Mana tangata came from the actions, inheritance or skill of humans, thus accidents or injuries through warfare, or lifestyle changes affecting nutrition, exercise and sanitation are all examples (ibid). Mana whenua derives from iwi and hapū exercising territorial rights such as pupuri whenua (retaining land) and tuku whenua (selling land). The health consequence is the alienation of land and subsequent erosion of an economic base and weakening of individual and tribal mana (ibid). Lastly, mana Māori identifies Māori people as being excluded from decision-making and concerns minimisation of Māori political power through the actions of the settler government (ibid). This is despite repeated Māori attempts to establish mechanisms for ensuring Māori decision-making and the exercise of Māori political power (Walker, 1990). What Durie's analysis reveals is a multi-layered understanding of the causation of illness. In the same way, Māori can understand the contribution of western medicine as providing a multi-layered explanation of illness. The tendency has, however, been to dismiss Māori explanations as 'superstitious phenomena and of doubtful diagnostic significance (Durie, 1998c, p 66).

At the Hui Whakaoranga held at Hoani Waititi Marae in 1984, the view that "there is no such thing as Māori health or Pakeha health; there is only people health" (Durie, 1998, p 66) was rejected despite the speaker's claims that healthy life-style choices such as good eating, plenty of sleep and exercise and moderation in all things would benefit Māori as it would other races (Durie, 1998c, p 66). Durie argues that such views,

Ignored Māori experience and the growing body of evidence which linked culture and health; and second, they disregarded socio-economic status as a significant determinant of good health quite apart from individual motivation (Durie, 1998c, p 66).

Rather, the Hui Whakaoranga concluded that cultural factors were important to health.

The notion of what is health varies between one organization, cultural group, iwi (tribal group), hapū (subtribal group), whanau (family), or individual or another ... A Māori view of health is broader in that it incorporates a spiritual component holistic philosophy. It is "a state of complete spiritual, mental, family and physical unity, harmony and well-

being". Māori people believe that these various dimensions cannot be viewed separately. They are interrelated to form a whole and are the cornerstones on which good health is founded (Department of Health, 1984, pp 14-15).

Māori rejection of western medicine is based on its inadequate explanation of, or response to, Māori illness as it is based on its dismal failure to address Māori illness (Durie, 1998). Māori responses therefore to the validity of such explanations are based on their experience of these 'treatments'. In particular there are questions about how these theories of health are used to justify western explanations of health, and why consequently there are 53% more Māori deaths within each social class, than if they had the same mortality rates as non-Māori (Fougere, 1990, p 149).

These theories of health continue to have a major effect on explanations of illness and health and they are therefore worth considering in greater depth. Germ theory has arguably been the most pervasive (ibid). It views

human beings [as] locked in battle with nature and sickness results from invasion by hostile micro-organisms. Medical science aims to identify and deal with the organisms responsible (Fougere, 1990, p 149).

Solutions to the invasion of these micro-organisms are drugs and vaccinations created by biomedical science. As such this legitimises the specialist biomedical knowledge of doctors and thus maintains their privilege (Fougere, 1990, pp 149-150). Other dominant groups also benefit from this, since it relegates health decisions to the realm of politics and health outcomes to the realm of medicine. Clearly germ theory has contributed to improved medical care but it is obviously inadequate when explaining the 'level and distribution of illness within societies' (ibid).

Most importantly Māori should consider McKeown's seminal work, *'The Modern Rise of Population'* where he says

They [medical historians] have investigated the behaviour of individual diseases, particularly of infectious disease, and a good deal has been written about the decline of mortality from tuberculosis, smallpox, typhus,

scarlet fever and some other infections. But the medical historian has had little incentive to consider the decline of mortality as a whole, and while by remaining silent he may seem to have endorsed explanations suggested by economic historians, he has really ignored them (McKeown, 1976, p 4).

McKeown found that the impression created by the medical profession that the late nineteenth and twentieth decline in mortality, which occurred largely as a result of a decline in infectious diseases, was in part due to the 'modification of the relationship between organism and host' could not alone explain the enormous reduction in mortality. (McKeown, 1976, p 153). Falls in mortality were not substantially influenced by immunisation or therapy before 1935 when sulphonamides became available, rather the decline in rates of mortality from infectious diseases such as 'smallpox, syphilis, tetanus, diphtheria, diarrhoeal diseases and some surgical conditions' made only a small contribution to the total decline (McKeown, 1976, p 153). Some of the explanation could be related to the reduction in 'intestinal infections' and the introduction of 'hygienic measures' during the second half of the nineteenth century. However, the most acceptable explanation for the 'large reduction of mortality and growth of population which preceded advances in hygiene is an improvement in nutrition due to greater food supplies' (McKeown, 1976, p 153) and the decline in mortality from non-infective causes of death such as infanticide and starvation due to contraception, improved nutrition and women's greater ability to avoid unwanted pregnancies (McKeown, 1976, p 154). It should be noted that medical professions were actively involved in promoting better hygiene practices internationally. In New Zealand this was also true, although Apirana Ngata and Maui Pomare were especially active in promoting good hygiene at the turn of the century with respect to Māori villages (Lange, 1999, Dow, 1999).

McKeown questions the destructive micro-organism premise of germ theory by arguing that 'micro-organisms and man have evolved in balance, and [that] their relationship is changing constantly through the operation of natural selection in parasite and host ... it is not to the advantage of a micro-organism to kill its host, and after a period of adaptation the two may settle to a relation of mutual tolerance, or, occasionally, advantage.'

(McKeown, 1976, p 157). The condition of the host is therefore important and nutrition plays a major role in this. Malnourished people are usually poor, and exposure to infection amongst populations is more likely to lead to death (McKeown, 1976, p 157-158). McKeown's thesis is that the greater availability of food from the end of the seventeenth century, due to the 'more effective application of traditional methods' of farming, improved nutrition and when coupled with more effective contraception allowed a growth in population through a reduction in mortality (McKeown, 1976, pp 158-159). A reduction in exposure to disease due to improvements in the quality of the environment also contributed. Such improvements included

Purification of water, efficient disposal of sewerage, and food hygiene, which together led to a rapid decline of intestinal diseases spread by water and food (McKeown, 1976, p 159).

Socio-Economic Determinants

While medical research has focused on the causal pathways for illness challenges have come from within the profession in the form of a realisation that who gets well and who gets sick 'is largely determined by social rather than biological facts' (Fougere, 1990, p 148). This has focused attention on broader explanations of health. The unequal distribution of illness within populations draws attention to matters which are in part technical, but are also in a large part political and it is this latter part that creates nervousness amongst scientists, physicians and policy makers. It suggests ultimately that excess mortality and morbidity is to a large extent preventable if there is sufficient political will to address the problem according to the interests of society.

The evidence is premised on the association between these indicators and health and well-being supported by the socio-economic and cultural determinants literature (Howden-Chapman & Cram, 1998; National Health Committee, 1998).

Howden-Chapman and Cram identify key determinants of health in an industrialised country such as New Zealand as: household income which is not markedly below the average income, employment, safe working conditions, education, an adequate diet,

warm dry housing, family support and the absence of smoking (Howden-Chapman & Cram, 1998).

Interestingly, the Black Report (The Black Report, 1980) concluded that the following strategies were the best way of dealing with the impact of inequality on health; i) adopt a comprehensive anti-poverty strategy, ii) develop a policy for families and children comprising of a child benefit, infant care allowance, pre-school education and day care, guaranteed nutrition with school milk and meals, minimising accidents to children, iii) a series of strategies to address disability, improved working conditions and housing, addressing the machinery of government to enable this happen, and establishing a Health Development Council to oversee these (The Black Report, 1980). The report also identified the relationship between social class and access to service, revealing an inverse relationship between those with greatest need and their lack of uptake of services, especially prevention services (Te Puni Kokiri, 1993a, p 40). Māori are such a population.

The interest in socio-economic determinants springs from a population level analysis and the view that social conditions influence health is borne out in numerous studies (Berkman & Kawachi, 2000, National Health Committee, 1998). To better understand the contribution that can be made to improving the health of those affected by inequality, Berkman and Kawachi propose four concepts to assist any analysis. Firstly they identify that individuals are embedded in societies and populations, and therefore an individual's risk of illness cannot be considered in isolation from the disease risk of the population to which they belong (based on Rose, 1992). The second concept is the social context of behaviour. This is based on evidence that certain types of behaviour are not randomly distributed throughout the population, but are socially clustered. For example those people who smoke are also more likely to drink and those who are diet conscious are also more physically active. Also, people who are poor have low levels of education and are more socially isolated (Berkman & Kawachi, 2000, p 7). Thus behaviours occur within a social context and are not just an expression of individual choice. The third concept is contextual multilevel analysis. Conceptions of how culture, policy or the

environment influence health remain unclear, however it has become increasingly clear that there are 'ecologic-level exposures related to the social environment that are not adequately captured by an investigation at an individual level' (Berkman & Kawachi, 2000, p 8). Determinants such as housing availability, voting patterns and geographical location may all influence health. The fourth concept is a developmental and life-course perspective associated with cumulative risk. Berkman and Kawachi identify three hypotheses to explain early life influences and the onset of disease in later life. 'The first is that some exposures in early childhood could influence developmental processes – particularly brain development during periods of great plasticity' (Berkman & Kawachi, 2000, p 8). The next hypothesis is 'one of cumulative disadvantage', where early disadvantage in life sets in motion a series of subsequent experiences that accumulate over time to produce disease after 20, 40, 50 or 60 years of disadvantage' (Berkman & Kawachi, 2000, p 9). The last hypothesis is that while early experiences set the scene for later experiences, it is only adult experiences that are directly related to health outcomes. 'For instance, low educational attainment in earlier life might matter only in so far as it constrains the range of job opportunities and job experiences' (Berkman & Kawachi, 2000, p 9). Berkman and Kawachi conclude that the evidence does not strongly support one hypothesis over another, but does show how complex the patterning and accumulation of social experience may be in shaping health outcomes.

In 1996 Wilkinson proposed that health was affected by the relativities between populations within any given society and that furthermore, this trend could be observed between countries as well as within countries. The more equal the society, then the more likely that the population as a whole enjoyed better health. This was known as the relative income hypothesis. Despite criticisms, evidence has been building about the validity of this finding. In a recent publication Kawachi, Kennedy and Wilkinson found,

The evidence shows that the distribution of income among members of society matters as much for their health and well-being as does their absolute standard of living. These research findings are increasingly important because the world's wealth is daily becoming concentrated in fewer hands (Kawachi, Kennedy & Wilkinson, 2000, p xi).

The significance of this for Māori is obvious. During the past 16 years New Zealand's inequality has risen dramatically (Podder and Chatterjee, 1998). Māori have consequently been detrimentally affected by this. Relativities between Māori and non-Māori have decreased with increased disparity evident in income, educational attainment and housing. Employment has fluctuated but unemployment has hit Māori hardest of any population in New Zealand. If poverty, racism⁹ and inequality are major contributors to Māori illness and early death, then these have actually worsened during the period of neo-liberal reforms and it is doubtful that the gains created by Māori providers can bridge the gap.

The Ministry of Health identify three theories for explaining health expectancy for populations. These three theories are 'compression of morbidity', 'expansion of morbidity' and 'dynamic equilibrium' ((Ministry of Health, Our Health Our Future, 1999, p 239). These are summarised in the Table below.

Table 9 Health Expectancy Theories

Source: Ministry of Health, Our Health Our Future, 2000, p 239.

Expansion of Morbidity	Gruenberg (1977), Kramer (1980)	Mortality rates would decline as the result of decreases in chronic disease fatality rates, rather than declines in the incidence or slowing of the rate of progression of these diseases
Compression of Morbidity	Fries (1980)	The onset of chronic disease would become increasingly postponed to later ages largely as a result of improved socio-economic conditions and healthier lifestyles. However, the human life span is genetically fixed at a biological limit that we are approaching. Morbidity will

⁹ Camara Jones' explanation is that racism resulted in the initial structural disparities between Māori and non-Māori and that her experience of Black Americans suggests that there are physiological consequences to such racism, exhibited in things such as raised blood pressure.

therefore become increasingly compressed into the last few years of life.

Dynamic Equilibrium	Manton (1982)	Decreases in fatality rates are accompanied by decreases in the incidence and progression of chronic diseases. Increases in improved morbidity through survivorship, are offset by decreases in severity through the delayed onset and effective medical care that slows the progression of many diseases. An equilibrium results between life expectancy and health expectancy with both increasing, although the ratio remains stable.
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The implications of these theories for Māori are unclear since Māori have fewer aged in the population and risk for burden of illness is more evenly distributed across the whole population rather than located in the elderly (Ministry of Health, 1999, p 256). However, it is significant that a fundamental premise of all three theories is improvement in access to medical care. Studies suggest that Māori actually have poorer access to services than non-Māori in both primary and secondary care (Malcolm, 1996, Malcolm, 2000, Jackson et al, 1999, Viathianathan & Mutch, 2000), and furthermore, this is even more significant when accounting for health need (Ministry of Health, 1999, Scott, Ministry of Health, personal communication, 1999).

Mortality, Ethnicity And Social Class

Pearce and colleagues (1984) investigated the relationship between mortality, ethnicity and social class for men of working age (and thus men whose occupations were given on death certificates) between 1970-1978. All ethnic groups (Māori, Pacific Island, and other) showed strong social class gradients. For Māori, the overall mortality rate was 50% higher than for the non-Māori non-Pacific (and predominantly European) ethnic group. Māori mortality rates were much higher for respiratory illness, infectious diseases, genito-urinary diseases, endocrine, nutritional and metabolic disorders and diseases and those of the circulatory system (with the exception of coronary heart disease and cerebrovascular disease. Questions have been raised about these exceptions since

they are believed to be due to under-reporting (such as in an unpublished study by Tipene-Leach on cerebrovascular and coronary heart disease for Māori, 1999). These differences in mortality were largely independent, so that only 19 per cent of the Māori excess mortality was attributable to social class factors. The researchers concluded that interventions aimed specifically at lower socio-economic groups would not eliminate the mortality differences between Māori and non-Māori (Pearce et al., 1984, p 29).

In a follow-up study, Pearce and colleagues (Pearce, Pomare, Marshall, & Borman, 1993) found that mortality for Māori men fell by 28 per cent from the mid 1970s to the mid 1980s, which was twice the reduction for non-Māori men. However an increasing proportion of the excess mortality (30 per cent) was attributable to social class differences.

Research by Brown and Salmond (Brown, 1998; Brown, 1999; Brown & Salmond, 1997) found that from 1984, the ratio of Māori to non-Māori mortality increased for all age groups except those under 25 years and over 79 years. Brown and Salmond linked these changes with the economic reform period. Brown concluded that Māori decline in economic stability was a source of stress for middle-aged Māori and may therefore be a contributing factor to an increase in relative mortality (Brown, 1999).

In a study by Pearce and Sporle on Māori male mortality (a follow up study on an earlier study on Māori male mortality published in 1984), they found that;

Māori / non-Māori differences in SES and mortality in the years 1994-96 were analysed as part of our study on time trends in social class and ethnicity differences in mortality in males aged 15-64 in New Zealand. The data indicated a much larger SES gradient in mortality rates by SES (NZSEI) for Māori than for non-Māori in both relative and absolute terms. A corollary of this is that there is little Māori / non-Māori difference in the higher social classes, but very large differences in the lower social classes (Sporle, 1999).

Comparisons between mortality statistics before and after 1995 are complicated by the change in recording of ethnicity. There is a marked increase in the proportion of all male deaths that were recorded as Māori from 1994 (11.3% of deaths recorded as “50% or more Māori blood”) to 1996 (20.9% recorded as Māori ethnic group). As a result, the relative risk for mortality in Māori increased from 1.64 in 1994 (Sole Māori denominators) to 2.46 in 1996 (Māori ethnic group denominators) (Pearce, 1999, p 412).

The findings of a recent study by Blakely, Kiro and Woodward found evidence to support the significance of ethnicity in mortality (Blakely, Kiro and Woodward, paper in press NZMJ). This provides support for earlier work by Pearce et al on Māori male mortality. The study also found that there was a marked geographical gradient across the country with northern Māori experiencing higher rates of mortality than those in southern geographical areas. There also appeared to be an age related effect with those aged over 49 years even after adjusting for age.

While these studies attempt to explain the relationship between economic reform or policy reform and mortality, especially when considering the impact of social class and ethnicity on mortality, there is other information that suggests that this fits within a broader framework of equity as a legitimate health goal. For example in its draft report on Equity and Health, the Taskforce for the World Health Organisation found that,

In contrast, the southern “social welfare model”, New Zealand has seen a dramatic increase in income inequalities since the mid-1980s, and the gap in health status between Māori (the indigenous population) and the rest of the population is widening after decades of gradual narrowing (Mills, 1998, p 7).

The WHO report goes on to note that between 1985/7 Māori male life expectancy was less than 4 years lower than for all males; by 1996 this gap had widened to nearly 7 years, with Māori male life expectancy static / slightly declining. Female statistics showed similar trends. During the period between 1980 to 1984 and 1987 to 1991, the overall reduction in the Māori age-standardised death rate was similar to the non-Māori rate, whereas between 1970 and 1984 the reduction was twice that for non-Māori.

Davis (1984) has argued that health patterns for Māori in particular draws on our distinctiveness, including our colonial past (Davis, 1984). This past reflects not just Māori history of colonisation but also the unique history of a people who have lived in Aotearoa New Zealand for over 1,000 years. Māori have a unique language, cultural practices, beliefs and values that while shared with many other indigenous peoples, are also unique to Māori.

There are close comparisons with other indigenous peoples internationally. In particular the experience of native Americans, including Hawaiians, native Canadians, Aboriginals and parts of the Pacific Islands have been used as a basis for comparison with Māori (World Health Organization unpublished report on Indigenous Health, Geneva, 1999).

There are direct parallels with overseas health trends. For example Navarro (1990) identified significant mortality differentials in the United States based on race and class (Navarro, 1990). Kunitz (1994) also found that the history of European colonisation led indigenous peoples to experience detrimental health outcomes such as lower life expectancy.

Conclusion

Māori health results from the interaction of many factors. Māori clearly experience a disproportionate burden of illness and poorer health expectancy (Ministry of Health, Our Health Our Future, 1999). Theories of compressed morbidity, expansion of morbidity and dynamic equilibrium in health expectancy all lead to significantly different outcomes for Māori depending on which one will prove to be correct (Ministry of Health, Our Health Our Future, 1999, p 239).

Evidence about the impact of social and economic inequality on health raises concern for Māori since the policy reforms over the past 16 years have increased inequality and poverty among Māori. Therefore theories about the impact of relative incomes on health,

impacts of age structure on life opportunities and health outcomes are of special interest here.

These theories are more consistent with Māori views of health because they assume a more holistic understanding that encompasses the social, cultural and environmental world. The particular 'pathways' for morbidity and mortality have been of less interest to Māori than concerns around ownership and participation since the mid-1980s. These interests must be balanced to ensure that major health gains and opportunities for improvement are possible and not solely dictated by a limited view of possibilities for Māori health. A population level analysis that incorporates ecological explanations is likely to fit more with traditional Māori values and beliefs.

CHAPTER 7

Examining The Evidence: Māori Social And Economic Outcomes, Determinants And Indicators

Introduction

It is methodologically difficult to make direct links between particular policy decisions and specific health outcomes and there may be insufficient evidence to suggest strong associations between policies and outcomes. However, some conclusions can be drawn about these associations. This Chapter looks at changes in health outcomes for Māori, and changes in the determinants of Māori health, as shown by the fallacy markers or indicators: unemployment, income, educational achievement, housing tenure and health status.

In 1998 four official reports (Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori from Te Puni Kokiri, The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health from the National Health Committee, New Zealand Now: Māori from Statistics New Zealand 1998 Edition, Our Health, Our Future: Hauora Pakari Koiora Roa from the Ministry of Health 1999) provided compelling evidence of the well-being of Māori. These four reports gathered evidence from a wide variety of official sources and together provided a comprehensive analysis of what was happening in New Zealand society for Māori, especially in comparison to the rest of the population.

While Māori die of similar diseases or events to those that non-Māori die from, they die at consistently higher rates and in many cases, at earlier ages. Across a range of measures for morbidity and mortality, Māori experience higher burdens of illness, lower life expectancy and curtailed quality of life. Māori rates of avoidable death were 2.5

times that of European/Others in New Zealand in the period 1996 to 1997 for those aged between 0 and 74 years of age (Ministry of Health, 1999, p 320).

Limitations Of Information About Ethnicity

There are serious problems with the data that limit any trend analysis of Māori health and well-being (He Kakano Handbook of Māori Health Data, Te Puni Kokiri, 1993, p 1, Hauora Māori Standards of Health III, p 30, Our Health Our Future, Ministry of Health, 1999, pp 59-60). The changing criteria used in censuses and variable definitions used between government departments to collect official data on deaths, births and general practice consultations and hospitalisations in primary, secondary and tertiary care, make it impossible to develop meaningful time series comparisons.

Denominators for New Zealand ethnic populations are derived from Statistics New Zealand census data. Discontinuities have occurred in the census data as a result of changes to definitions of ethnicity. The 1971 Census question on ethnicity departed significantly from that used in earlier censuses, so affecting the ethnic specific time series. The change from a biological definition of Māori in the 1981 Census to a broader self identification of cultural affiliation in the 1986 Census (with respondents being able to identify with one or more ethnic groups) resulted in discontinuous change to the enumerated 'Māori' population between these years. Changes to the census ethnicity questions in 1991 and again in 1996, to further allow for classification on the basis of multiple ethnic group affiliation, further disrupted the time series (Our Health, Our Future, Ministry of Health, 1999, p 59).

In addition to these problems with consistency in collection of ethnicity data, there is an absence of data collection in key policy areas over the period of the reforms such as in housing. For Māori particularly the question of validity of ethnicity data is crucial. Māori deaths and hospitalisations may be under-reported (Mason, 1999; Pearce, 1999; Reid & Robson, 1998). There are several reasons for this under-reporting including changes to classification of race and ethnicity:

On September 1 1995 there was a change in the official methods for collecting ethnicity information for births and deaths in New Zealand. Death registrations before this date involved obtaining information on the deceased's degree of Māori or Pacific Island 'blood' and deaths were classified as 'Māori' if the deceased was reported to be of 50% or more Māori 'blood'. The completeness of responses was unknown, but several studies indicated that official statistics significantly underestimated Māori deaths (Pearce, 1999, p 411).

The use of '50% or more Māori blood' numerator and 'sole Māori' classifications for the denominator, were found to be similar and were therefore used to calculate risk. Ethnic affiliation of the deceased is now recorded using the same system as the 1996 Census and this allows for multiple ethnic affiliations (Pearce, 1999, p 411). These changes were made in an attempt to more accurately reflect what Māori themselves use as a basis for classifying their belonging to a population called Māori.

This reclamation of Māori identity by Māori during this century must be viewed along with an element of protest by Māori that the Crown had assumed the power to decide who was a Māori (Reid & Robson, 1998, p 268).

Reid and Robson (1998) state this is not merely an academic exercise, since the way in which ethnicity is calculated has a significant impact on our understanding of health status.

For example, if we compare the first admission rates for Māori and non-Māori women with psychiatric disorders between the years 1991-1993, we find there is a significant disparity using sole Māori as the denominator. By using the Māori ethnic group as the population denominator, this disparity is sizably reduced and may result in different policy advice being proposed (Reid & Robson, 1998, p 269).

There are also problems with Māori hospitalisation statistics because of the impact of self-identification, and the changeover in the time period from calendar year to fiscal year for 1997/98 data.

Hospital ethnicity data is supposedly based on self identification upon each admission, but in some cases (eg. emergency treatments) the person may not be asked to state their ethnicity. These cases will be classified in our statistics as non-Māori, and consequently Māori hospitalisation data may be underreported (Mason, 1999).

How Many Māori Are There?

Answering the question of “how many Māori are there?” is problematic because of difficulties in conceptualising race and ethnicity, problems with the recording of data which include inconsistent and unclear guidelines, and the personal behaviour of New Zealanders who may respond to questions on ethnicity in different ways. The discourse about the problems of ‘being counted’ has moved more centrally onto the Māori health research agenda because of the reliance on accurate and timely information to monitor Māori health outcomes.

Difficulties in classification have changed from a ‘race-based’ concept which used proportion of blood, to self-identification with multiple iwi as a ‘de-facto’ indicator for identifying as Māori and belonging to this ‘group’ (see Ministry of Health, 1999 quote above). At one level the debate about how to best count Māori focuses around the mechanisms for data collection used by various official agencies. At another level it is about the right of Māori to be counted accurately in the birth and death statistics, and the possible masking of the magnitude of particular political changes on Māori health. The inherent inaccuracies of using race as the basis for classification of health outcomes and the preference for using ethnicity is more consistent with British thinking on the relative importance of class and race (Smaje, 1995; Smaje, 1996a; Smaje, 1996b). This does not however, answer the question of how many Māori there are.

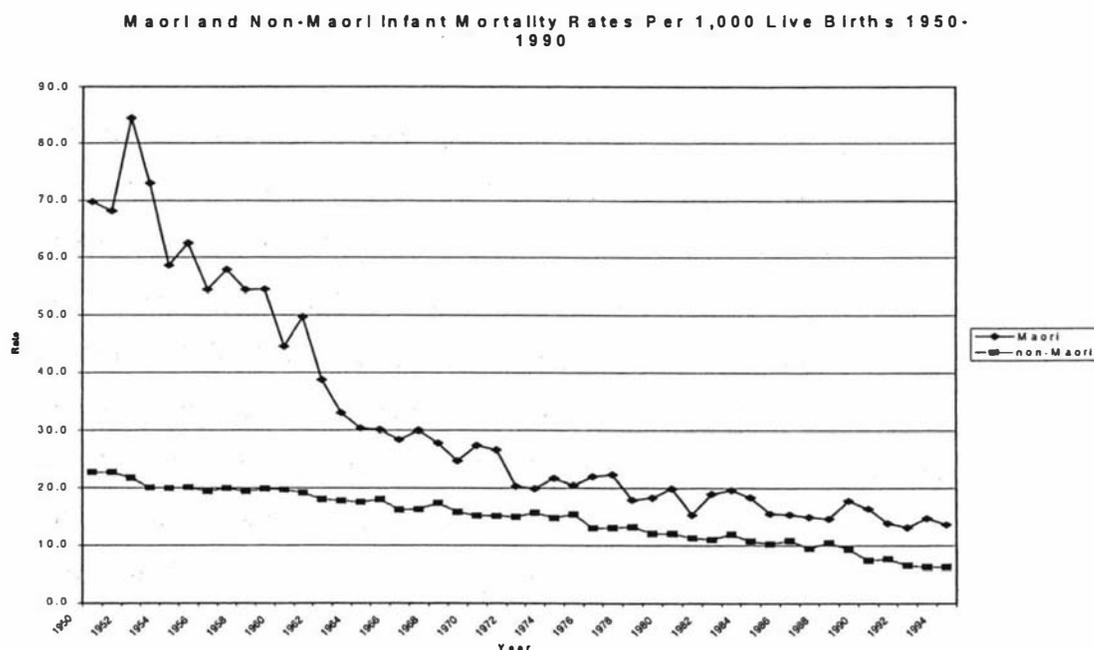
The difficulties in ethnicity collection data make long term trends difficult to identify because there is a broken axis between census data and births and deaths data (Pearce, 1999; Reid & Robson, 1998). Hospital admissions may be slightly more reliable given the reliance on self-reporting of patients and kin, compared to what happens in death certificates when undertakers allocate ethnicity (McKegg, 1996).

Life Expectancy and Mortality

During the eighteenth century Māori life expectancy was similar to most western Europeans (Pool, 1991p 57), although this had changed considerably by the early twentieth century following British colonisation of New Zealand. Māori life expectancy has continued to improve through much of the last century, converging slowly towards non-Māori life expectancy (Figure 7.1). In 1951 a Māori baby boy could expect to live to around 54 years, or 56 years for Māori baby girls. By 1996 this life expectancy had increased to around 67 years for Māori baby boys and 72 years for Māori baby girls. The differences in Māori and non-Māori life expectancy have been closing from 13 years for Māori male babies in 1950-52, and by 1996 this had closed to seven years less than New Zealand males generally. Similarly, Māori girl babies had closed the gap from 15 years in 1950-52 to around seven years by 1996 with non-Māori baby girls (Statistics New Zealand, 1998, p 19).

Figure 2 Māori and Non-Māori Life Expectancy At Birth

Source: Statistics New Zealand, New Zealand Now Māori, 1998 Edition.



The New Zealand Health Information Service data of 1997 shows that,

Maori and Total Population Death Rates 1961-1993

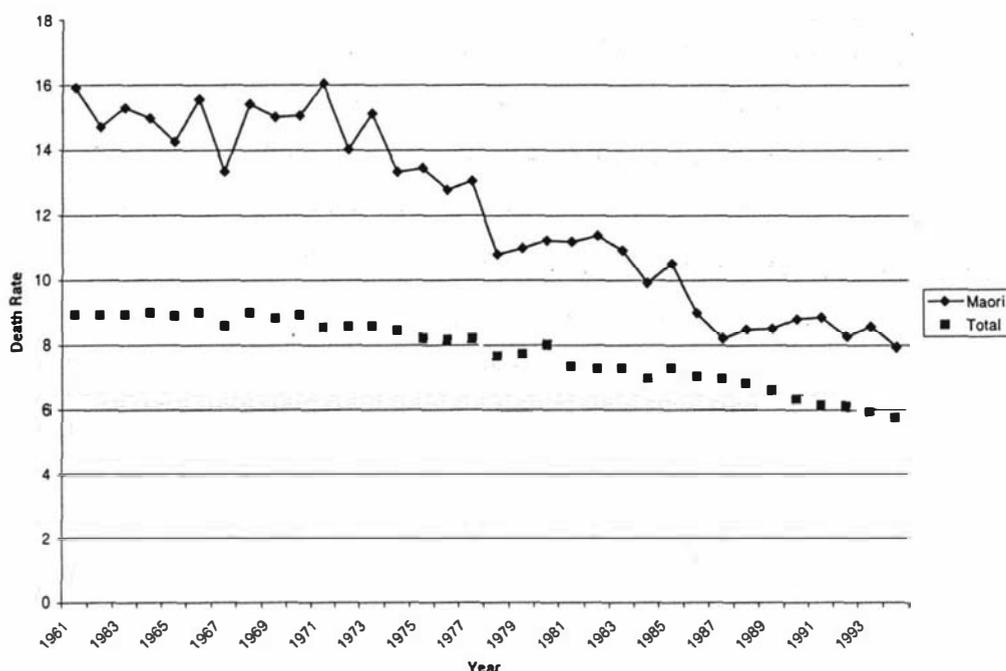


Figure 3 Māori And Total Population Death Rates 1961-1993

Source: Demographic and Mortality Data, New Zealand Health Information Service, December 1999.

During the period 1972 to 1987 Māori age standardised mortality rates fell more rapidly than those for non-Māori with Māori male rates dropping by 38 percent and Māori female rates by 43 percent, compared to a 16 percent and 18 percent drop for non-Māori males and females respectively. By 1987 mortality rates for Māori males were only 14 percent higher than those for non-Māori males, and rates for Māori females 35 percent higher than those for non-Māori females. However since 1987 Māori mortality rates have declined more slowly than non-Māori, and the gap between Māori and non-Māori mortality has widened. In 1994 Māori age standardised mortality rates were 33 percent higher for males and 56 percent higher for females compared to non-Māori (Statistics New Zealand, 1998, pp 19-20).

Māori Morbidity

Māori bear a disproportionate burden of death and illness in the New Zealand population. Age standardised mortality rates¹⁰ for Māori were 9.8 per 1,000 in 1995 compared to 5.9 per 1,000 for the total New Zealand population (Statistics New Zealand, 1998, p 19). Making a comparison with the total population – which includes Māori – gives a smaller disparity than would be evident from a comparison of age-standardised mortality between the Māori and non-Māori populations.

Māori die of the same types of illnesses as non-Māori such as cardiovascular disease, ischaemic heart disease, stroke, respiratory illnesses such as chronic obstructive respiratory disease, asthma, diabetes and cancers such as colorectal, lung and breast (Ministry of Health, 1999). Most of these are preventable because they are caused by modifiable risk factors such as smoking, high fat diet, physical inactivity and obesity. Using the measure of disability adjusted life years (DALYs), cardiovascular disease accounts for 24 percent of DALYs followed by 20 percent for cancers and 12 percent for mental disorders (Ministry of Health, 1999, p 34). Māori have higher rates, once standardized for age and sex, of DALY loss than non-Māori for most causes. This is especially so for infectious diseases, endocrine disorders such as diabetes, cardiovascular disorders and respiratory diseases (Ministry of Health, 1999, p 34).

Māori and Pacific Island people also have higher age standardized rates for avoidable hospitalizations at approximately 60 percent higher than Europeans/Others (Ministry of Health, 1999, p 44). Risk factors such as smoking, alcohol consumption, diet, physical activity, obesity are all again credited with contributing to this (Ministry of Health, 1999, pp 44-45). Issues surrounding Māori access to primary care and preventive services that contribute to the higher rate of hospitalization have been highlighted in a number of studies in New Zealand (Ministry of Health, 1999, p 192).

¹⁰ Age standardised rates are rates that have been statistically adjusted to enable comparisons between populations despite the differences in age structures of the different populations.

Māori have argued that this type of analysis continues to focus on the lifestyle 'failures' of Māori, rather than identifying the systemic causes of this behaviour. For example causes could relate to the high level of stress experienced by Māori as a colonized, marginalised and low income group within New Zealand society who experience institutional racism. These experiences lead Māori to adopt higher risk behaviours that expose them to disease and accidents. Such stress may also be caused by their relative social position. These arguments are consistent with a developing field of medical study.

Among the most critical has been the development of work on stress and physiologic responses to stressful experiences ... stressful conditions may exact a direct toll on the body, offering powerful biological models that link external stressors to physiologic responses capable of influencing disease development and prognosis. Work on psycho-physiology, psychoneuroimmunology, and most recently on allostatic load has helped trace biologic pathways as well as specific behaviours and exposures to noxious agents that link social conditions to important health outcomes (Berkman & Kawachi, 2000, p 4).

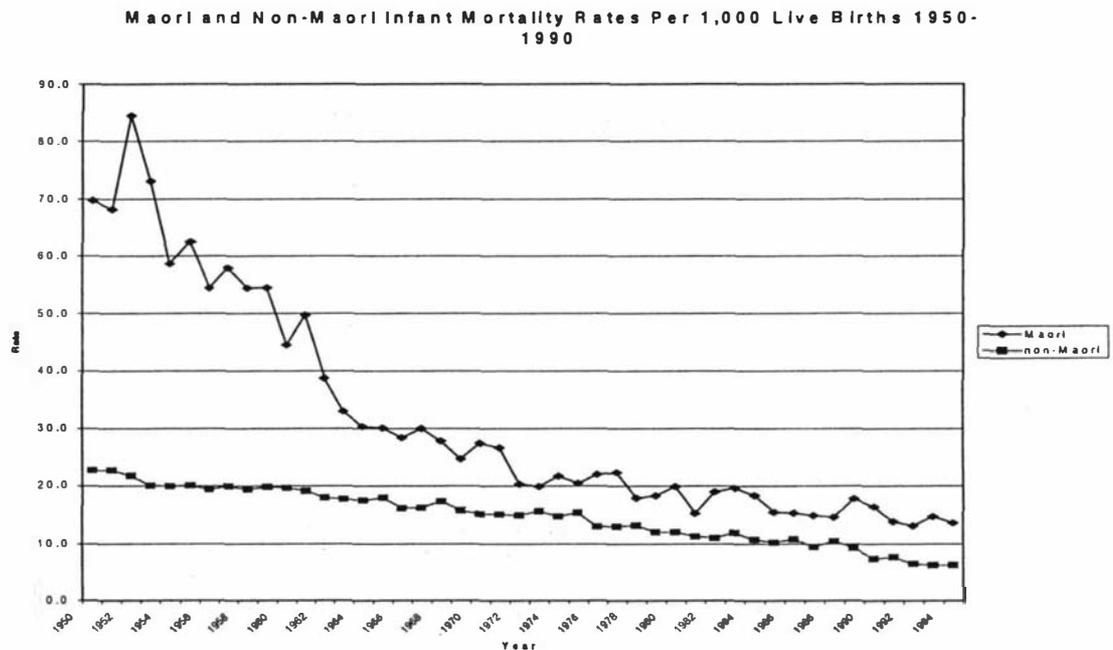
Despite the growing evidence of biological mechanisms linked to stress and social situations and health outcomes, Māori researchers are interested in a more contextualised analysis of causes of Māori illness. This allows an understanding of how specific history and experiences of Māori contribute to our health.

Infant Mortality

Infant mortality is recognized internationally as one of the best single indicators of a nation's well-being. The gap between Māori and non-Māori infant mortality was closing until the mid 1980s when it started to widen. In the 1970s New Zealand had one of the best rates of infant survival in the OECD, by 1990 this had changed considerably (Blaiklock et al, 2000). Infant mortality is often considered a sensitive indicator of social change as infants are among the first affected by social upheaval.

Figure 4 Māori and Non-Māori Infant Mortality Rates Per 1,000 Live Births 1950-1990

Source: Statistics New Zealand, *New Zealand Now Māori*, 1998 Edition.



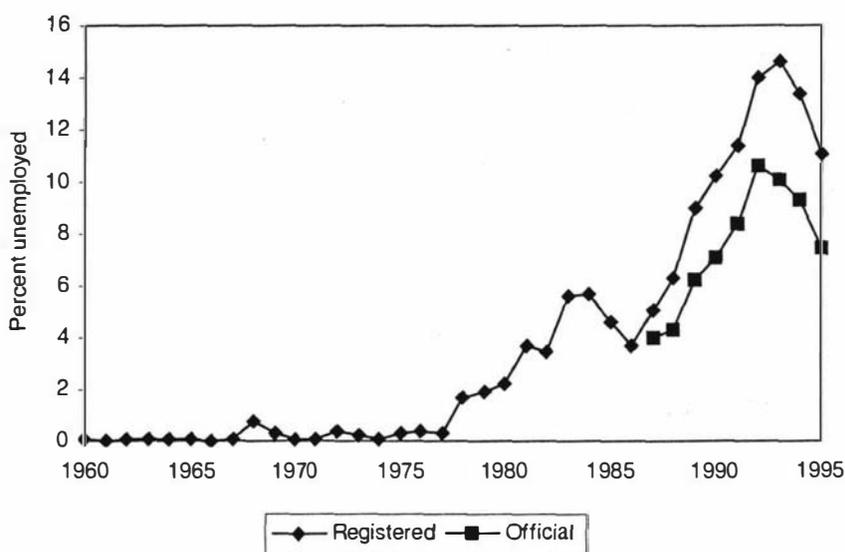
Social And Economic Indicators

In their unpublished report for Te Puni Kokiri, BERL (a private economic forecasting company) relates economic well-being of Māori through income to the following features; family composition and size, life cycle effects, labour market conditions, economic variables, urbanisation, socio-demographic variables and government policy (Williams et al., 1999, p 16). Many of these indicators were also used by Te Puni Kokiri in their *Closing the Gaps Report* and by Statistics New Zealand in their *New Zealand Now Māori* publication. Many of these variables are therefore examined in this Chapter. Unfortunately cultural indicators as identified by the National Health Committee in their report on the *Social, Economic and Cultural Determinants of Health* report, are much more difficult to both identify and measure. Further work will need to be done on this in the future by Māori health researchers and policy analysts.

Unemployment

Unemployment and labour force participation has a significant association with health that cannot be explained by the healthy worker selection effect alone. During the period of neo-liberal reforms in New Zealand, unemployment rose dramatically (Figure 7.4).

Figure 5: Unemployment Rates, 1960-1995



Note: Dalziel and Lattimore, the source for this information, explain that the 'official' unemployment rate constructed from the definition of an unemployed worker used by the International Labour Organisation as a person not in employment who is both available for work and actively seeking work. The unemployment rate is the number of unemployed divided by the number of unemployed and employed workers (the labour force). The data for the official unemployment rate come from the Household Labour Force Survey that was introduced in December 1985. The registered unemployment rate is an estimate based on the number of people registered as unemployed with the Department of Labour divided by the labour force recorded in the Quarterly Employment Survey. The authors note that the registered unemployment rate 'overstates the official measure' (p 17) but follows a similar trend. Source: (Dalziel, 1996, p. 74, & p. 123).

Māori were especially affected by this with Māori three times more likely to be unemployed and disparity with non-Māori greater in 1998 than it was in 1988 (Te Puni Kokiri, 1998). This disparity was ascribed to a number of structural features that made Māori more vulnerable to market vagaries (Kiro, 1998). These structural features were identified by Te Puni Kokiri as: a youthful age structure; low levels of educational

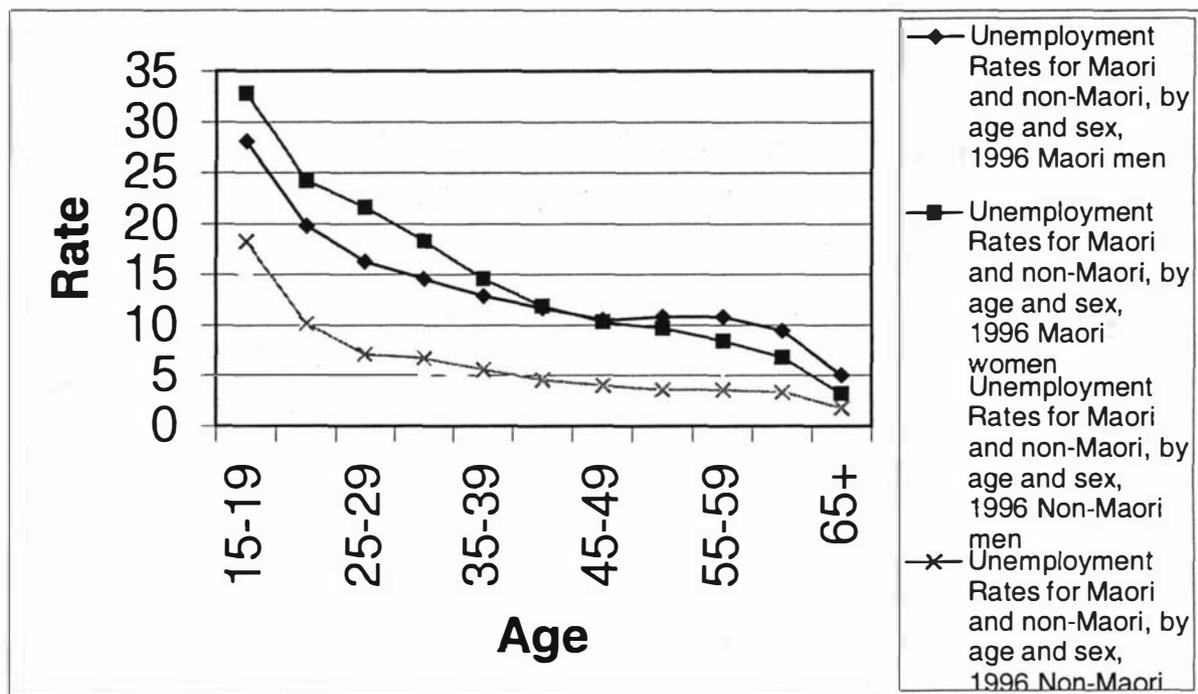
attainment; under-representation in formal systematic training; over-representation in low skilled occupations; under-representation in high growth industries; and a comparatively high proportion of long term unemployed (Te Puni Kokiri, Monitoring and Evaluation Branch, 1998).

Māori unemployment peaked in 1992 following the radical dismantling of jobs due to the neo-liberal reforms from 1984 (Durie, Te Mana Te Kawanatanga, 1998, p 88). Improvements in employment from 1992 to 1996 were due to the increased participation of Māori women in the work force and to increases in certain job sectors such as services and part-time work (Statistics New Zealand Now Incomes, 1999). The industries most affected in the period 1988 to 1992 were Forestry, New Zealand Post, the Telegraph Office and the New Zealand Post Office where many Māori worked. Prior to the neo-liberal reforms Māori employment and labour force participation rates had been among the highest in the population. By 1990 Māori male unemployment had reached 20.5 percent while non-Māori male unemployment had risen to 7 percent. Female unemployment rose more slowly reaching 19 percent for Māori women and 6 percent for non-Māori women (Durie, 1998, p 88).

Māori bore the brunt of economic reform and even when economic recovery was evident in 1996, the Māori unemployment rate of nearly 16 percent was more than twice as high as the non-Māori rate and much higher than it had been in 1986. Moreover, Māori were still disproportionately over-represented in the poorly paid and insecure jobs (Durie, 1998, p 88).

Figure 6 Employment Status of Māori and Non-Māori 1996

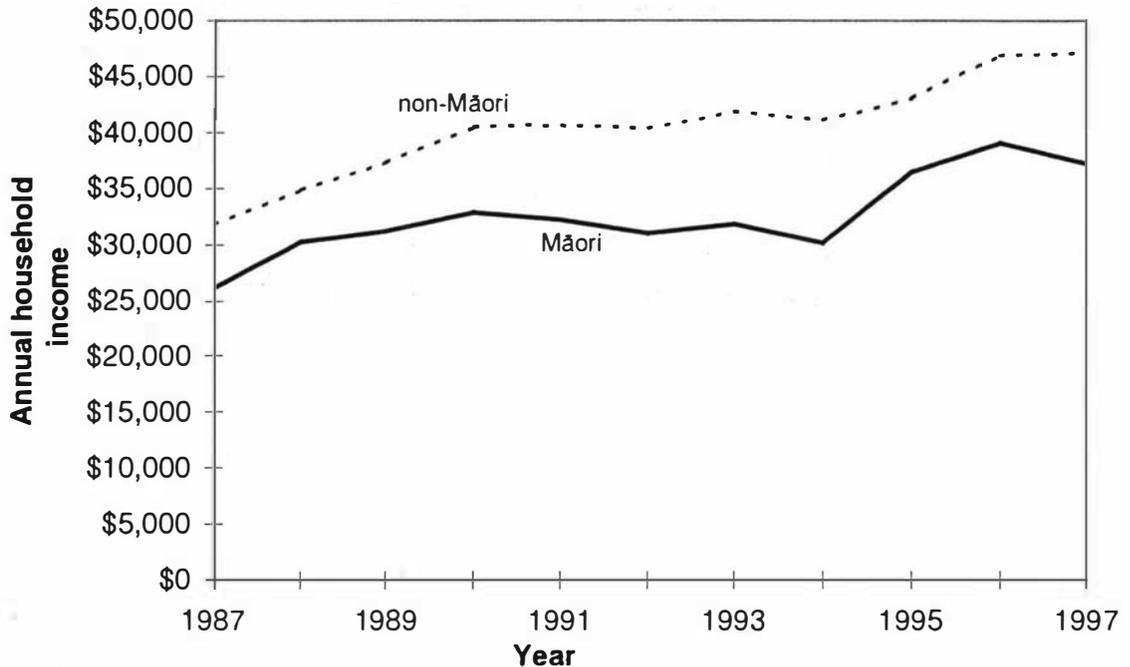
Source: Statistics New Zealand, New Zealand Māori Now, 1998.



Employment is closely related to income. The high Māori unemployment rate and low labour force participation rate had an impact on Māori household incomes over the same period. The restructuring in the government sector and structural features of Māori employment also increased Māori dependence on government assistance.

Figure 7 Māori and Non-Māori Average Household Income 1987 – 1997

Source: Te Puni Kokiri, Closing the Social and Economic Gaps, 1998, based on Census of Dwellings and Populations 1996.



During the period 1987 to 1997, Māori annual household incomes rose but not as much as non-Māori households. While the average difference was \$5,000 in 1987, by 1997 this had grown to \$10,000 (Te Puni Kokiri, 1998, pp 17-18). Such a trend was consistent with changes within New Zealand society that saw inequality increase with the highest income earners increasing their wealth and low income earners losing wealth (Podder & Chatterjee, 1997, Statistics New Zealand Now Incomes, 1999). Podder & Chatterjee made the following observation.

Inequality has increased sharply over the period, confirming the findings of some other researchers. While it is difficult to connect directly the economic reform measures used in New Zealand with the observed deterioration in inequality, the possible channels through which policy-induced changes in the economy might have been transmitted to the distribution of the “national cake” can be, and have been, identified in this

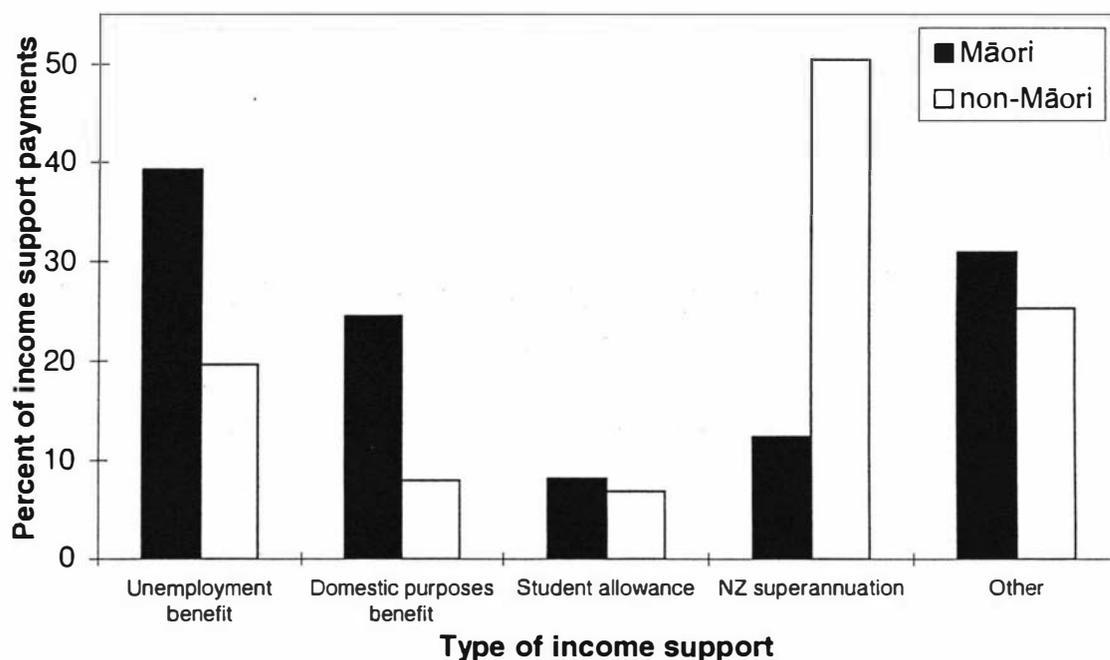
paper. The sharp increase in unemployment over the latter part of the 1980s and early 1990s while, again, not a direct *cause* of increased inequality, has certainly contributed to the process. Likewise, the distortions in the financial markets, which saw the nominal interest rates soar to unprecedented levels in the later 1980s and early 1990s, resulted in changes to household incomes in a way that, again, contributed to the increased inequality (Podder & Chatterjee, 1997, p 25).

The increased inequality affected Māori with, “Wages and salaries, and market income [falling] for Māori and Other ethnic groups relative to the European group” (Statistics New Zealand, *New Zealand Now Incomes*, 1999, p 37), although they noted that there was a ‘relative recovery by Māori in the 1991-1996 period, presumably from better labour market conditions’ (p 31). The increase in jobs was however located mainly in casual and part-time work that offered little security for workers.

Podder & Chatterjee speculate that the cause of this increased inequality was the policy environment that changed the basis of the distribution of income within society. Jesson (1999) supports this argument by saying that the restructuring in New Zealand was intended to free up the public sector for exploitation by the speculative private sector (Jesson, 1999), a view hinted at by Easton (Easton, 1997).

Figure 8: Income Support Payments Received By Māori and Non-Māori In 1996

Source: Te Puni Kokiri, Closing the Gaps Report 1998, based on Census of Dwellings and Populations 1996.



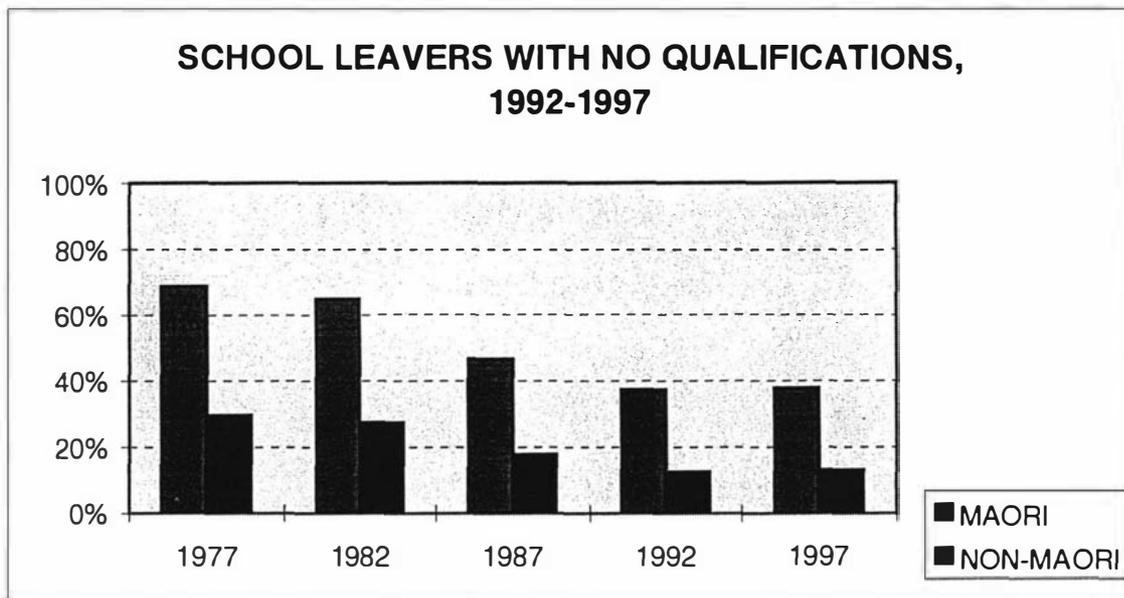
In 1996 Māori were more reliant on government assistance for unemployment and domestic purposes support: a reflection on their participation rates in the labour market and their longer life expectancy relative to non-Māori. In comparison, non-Māori were more reliant on superannuation, a government funded retirement scheme, which reflected their aging population structure. Figure 7.7 shows the relative reliance on these sources of support payments rather than actual numbers. Superannuation accounts for significantly more government spend than unemployment and domestic purposes benefits.

Non-Māori also receive a greater share of their income from sources outside salaries and wages from sources such as rents, dividends and interest (Statistics New Zealand, New Zealand Now Incomes, 1999). Non-Māori are more likely to be self-employed than Māori and more are located in higher paying jobs than Māori, affecting average

household income. These job opportunities are largely influenced by training and qualifications and Māori continue to leave schools with fewer qualifications than non-Māori (Figure 8).

Figure 9 School Leavers With No Qualifications Māori And Non-Māori 1992-1997

Source: Ministry of Education data supplied by Te Puni Kokiri, Closing the Social and Economic Gaps, 1998.



Note: The school leaving age was raised to 16 in 1993

Between 1977 and 1992 the numbers of Māori leaving school with a sixth or seventh form (last two years of secondary school) qualification has almost trebled, but the gap between Māori and non-Māori remains unchanged. The trend for higher proportions of Māori and non-Māori students to leave school with sixth and seventh form qualifications has also stalled. Furthermore, Māori students continue to be located in subject areas that are less likely to lead to employment.

Figure 10 School Leavers With Sixth Or Seventh Form Qualifications 1977-1997

Source: Ministry of Education data supplied by Te Puni Kokiri.

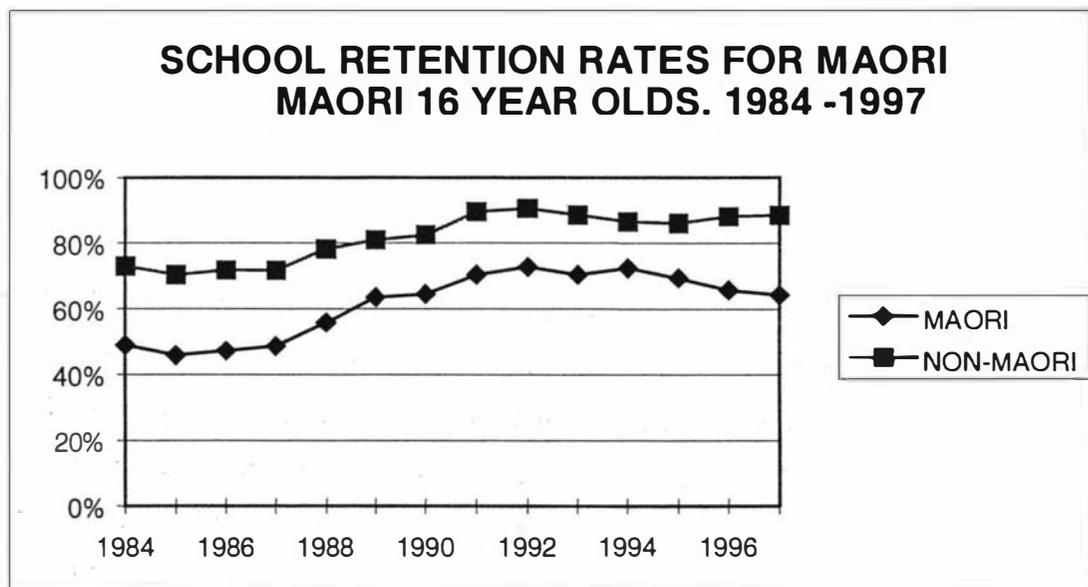
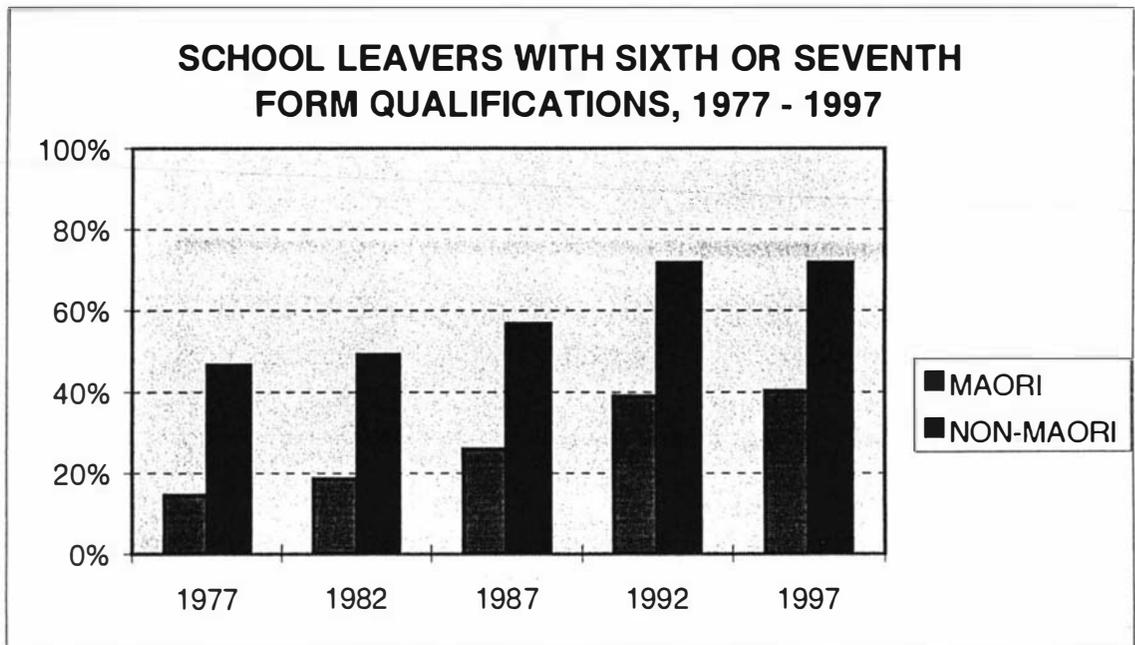


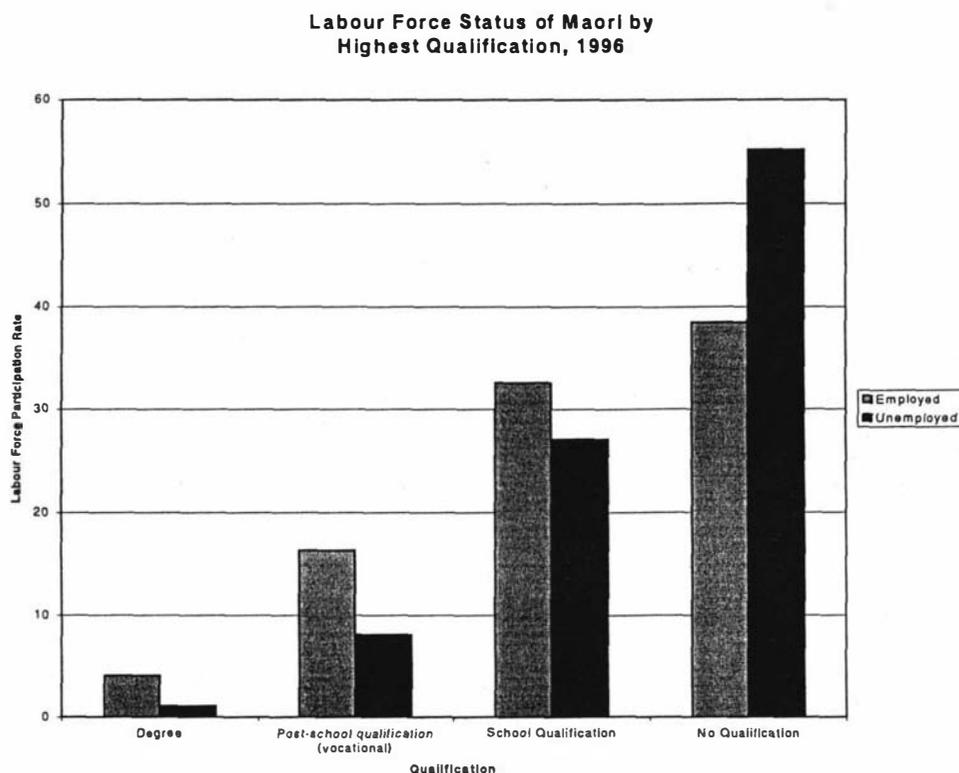
Figure 11 School Retention Rates For Māori 16 Year Olds 1984-1996

Source: Ministry of Education data supplied by Te Puni Kokiri.

Note: Rates calculated by taking the number of students at age 16 as a proportion of the numbers of 14 year old students two years earlier.

Figure 12: Labour Force Status Of Māori By Educational Attainment

Source: Statistics New Zealand, New ealand Now Māori, Census of Population and Dwellings 1996



Housing

Housing has a strong association with health (Howden-Chapman & Cram, March 1998). Changes to housing policy introduced in 1991 were found by Waldergrave and Sawrey (1993) using the National Housing Commission method to have increased serious housing need between 1992 and 1993. The main factor identified was paying rent. In 1991 the government removed income related state rentals and introduced market rentals. This meant that beneficiaries, such as sole parent households, paid market rents with the difference being made up by an accommodation supplement (introduced in 1993). The supplement did not cover the whole increase in rent.

Māori were therefore disproportionately affected by such a policy because they are over-represented in low income and benefit dependent families who rely on state housing. Stephens and Waldergrave (1997) found that in 'poverty line' studies, Māori who comprise 13% of the New Zealand population, made up 39.3% of those in poverty once housing costs were included (Measuring Poverty In New Zealand, in P. Crampton & P. Howden-Chapman (Eds), 1997).

The decrease in purchasing power by Māori households and the demonstrated racism in the urban housing market are inter-linking factors that mean Māori households are more likely to be concentrated in areas of inadequate housing (Howden-Chapman & Cram, 1998, p 21).

Between December 1988 and December 1997 overall prices for housing as measured by the Consumer Price Index (CPI) increased by 27.5 percent, while the housing index of the CPI increased by 48.3%. Higher housing prices resulted in greater expenditure on housing in nominal terms and as a proportion of total household spend rising from 20.5 percent of total average weekly expenditure in 1988 to 24.5 percent in 1997 (Statistics New Zealand, New Zealand Now Housing, 1999, p 65).

Increases in rent prices were higher in metropolitan centers where demand for rental housing was greater and since Māori are disproportionately concentrated in these centers, they were more affected by such rises as a population. The shift from state to private sector landlords was particularly noticeable among Māori. Between 1991 and 1996 the proportion of Māori living in rented dwellings with a state sector landlord dropped by 16.3 percent compared to an overall average (for the whole population) of 10.0 percent (Statistics New Zealand, New Zealand Now Housing, 1999, p 73).

Two-fifths of Māori live in rented accommodation making them more likely than others (with the exception of Pacific Islands peoples) to live in such accommodation. Māori are correspondingly less likely to live in homes owned without a mortgage than others (Statistics New Zealand, New Zealand Now Housing, 1999, p 73). This is attributed to Māori and Pacific Islands younger age structure as well as income (Statistics New

Zealand, New Zealand Now Housing, 1999, p 73). Māori and Pacific Islands ethnic groups are also more likely than Europeans to live in households with more occupants (Statistics New Zealand, New Zealand Now Housing, 1999, p 73).

Overcrowded, damp and cold housing is associated with higher rates of infectious diseases such as meningococcal meningitis, tuberculosis, rheumatic fever, measles and mental health problems (Howden-Chapman & Cram, 1998, p 21). A study by the New Zealand Housing Commission in 1988 found that around 20-35% of those with chronic psychiatric illness living in the community lived in inappropriate or substandard housing. Furthermore, the mental well-being of people with psychiatric disorders was correlated to their quality of housing¹¹. This signals future problems for Māori with rapid increases in a range of mental illnesses emerging in the population.

Conclusion

Culture is sometimes used to denote behavioural and lifestyle choices such as patterns of high rates of smoking amongst Māori women and risk taking behaviour leading to motor vehicle crashes among young Māori men. 'Culture' also means those attributes that define Māori as distinctive with characteristics such as te reo, tikanga and participation in our cultural institutions. These attributes separate Māori from mainstream society and, because Māori are a colonised society, are associated with institutional racism that results in negative health outcomes. These are both different to those structural features that are unique to Māori in New Zealand society that also set Māori apart and are associated with particular characteristics and outcomes - for example, earlier fertility, more youthful population profile, fewer qualifications and living in more one parent households and more extended family households. These structural features (Te Puni Kokiri, 1998) interact to be self-reinforcing, ensuring lower levels of educational achievement, fewer qualifications at school leaving, lower paid jobs that are more insecure in a volatile job market, poorer quality housing with more overcrowding and greater mobility because of high market rentals and insecure housing, leading to poorer health, poorer employment prospects and lower incomes. Despite this similar

profile distinguishing Māori from non-Māori, Māori are also a heterogeneous population with substantial differences between them. The distribution of health within the Māori population is therefore a function of social, economic and behavioural (cultural) distributions, but this does not entirely explain the basis of a distribution between ethnic groups. This residual difference is often attributed to ethnic differentials, but it may in fact result from structural differences such as racism that are then embedded within other structures. The recent policy environment has increased this distribution of inequality and the effects of this can therefore be seen in health and other social indicators.

This myriad of factors affects the health status of Māori as a population and the personal health of individual Māori. This occurs at two 'levels' by shaping the wider environment in which Māori live and by shaping the individual choices and actions of Māori at a personal level. These levels interact, leading to particular outcomes that are common to the group as a population, being more likely to share more things in common at an individual level, and also sharing some things in common as a population that distinguishes them from other groups.

The evidence shows that Māori are overwhelmingly experiencing poorer social and economic outcomes than non-Māori and they bear higher levels of poverty, illness and death than the rest of New Zealand society. Furthermore, there are indications in key indicators such as mortality, employment, income and educational achievement and housing, they are actually starting to lose ground relative to the rest of the population. This is likely to have profound effects on the health and well-being of Māori in the future. Māori have a more youthful population with high social needs and distinctive cultural needs. This makes it especially important that there be Māori specific strategies to address these experiences. There are socio-economic and political features that also require addressing to change the overwhelming burden faced by this population.

¹¹ Kearns, Smith & Abbott on Housing stressors and persons with serious mental health problems in 1993

Increases in disparity between Māori and non-Māori raises serious questions for those concerned with Māori health, since there is growing evidence of the impact of such inequality on health (Ministry of Health, 1999, Berkman & Kawachi, 2000, Kawachi, Kennedy & Wilkinson, 2000, Wilkinson, 1996).

CHAPTER 8

North Health and MAPO: Purchasing Grand Vision

Introduction

North Health yields valuable insights as a case study into the way in which a Māori health purchasing strategy was developed and implemented in New Zealand during the 1990s. Although Regional Health Authorities had only a brief life (1993-1997), their strategies for addressing Māori health deserve greater attention, not least because many existing strategies are still premised on the same ideas and values. These purchasing strategies were part of a reforms process in health services and policy that was marked by the congruence between New Right neoclassicism and Māori desire for tino rangatiratanga.

Rather than being a discrete policy stream, RHAs can also be seen as an extension of previous government policy around Māori health. The decision to pursue Māori provider development reflected government policy about devolution to communities of interest and also contained opportunity costs for Māori. These opportunity costs were in investing time and energy on Māori health service provider development and consolidation rather than an investment in making the majority of mainstream providers more responsive to Māori health need (although there was theoretically an interest in doing both). This argument will be examined closely in the following three chapters.

Limits on health expenditure during the early 1990s and the incremental increase since then, has put pressure on other mainstream health services. Māori health has been able to attract some new funding in health for initiatives such as Māori health provider establishment. However the extent to which new money or recycled 'Māori' money from the disestablished Department of Māori Affairs, and also the extent of the investment in Māori provider development will be examined. There is evidence that Māori health investment was around 10% of total North Health spend (Shea, interview,

1997) although it is difficult to know if overhead costs were included for running the Māori Health Development Division (MHDD) or includes all initiatives undertaken by other services. Others have suggested it is actually around 0.3 of 1% of the total North Health spend (Hudson, interview, 1998).

A new cultural orthodoxy emerged in the 1990s reflecting a more contemporary view of Māori nationalism establishing an 'us and them' mentality between providers during the early competitive stages. This extended to Māori working within mainstream services. Competition underpinned this and was clearly evident throughout the health sector during this period (Ashton, 1999; Cheyne et al., 1997; Easton, 1997a). Such thinking pitted health providers against each other. For Māori, such thinking emerged from the debates about the right to represent Māori within the iwi Treaty settlements debate and the right to access public resources for Māori benefit.

The relationship between health providers became more collaborative in the latter 1990s, and was also reflected in Māori provider relationships, including Māori provider relations with each other and with other health providers. Many territorial disputes had been settled and a more moderate policy environment operated.

The growth of Māori providers emerged from a powerful critique about the inability of existing services to meet Māori health need. Such growth was further strengthened by the achievements of Māori health providers within a relatively short period.

This Chapter examines the role of the Regional Health Authorities, and particularly North Health in shaping Māori health policy. While Regional Health Authorities were to implement policy developed by the Minister of Health through the Ministry rather than develop strategic policy in their own right, which was not necessarily the case from 1993 to 1997. Some of the strategic policy regarding Māori health actually originated from within the Regional Health Authorities rather than within the Ministry. While the Ministry had the legal responsibility for developing and monitoring such policy, Regional Health Authorities had the money to make their strategic policy reality through their

stream of operational policy decisions, thus effectively driving them as strategic policy through their purchasing policies. Certainly there is evidence that the fragmentation of health authorities established under the National government through the health reforms led to some role confusion between various health agencies (Health and Disability Commissioner, 1998).

The battle between the Ministry of Health and Regional Health Authorities (later the Health Funding Authority) around formulation of strategic Māori health policy has inevitably engaged other stakeholders such as the Crown Company Monitoring and Advisory Unit, Treasury, the Ministers of Health and Crown Health Enterprises, the National Health Committee and providers themselves, in discussions about who would effectively set policy for New Zealand and what that policy should be.

North Health established MAPO (Māori Assisted Purchaser Organisations) to assist in co-purchasing of Māori health services. MAPO continued to be supported by the General Manager of Māori Health for the Health Funding Authority from the time of their inception to the year 2000. Cooper was General Manager of the Māori Health Development Division for North Health during the period under review in this thesis, and so has played a crucial role in shaping a grand vision for Māori health purchasing and thereby effecting a de facto Māori purchasing policy.

It is important to understand that the Case Study analysis is located within the period 1993 to 1997. Obviously strategies for Māori health providers were refined during the 1990s as a result of the learning by purchaser / funder and providers. It would be a mistake to view the decisions as stagnant. The research looks at a particular time period in an attempt to capture the reasoning behind strategies and policies in Māori health during this period. Underlying strategies consistent with Crown objectives did not change much though, for example the emphasis on Māori participation as a strategy for ensuring Māori health gain, and the emphasis by North Health on Treaty relationships that emphasized the pre-eminence of iwi as a channel for delivery of health services did not change significantly. However, there were changes that resulted from changed

political directions within government during the period and changed structures. Key informant comments should therefore be viewed within the context of their time.

Regional Health Authorities And Māori Health Policy

Regional Health Authorities (RHAs) were formed under the Health and Disability Services Act 1993. They enacted Māori health policy based on government policy identified through the Ministry of Health. The most significant of these policies was a de facto policy titled *Whaia te ora mo te iwi* (1992), which spelt out Crown (government) objectives for Māori health. The Ministry of Health and Regional Health Authorities identified the participation of Māori in the health sector as their major Māori health strategy. Māori would achieve improved participation through a consequent set of strategies that included the growth of for Māori health providers. The mechanisms for enacting these strategies were through RHA purchasing plans with the Minister of Health via the Ministry of Health. Māori energy became focused on securing contracts with RHAs that would enable them to deliver health services to Māori. Negotiations between RHAs and potential Māori health providers occurred between 1993 and 1995 with contracts agreed from around 1994. North Health implemented most Māori provider contracts and the Māori health purchasing Grand Vision from 1995 once North Health had been established and purchasing strategies developed.

Legislation governing the health sector is extensive, but the major pieces of legislation that relate to the biggest funding areas were the Hospitals and Charitable Aid Act 1885 (amended in 1909), Health Act 1920 (amended in 1947 and 1951), Social Security Act 1938, Hospitals Act 1957 and Area Health Boards Act 1983. The Health and Disability Services Act 1993 was amended in 1995 and 1997 to encompass changes to various structures in the health sector.

Historically, New Zealand's health sector legislation reflected regional parochial interests because health care consisted primarily of charitable hospitals who serviced Māori and indigent poor populations (Dow, 1995). A gradual evolution towards a more centrally organised and universal entitlement system through the introduction of the Public Health

Act 1920 and Social Security Act 1938. This trend would be reversed with the Health and Disability Services Act 1993, with a return to a more regionally responsive model. Such changes were more consistent with the overall trend in government returning New Zealand to a nineteenth century model of welfarism that promoted individual and family responsibility (Thomson, 1998).

Māori Health Purchasing

Purchasing services requires a different orientation to being a service provider (Māori providers or Crown Health Enterprise or GPs) or policy developer (Ministry of Health). Responsibility for purchasing was prescribed by the Health and Disability Services Act 1993 and subsequent amendments, along with government policy. Legislation and policy were then 'married' with health evidence and political conditions at the local level to produce a purchasing plan for Māori health.

These different pressures were inevitably reflected in patterns of decision-making and thus the way in which strategic decisions were formulated and operationalised. The way in which the Māori Health Development Division, North Health operationalised government policy was to some extent idiosyncratic, reflecting the dominant personalities of the organisation and their interpretation of government policy. However it was also a response to the particularities of the needs of Auckland Māori.

An idiosyncratic culture was encouraged by a government policy approach that sought 'local solutions to local problems'. Such an emphasis for ostensible devolved authority was consistent with neo-liberal thinking dominant in the National cabinet during the early and mid-1990s. Such an approach therefore encouraged (at least in the early days) local operational innovation on national policy and therefore favoured more localised solutions to nationally co-ordinated strategies. Government's role was to provide the architectural plan while Regional Health Authorities would do the building. This approach in some instances undermined rather than encouraged a population approach to health services, since the focus was more on local responsiveness through the limited scope of contracting.

Evidence for this can be seen most clearly in the rapid dismantling of the Public Health Commission which had been developing a population approach – including one for Māori health. Established in 1993 under the Health and Disability Services Act, the Public Health Commission provided public health oversight and purchasing nationally. It was dismantled in 1995 and responsibility for public health and population approaches was given over to the RHAs who had by now a firmly established culture around personal healthcare. In particular, North Health would have major responsibility for public health purchasing.

Māori input into these processes continued throughout the term of the RHAs to be defined in terms of the dominant cultures of these organisations - although Māori staff within RHAs worked hard to claim Māori 'space' within them. A Māori 'space' to operate relied on the quality of personal relationships between Māori staff within the purchasers who were responsible for sponsoring Māori health initiatives and their colleagues responsible for the overwhelming bulk of the budget. Sponsors were needed not only with RHA colleagues but also with political leaders on their respective Boards, in cabinet and amongst the multitude of Wellington stakeholders including CCMAU and Heads of Government agencies.

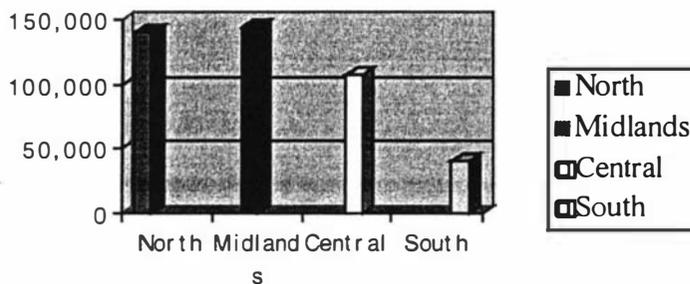
What emerges from this research is that Māori have always attempted to turn government policies, in whatever form, to their advantage by innovating Māori concepts and ideas around these policies. An example of this can be seen around the way Māori used the proposed Health Care Plans. Māori preparedness in Auckland during the late 1980s to back the Area Health Board proposal of a Regional Māori Authority, and later by the enthusiasm shown for Māori provider development, co-purchasing and Māori Integrated Care Organisations (MICOs). These are not merely pale imitations of Pakeha policies, but active attempts to shape government policy for Māori purposes.

Health Care Plans which were promoted during the late 1980s as a means of planning for the health needs of particular populations such as iwi Māori. While iwi Māori have never

surrendered their desire to implement Health Care plans, the form of these health care plans continued to change. The attraction of managed care, co-ordinated care or integrated care is largely the same as that which Health Care Plans held in the late 1980s, namely the ability of iwi Māori themselves to plan and decide what services to have on behalf of their people.

Māori and general populations were allocated to RHAs to create approximately similar sizes with the exception of Southland Health that had considerably fewer Māori and general population within it. Despite this, there remained significant differences between these regions. Most noticeably North Health had the largest concentration of population in the Auckland metropolitan centre. It also had the most diverse Māori population representing the entire range of Māoridom. Auckland has been the major immigration gateway to New Zealand which also raised particular problems not experienced as keenly in other RHAs with relations between new immigrants and Māori coming most sharply into focus.

Figure 13 Regional Total Māori Populations (Number of Persons)



Source: 1991 Census of Population and Dwellings, Statistics New Zealand.

The question of personality and its impact on the development of policy can be seen most clearly in the MAPO which were a distinctive feature of North Health's Māori purchasing strategy. According to Cooper, the strategy developed for Māori health emanated in part from his prior work on Te Tiriti O Waitangi as well as his work in developing countries. Cooper was clear that Māori health and Māori development were

intimately linked (Cooper, interview). The strategy came to define Māori health in Auckland for most of the 1990s and continued as part of the Health Funding Authority's strategy.

North Health Organisation

North Health was divided into a series of purchasing teams located around service areas such as medical and surgical, primary care, disability, Māori, child and youth health, mental health, public health, health of Pacific Islands people, Drug and Alcohol and Dental (North Health, 1997a). The Government's strategic directions for the medium term and specific objectives for the following year were spelt out in purchasing plans in a rolling three-year agreement with the Minister and Ministry of Health. These formed an essential part of the Māori health planning and purchasing cycle.

Despite having no previous experience in the health sector, Garry Wilson was appointed Chief Executive Officer of North Health following his experience in restructuring the New Zealand Post Office into New Zealand Post. Such a pattern was repeated throughout both the health sector and restructured public sector, reflecting Government's belief that business skills could be translated across sectors, and what was needed was good business sense more than specific sectoral knowledge which, it was thought, could be learned on the job.

North Health shared a similar Māori population to other RHAs, but had three distinctive major iwi groupings and two major urban Māori organisations within its region. These three major iwi are Te Tai Tokerau (incorporating all those in Northland, but dominated by Ngapuhi), Ngati Whatua (which includes Orakei and Kaipara Ngati Whatua, and remains disputed by other hapū and iwi who claim Ngati Whatua status), Tainui (a federation of tribes dominated by Waikato, but incorporating iwi such as Waikato, Hauraki and Maniapoto). This configuration of iwi would be officially recognised in North Health policy through their co-purchasing strategy and would later be described as part of the Treaty Relationships policy.

Table 10 Numbers of Māori People by Iwi in the North Health Region

Sub region	Number of Māori
Te Tai Tokerau	31,215
Ngati Whatua	56,529
Tainui	52,674
Total	140,418

Source: Table 1, Number of Māori People by Iwi in the North Health Region, North Health, December 1995, p7.

Socio-economic indicators for Māori in the North Health region were marginally better than the rest of the country. However the picture is skewed since North Health included pockets of considerable size and disadvantage nationally, such as Northland and South Auckland.

Table 11 Socio-Economic Indicators for North Health Compared to Rest of New Zealand

SES Indicator	North Health / Rest of New Zealand	
% Full time employment Māori	36.4	35.4
% Full time employment others	46.7	45.0
% Income support Māori	61.0	64.6
% Income support others	50.0	56.1
% Unemployment benefit Māori	15.5	17.3
% Unemployment benefit others	5.6	5.9
% Total income of \$30,000 + Māori	8.1	7.7
% Total income of \$30,000+ others	20.4	16.9

Source: Table 2, Socio-Economic Indicators, and Māori in the North Health Region, North Health, December 1995, p. 8.

Population based funding formula

A population based funding formula was used by the Ministry of Health to determine the amount of money paid to the various RHAs. North Health consistently argued that it was under-funded on the basis of this formula, in relation to the rest of the country. The

formula was based on their population size (North Health, 1997a, p3). All other RHAs received more money per head than North Health.

Table 12 Difference per head \$ for Regional Health Authorities in 1996/97

North Health	-
Midland	+111.69
Central	+86.95
Southern	+143.41

Source: North Health 1997 Interim Report, p3.

There were additional problems for North Health in respect of meeting its costs. Auckland is a tertiary centre of excellence for the South Pacific, yet North Health was funded for residents only. Such factors placed additional burden on Auckland's services as securing money for these patients from the Ministry of Foreign Affairs and Trade was extremely difficult.

Between 1993 and 1997, there was ring-fenced funding for DSS (Disability Support Services) from Social Welfare, Public Health and Personal Healthcare. Māori health required transfers from within Personal health, although special projects funding such as Māori Provider Development and Transitional Assistance Grants (TAGs) was made available through the Ministry of Health separately following Government prioritization of these projects. Māori mental health was also funded through mental health, not Māori health.

While Māori are perceived by the public as excessive users of public services, only 4% of Māori get to 65 years, therefore Māori are not long-term users of these services. In the year 2011 there is expected to be a 4 to 6 times increase in the number of elderly Māori - and health services are not yet planned for them.

North Health Finances

North Health received \$1.5 billion in 1996/97 for a total population of 1.233 million people. This was spent on Personal Health services, Disability Support services and

Public Health. In 1995 the proportion of public health spend was 0.16% of personal health spend. By 1996 the budget had increased slightly to 0.19% of personal health spend (North Health, 1997a, p18). A balance in favour of personal health spending reflects a traditional bias in New Zealand to funding of hospital services and to a lesser extent, GP services. It also reflects medicine's bias towards personal healthcare at the expense of a more population based approach (Rose, 1992).

When responsibility for public health purchasing was passed to North Health, a proportion of money spent began to sway in favour of public health. However public health remains the poor cousin of personal health services. The amount of money spent in these respective activities by North Health was also strongly influenced by the historical and political sensitivities of national spend in health. Despite repeated commitments to population based funding, and has remained inequitable as table 5.3 demonstrates.

Table 13 Regional Funding Comparisons for Year 1996/97 (Exclusive GST)

Region	by Budgeted %	Population %	Revenue per head \$	Difference per head \$		
RHA	Revenue \$Millions	Number				
Northern	1,500.3	32.1	1,233,000	34.0	1,216.79	-
Midland	961.8	20.5	724,000	20.0	1,328.48	111.69
Central	1,155.1	24.7	886,000	24.4	1,303.74	86.95
Southern	1,063.7	22.7	782,000	21.6	1,360.20	143.43
TOTAL	4,680.9	100.0	3,625,000	100.0		

Source: North Health 1997 Interim Report, North Health, February 1997, p3.

Changing Organisational Culture

A deliberate part of the health reforms strategy was to eliminate those with an attachment to the old system. Their removal would ensure that the reforms had a better opportunity to succeed and would minimise undermining by vested interests. However, a negative consequence of this would be the loss of institutional memory amongst staff in both

purchasing and those providing health services. A loss of institutional memory would also occur with each restructuring of the purchaser / funder.

Part of the aim of the blitzkrieg seems to have been to replace people well experienced in the health sector with outside business people who were often very ignorant of it ... Those who became redundant were not necessarily the least competent, as is evidenced by many being recruited to positions in overseas health systems (Easton, 1997a, pp 159-160).

The elimination of those attached to the old system weakened any opposition within key agencies to change and the development of a new culture within these health agencies. Easton (1997) quotes a Coopers and Lybrand 1993 report as saying, "Don't shelter non-committed employees". He goes even further in suggesting that the deliberate loss of institutional memory also served political ends in minimising opposition to the reforms.

Astonishingly, for that is what a blitzkrieg is all about, the government chose to drive its reforms through the centre, eliminating the AHBs [Area Health Boards]. It passed legislation to abolish the (two-thirds) elected boards - an extraordinary constitutional innovation more characteristic of dictatorships, but one which had the advantage of erasing overnight the one institutionalised and well-funded group with official moral authority who could have resisted the reforms. The philosopher-kings showed their contempt for democracy yet again (Easton, 1997a, p 154).

The overturning of previous (although relatively new) structures was further aided by the appointment of Cabinet sanctioned Directors to the Boards of all these new bodies who then appointed leadership within these organisations (CEOs, senior managers) recruited largely from the private sector or outside of the health sector. The Cabinet had not enjoyed such control over these agencies since the Hospital Boards were established because they had been largely locally elected.

The recruitment of CEOs from the private sector also applied to North Health with the recruitment of Garry Wilson from New Zealand Post (a State Owned Enterprise or SOE). Other General Managers in CHEs within Auckland would largely be recruited from private consultancy firms and private companies such as Dominion Breweries (Denis

Pickup, previously of Dominion Breweries became CEO of Auckland Healthcare, the largest Crown Health Enterprise in New Zealand). Despite this, a number of Chairmen and CEOs resigned within a few years (over half went within three years according to Easton, 1997) claiming the same problems with the health reforms as the early critics, namely the chronic under funding of hospitals, interference by Wellington, difficulties of reconciling public and political expectations with available monies and the limitations of a competitive model for healthcare delivery.

Māori Health Development Division, North Health (MHDD)

The Māori Health Development Division (MHDD) was established in North Health between 1993 and 1994. North Health's General Manager of Māori Health was appointed from outside the health sector, although he had extensive experience in Māori development. The core team consisted of Manager of Māori Health Planning (a qualified nurse) and Contracts Manager (a qualified lawyer). A small staff, the membership of which changed between 1993 and 1997, supported this core team. Some of these staff went to work for MAPO (Māori Assisted Provider Organisations), private consultancy firms or Māori providers when they left North Health / Health Funding Authority. All of the key staff in MHDD for North Health transferred to the Health Funding Authority in 1998.

The Māori Health Development Division enjoyed a unique relationship within North Health, partly due to conditions imposed by Cooper in accepting the job in North Health. These included having direct access to the Māori board member of North Health, and a commitment to establishing partnerships based on the Treaty of Waitangi (Cooper, interview, 1997). Such an orientation resulted in the development of MAPO who were Māori co-purchasing partners with the Board of North Health. Cooper was also a member of the North Health Senior Management team as a General Manager, which was important for ensuring the Māori health strategy was reflected in other service areas through senior management patronage.

North Health Culture And Development: Corporate And Strategic

North Health developed the most corporate culture of the RHAs, which is not surprising given its location in the largest metropolitan centre in New Zealand. North Health displayed a sophisticated analysis of iwi and Māori politics in its strategies, ring-fencing key Māori health providers within their geographical areas. Arguably such an analysis arose because of the complex mix of iwi and pan-tribal politics that would have forced a response from a Crown agency such as an RHA. Despite this, there were unhappy Māori providers, in particular Urban Māori Authorities who had delivered numerous services to Māori clients irrespective of iwi links, and who viewed MAPO as iwi-centric and not based on merit.

Threats of legal action from Māori organisations unhappy with their contracts, or lack of contracts continued even after the dis-establishment of RHAs. Legal action was largely avoided between Māori organisations and North Health in part because of the way that Māori Health staff North Health defused some of these situations (Māori have enormous respect for those who will front providers “kanohi ki te kanohi” to defend their decisions - even when it is at odds with their interests). There was also reluctance by Māori providers to engage in legal action except as a last resort for resolution to disputes. There is also a strong likelihood that lack of resources for such action, and the perception that this may alienate the purchaser could also have contributed to their inaction.

The political analysis in North Health extended to an understanding of the distinction between being Māori, and being indigenous. The significance of this analysis for Māori was to link Māori to a wider critique of development informed by international experience of indigenous peoples, thereby cementing the intellectual basis for the strategies developed by North Health. Their co-purchasing arrangements through the MAPO structure were innovative, iwi-based (and therefore consistent with government policy and the 1987 Māori Health Committee recommendations) and politically sophisticated. Although lacking the solution to some major issues such as what to do about Māori Urban Authorities, North Health’s Māori Health Development Division

came up with a solution to achieve greater Māori input into the purchasing decisions by using the legislation to their advantage.

North Health's use of the legislation to establish alternate bureaucracies with co-purchasing power was not what the government had in mind. This approach caused ructions amongst other RHAs, the Ministry of Health (MOH) and with the Minister who did not understand the MAPO model. MAPO added another layer of bureaucracy between purchasers and providers, raising questions about their ability to develop effective working relationships directly with RHAs. The devolution of appointments of iwi representatives to iwi themselves may also have raised concerns about the ability of health authorities and political masters to control delicate relations in the health sector, namely those around Māori health.

However the North Health MHDD budget was considerable because of their size. Even with less than 1% of North Health's budget, they still managed to control around \$7-9 million per annum. Furthermore, they influenced other purchasing services such as mental health, public health and disability support services within North Health to develop Māori health strategies and to contract Māori providers where possible. Thus the degree of influence of the MHDD was substantial and was therefore greater than that reflected in their budget. The General Manager Māori Health Development also sat on the Senior Management team that was not large and presented another opportunity to influence policy and strategy in North Health purchasing.

North Health's key strategy reflected the Crown's objective of increasing Māori participation in the health sector - but went further than other RHAs interpretation by also including governance. Their strategy was, "Active Māori participation with providers at the governance, management, personnel and consumer levels" (MHDD presentation to Chair of Transitional Health Authority, 1997). MAPO was North Health's strategy for ensuring governance participation for iwi Māori.

Grand Vision

Durie (interview, 1997) and Cooper (interview, 23 April 1997) both identify the 1984 Hui Taumata as a strategically important development for Māori, in that it set the agenda for Māori development on an optimistic note. The optimism and enthusiasm of this hui, reflected Māori views that they were to be more involved in their own development, given the political signals emerging from the newly elected fourth Labour government. This reflected a crucial change in perception, if not fact, because Māori had largely been relegated to advisory roles in the formulation of policy in respect of Māori, the delivery of services to Māori and the evaluation of these.

As a result of this experience with a focus on Māori development, and experience of both theoretical and practical applications of development in Asia, Cooper as General Manager of North Health's Māori Health Development Division developed a grand vision. A vision of this nature included a broad political strategy to address Māori health needs and Māori desire for rangatiratanga under the Treaty of Waitangi. He gained acceptance for this view amongst the RHA Board as a means of operationalising Māori health policy within Auckland and Northland. That the Board and senior management retained the will to introduce a substantially different approach than that trialed elsewhere in the country testifies to the strength of their convictions. MHDD developed a more evangelical approach rather than a more direct health gains focus preferred, perhaps, by health managers. The rationale for such thinking was presumably the long-term engagement of Māori authority in the processing of health decisions, coupled with the development of increased operational delivery of health services by Māori providers. This grand vision, it was believed by North Health, was more likely to gain ownership by Māori communities over their health.

This grand vision for Māori within North Health reflected the broader political critique that sees that Māori are alienated from some structures in society, and thus may not receive the sustenance necessary to enjoy good health. In order to take radical political action it was necessary to establish close personal relationships where these risks could

be taken. This required a leap of faith on the part of a Crown agency, which was unprecedented in New Zealand (Cooper, 1997).

How did a strategy which was radical and targeted to political outcomes based on a Treaty expert's opinion, hold sway in the largest purchaser in the country?

The start of Cooper's personal journey was with the Hui Taumata of 1984 held at Hoani Waititi Marae. This Hui concluded that it was essential for Māori to be involved in their own development if things were ever to change for Māori. The key theme therefore was of the need for Māori participation in all aspects of service delivery, and the need therefore, to use locally available Māori expertise. This theme was later expanded to include Māori wanting to run and own the services delivered to Māori people.

Such thinking underpinned the grand vision developed by MHDD at North Health. The process of enacting this grand vision required adoption by the North Health Board and management and therefore relied on the commitment of key personnel, particularly Board members like Denise Henare and Harold Titter, and support by Garry Wilson (CEO of North Health). Clearly the enthusiasm of the MHDD in promoting this vision within the organisation particularly with the other service teams, was instrumental in its organisation-wide adoption.

Applying for funding and negotiating contracts was a complicated business for Māori health providers. They were required to deal with MHDD and MAPO (when established). Furthermore, many also had to negotiate with service teams such as mental health and CHEs. These overlaps were often unclear, both to North Health staff who were in the process of developing procedures themselves, and also to other providers, who were consumed with the business of providing healthcare services to Māori clients.

Despite these problems with the mechanism of contracting for Māori providers, MHDD adopted a developmental approach based on the assumption that the only way to overcome Māori health inequalities was by including Māori (to the extent possible) in the

political decision making process. Therefore the focus of attention has been the creation of Māori Health Authorities to take up this responsibility.

The scope of services within the health sector was limited by what was acceptable to the Government of the time. An example is the view taken by Jenny Shipley as Minister of Health with respect to the MAPO. Her concern was that the responsibility for all purchasing in North Health could not be shifted from the Board to another non-legislated body over which the Minister had no control. She was reassured by North Health in a meeting with the CEO and General Manager Māori Health, that the MAPO would not be making the purchasing decisions but rather advising the North Health Board on these purchasing decisions. However, North Health was clearly selling MAPO to iwi Māori on the basis of devolved decision-making and participation in the highest levels of decision making in health. Such 'political management' between these two views could be seen as an inevitable consequence of working in an environment still nervous about unleashing Māori expectations and from the Crown's perspective, about risk sharing with Māori bodies.

North Health - Three Pronged Approach

North Health's three-pronged approach to Māori health was unique and it incorporated these strands into the grand vision of MHDD. Political interests in the Treaty and iwi development drove this vision. It also included a dose of pragmatism in dealing with the complex mire of Auckland and Northland Māori politics. These three prongs to the Māori health strategy consisted of purchasing services in three areas: Māori providers, Māori provider development and mainstream enhancement. Only one contract in each of the two latter categories was ever purchased by North Health in Auckland.

The independent Māori provider strategy arose from the belief that Māori consumers needed a choice in primary care providers. The purchaser also believed that Māori had been poorly served by mainstream primary care providers historically and that the evidence for this was in the overwhelming poor health statistics of Māori. Māori continued to bear a greater burden of illness and early death by the 1990s. Evidence

about the 'success' of independent Māori providers is still sketchy (see following Chapters), however the widespread perception among health decision makers remains positive about such development. Māori providers are seen as having delivered quality services cheaply and effectively to Māori consumers.

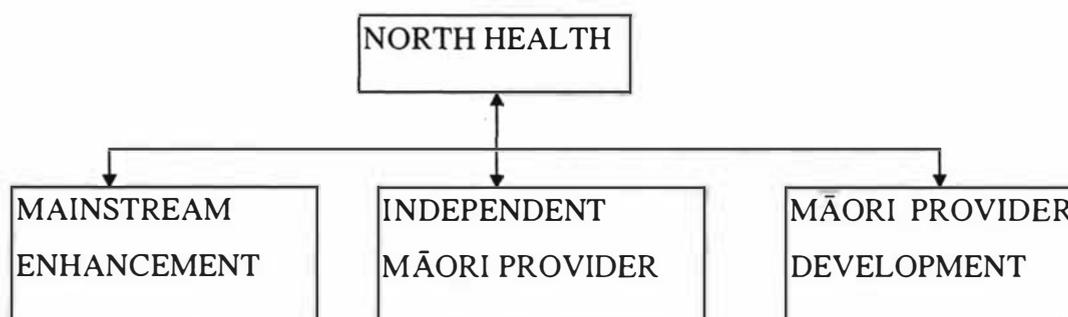
The health evidence is more difficult to assess since there are actually few hard 'facts' on which to base any findings. Immunisation rates are notoriously difficult to interpret, and long term health status trends need further information before they can be discerned. It is likely that Māori providers have improved access to primary care services for small pockets of Māori populations located around these services. These services do appear more responsive to Māori needs, including transportation, and health promotion education. The broader analysis however suggests that these services *limited* Māori while other social and economic changes were fundamentally affecting the livelihood and well-being of Māori in ways that would inevitably impact on their health.

The embryonic nature of independent Māori providers at the start of the health reforms led the purchaser to the Māori provider development strategy (pre-dating the later Government initiative of Māori provider development with special funding). A skilled and experienced Māori workforce was difficult to find for the Māori providers starting out. In particular, the paucity of Māori doctors, nurses and health managers required additional investment in training and education. Efforts were particularly focused on managerial concerns during the early phases of this strategy since contracting, reporting and accountability for public monies were an obvious concern for the purchaser during the early phase of health market development.

The mainstream enhancement strategy was a reflection of the importance of dealing with mainstream providers since most Māori continued to seek treatment from non-Māori health providers. Therefore the emphasis was on making these providers in primary, secondary and tertiary care, more responsive to Māori need. In many ways this strategy was frustrating for MHDD staff who felt they were often attempting to change funding in ways that may have raised concerns about the dominance of medical specialists and large

health bureaucracies in health service delivery. Achieving change with these providers would be difficult, energy, time and resource consuming. As such investment here for Māori health was seen as less attractive than the more immediate and 'rewarding' investment in independent Māori provider development.

Figure 14 North Health Māori Health Three-Pronged Strategy



Legal Mechanism for Implementing MAPO

Having had the vision about Māori co-purchasing, North Health had to find a mechanism that would allow it to pursue the MAPO vision. This required finding suitable legislation in addition to finding supporting policy and political will from within North Health via their Board of Directors. A mechanism was identified by Sharon Shea, the Māori Manager of Contracts in section 4.1.6 of the 1996/97 Funding Agreement between North Health and the Ministry of Health. She explained it as follows.

The commonality of strategic approach should be clearly highlighted to eliminate concerns of not having a strategic national approach to Māori health gain (Shea interview, 12 May 1997, p1).

North Health took on “partnered activity” in respect of their prioritisation of Māori health by establishing MAPO. This strategy was seen as ensuring greater Māori participation at all levels of the health sector.¹² MAPO are described as,

Responsible for prioritising Māori health within the RHA’s core business activity for all Māori within the North Health region ... [and] The MAPO

¹² Ministry of Health report on Regional Health Authorities’ compliance with the requirements with respect to Māori health, 1997

share joint responsibility for the selection and development of services and providers who are deemed to be safe, necessary, appropriate, effective and capable of efficient service delivery (Shea interview, 12 May 1997, p3).

MAPO were established using Transitional Assistance Grants from the fund operated by the Ministry of Health, providing each MAPO with its own premises and capital equipment. North Health met the operating costs of each MAPO.

MAPO were envisioned as co-purchasers at both the governance and operational management level. North Health has a Memorandum of Understanding and Deed of Partnership with each MAPO.

The Memoranda set out the fundamental principles under which the partnerships operate, and the Deeds formalise the statutory and contractual obligations of the parties. The Deeds have no fixed term and can only be terminated by either party giving the other at least 12 months notice in writing. Consequently, the contractual relationship between North Health and its successors, and the three MAPO will continue until such time as one or other of the parties gives notice to terminate (Shea, interview, 12 May 1997, p4).

North Health and MAPO

North Health's establishment of MAPO also reflected a social reality within Auckland, namely the division of Auckland into four large regions. These regions are: Auckland City covering central Auckland, Manukau covering South Auckland, Waitakere covering West Auckland and North Shore covering North Auckland. While there is considerable variation within each of these regions, there is also a cohesive identity that describes how they view themselves in relation to other sub-regions of Auckland, and higher socio-economic status in central and North Auckland compared to West and South Auckland.

The allocation of large contracts to significant Māori service providers within these regional areas prescribed boundaries among providers that minimised turf warfare.

Māori providers understood the geographical area within which they provided services. North Health effectively divided Auckland into four regions of North, South, West and Central Auckland and identified Māori providers that would operate within these areas. The criteria for choosing these providers included previous experience in social service delivery, health expertise, legal entity with whom they could contract, ability to offer services within their areas and dominant Māori identity within these areas.

Disputes about turf were usually subtle and rarely erupted into outright enmity, although some providers expressed strong opinions about the relative benefits of iwi providers over other pan-Māori organisations. These turf disputes reflected a larger national debate about who represented Māori and how Māori / iwi development was best achieved. While Māori policy shied away from an explicit preference for iwi delivery following Winston Peters time as Minister of Māori Affairs from 1990 to 1991 (Durie, 1998b, pp 159-160), antagonism was present, particularly in Auckland where the largest urban Māori population lives. Arguments for including pan-tribal Māori agencies in Māori social and economic development were advanced. Durie (1998) cites the following example.

Speaking at the 1993 Beehive Hui to discuss the appointment of Commissioners to the Treaty of Waitangi Fisheries Commission, [June Jackson] estimated that less than one-half of Auckland Māori did not have any meaningful contact with Iwi, nor did they seek one. Shane Jones, a Commissioner on the Fisheries Commission echoed her thoughts. Tribal sovereignty, he claimed, would do little for 'most Māori people who face daily disadvantage and struggle to educate their children adequately and care suitably for their health and shelter. The marginalisation of Māoris in education, health and housing is a greater threat to a secure and just society than the ideology of tribal sovereignty (Durie, 1998b, p 160).

Tamihere (24 July 1996) explained his view of the inequity between iwi and Māori Urban Authorities in respect of entering the new health services market in the early 1990s.

We started on our own money. We developed our own clinic. We developed our own knowledge base and then we put our hand up to say

that we're a Māori provider, "Can we get some?". Some of the big picture items were development funds for assets because everyone else that was competing with us in the so-called market-led deal, they had historical dollops of cash, capital and equipment from the previous regime [the Area Health Board] (Tamihere, 1996, p 7).

Tamihere provides examples to back up his claims.

Orakei they got \$500,000 from Dommett [Ave] right?

If you looked at Tainui, in 1987, they got \$450,000 out of their health board for buildings and had the capitalisation there after to move it forward (Tamihere, 1996, p8).

However major criticisms of MAPO remained, along with challenges to the legitimacy of such bodies to determine purchasing and later, funding contracts for Māori providers. These kind of criticisms are linked to bigger questions around the legitimacy of Māori organisations to speak on behalf of Māori (those who identify with that group), or to claim resources on their behalf. Legal and moral debate has occurred in regard to fisheries assets and legal action has been taken by Urban Māori Authorities against the Waitangi Fisheries Commission, the members of whom are government appointed and represent iwi interests.

However there are more than political questions at stake here. There is also the legitimacy of experience in social service delivery and of the degree to which new bodies could actually meet the service needs of their community.

In addition, there were concerns expressed about the creation of additional bureaucratic structures for Māori providers. This required Māori providers to negotiate with North Health (through MHDD) and also with MAPO, if and when they were operational. It was argued that such (potential) duplication of roles would require additional resources, lead to confusion among providers and purchasers about responsibility and skew decisions in favour of iwi providers irrespective of the quality of service provision

possible by others. These criticisms of MAPO have remained, in part because of the uncertainty in funding, role and authority of the MAPO.

Māori providers were intended to provide a range of primary preventative health clinics offering Māori patients a choice in health service providers. Such a choice emerged because there were almost no existing Māori GP practices available (and therefore accessible) through existing configurations of GP surgeries. Furthermore, the strategy was informed by research suggesting that Māori were under-utilising primary health services, relying instead on hospital services to meet health needs. Providing primary health services would address these needs, while increasing choice and probably Māori patient satisfaction.

Māori providers suggest that both assumptions have proved correct. For example Wai Health claim that their immunisation rates for young children has risen from around 40% to nearly 90% within a two-year period between 1995 and 1997 (Crengle, 1998). Immunisation rates are reported as having risen to around 70 to 80% in similar Auckland populations (GP Association, personal communication, 1997). There are questions however about the accuracy of immunisation rates data during this period. In particular, there are questions about the extent to which immunisation rates validly compared when Māori providers use enrolled patient figures and other figures include total populations.

A study of 105 Māori treated for drug and alcohol problems in Canterbury found that those using Māori providers (Māori-dedicated services) were 5.5 times more likely to be satisfied with their treatment, than those who went elsewhere (NZMJ, May 1998). The authors from Christchurch School of Medicine went further in saying that, "This finding is consistent with the ongoing assertion by Māori that separate health services for Māori, run by Māori, are necessary to ... bring about more equality in terms of health status for Māori" (NZMJ, 1998).

The total amount spent by North Health on Māori health initiatives of around \$1 million (staff MHDD, North Health) was seen as value for money compared to the historical health evidence of poor health outcomes from primary care interventions.

MAPO And Te Kaunihera O Nga Hauora Rangatira

Te Kaunihera O Nga Rangatira Hauora O Te Raki (The Directorate of Māori Health - Northern RHA) is the joint North Health / MAPO Committee. The primary aim of Te Kaunihera was,

To actively promote the health partnership relationship between North Health, as a Crown agent, and Māori, as Treaty partners, in the North Health region - represented by the Iwi - Te Tai Tokerau, Ngati Whatua and Tainui. This partnership is a means of promoting and enhancing Māori health status (North Health, 1996, p2).

The membership of Te Kaunihera included the full North Health Board and representatives of the three Hauora Rangatira (MAPO). They were to give effect to the Treaty of Waitangi for North Health, but also were encouraged to "invite North Health Board members to attend their Committees from time to time to deal with specific issues" (North Health, 1996, p4).

The Kaunihera was established under the Health and Disability Services Act 1993, Clause 13 of the Second Schedule of the Act (North Health, 1996, p5). This clause allowed the board of a government purchaser to appoint and dissolve committees of the board. On 24 May 1995, the Northern Regional Health Authority (NRHA also known as North Health) established a Committee pursuant to this clause. It resolved that the Board of North Health,

(I) Establish a Committee of the Board, pursuant to Clause 13 of the Second Schedule to the Health and Disability Services Act 1993, comprising all Board members and one representative of each of the Tainui, Ngati-Whatua and Te Tai Tokerau Iwi, when a Deed of Partnership has been agreed with each Iwi (North Health, 1996, p5).

Furthermore, delegations of powers to Te Kaunihera were effected under Clause 14 of the Second Schedule of the Health and Disability Services Act. On 24 May 1995 the Northern Regional Health Authority also resolved that the Board,

3 (ii) Delegate to this Committee, pursuant to Clause 14 of the Second Schedule to the Health and Disability Services Act 1993, the Board's powers, duties and functions in relation to Māori health (North Health, 1996, p6).

A manual by North Health explains that the role of Te Kaunihera was complementary to the governance role of each MAPO Board and that they represented North Health's implementation of the Treaty of Waitangi through their involvement as Crown and Treaty partners. Such 'systemisation' of the Treaty was to occur,

by Te Kaunihera O Nga Rangatira Hauora O Te Raki meeting the legislative functions, duties and powers of North Health and, more importantly, by Te Kaunihera O Nga Rangatira Hauora O Te Raki (and the operational units under its governance) focussing North Health towards improving Māori Health through strategic purchasing for Māori health needs (North Health, 1996, p 6).

Te Kaunihera allowed North Health to relate to all three MAPO together, in addition to relations with each MAPO board. The zeal with which these new structures were implemented is palpable in the document eg. "robust and durable ... new era of Māori participation is essential to Māori health, economic and social development" (North Health, 1996, p4).

MAPO were delegated authority under clause 14, Second Schedule Health and Disability Services Act 1993, which allowed the RHA to delegate its powers, duties and functions to another body (North Health, 1997e). Sharon Shea the Māori Health Contracts Manager in North Health had identified as a legal mechanism that would enable North Health to effectively include iwi as co-purchasers. The Health and Disability Services Act 1993, Second Schedule, section 14 reads,

14. Delegations --- (1) The board of a Government purchaser may, by written notice, delegate any of its functions, duties, or powers, or any of

the functions, duties, or powers of the Government purchaser, to any committee of the board, director, employee, consultant, or agent.

(2) A delegation may be to any named person or to any member of a specified class of persons. If the delegation is to a class of persons, it shall, unless otherwise provided in the delegation, apply to each member of the class for the time being irrespective of any change in membership of the class.

(3) Unless otherwise provided in the delegation, a delegate may exercise the function, duty, or power in the same manner and with the same effect as if the delegate were the board or the Government purchaser, as the case may be, and may further delegate the function, duty, or power.

(4) Every delegation shall be revocable at will and no such delegation shall prevent the exercise of the function, duty, or power by the board or the Government purchaser, as the case may be.

(5) Every delegate purporting to act under any delegation under this clause shall, until the contrary is proved, be presumed to be acting in accordance with the terms of the delegation (Health and Disability Services Act 1993).

This delegation was applied to Māori health through the establishment of Te Kaunihera o Nga Rangatira Hauora o Te Raki. In addition, North Health entered into a Memorandum of Understanding and Deed of Partnership with each MAPO.

The Memoranda set out the fundamental principles under which the partnerships operate, and the Deeds formalise the statutory and contractual obligations of the parties. The Deeds have no fixed term and can only be terminated by either party giving the other at least 12 months notice in writing. As the Deeds are formal contract documents, the normal rules and principles of the law of contract apply, as does relevant contract law legislation. Consequently, the contractual relationship between North Health and its successors, and the three MAPO will continue until such

time as one or other of the parties gives notice to terminate (North Health response to Performance Management Unit, Ministry of Health Review, undated, 1998).

The MOH observed that the inclusion of MAPO representatives and RHA board members on the Kaunihera, enabled Māori, “To participate in the RHAs strategic and operational roles and activities” (Ministry of Health, 1998, p vii).

However this strategy is more clearly associated with a strategic and policy role. Operational influence was exerted through three primary mechanisms. These mechanisms were, i) the Māori Health Development Division’s influence on the purchasing strategies of other service teams within North Health; ii) MAPO themselves; and, iii) the Hauora Māori Schedule inserted into every North Health contract.

MAPO have considerable ability to influence contracts because they,

Participate in all contracting decisions relating to Māori health services, and have comprehensive input into developing service contracts with, and monitoring of, mainstream providers (Ministry of Health, 1997, p viii).

Once established MAPO had a role in negotiating, agreeing and evaluating contract formation and performance for all Māori providers within their tribal region. Given the staggering of MAPO development, some MAPO have been in a stronger position to influence these contracts over a longer period of time. Most notable is Tainui who influenced contracts initially through Te Raukura Hauora o Tainui and then latterly through Tainui MAPO. Ngati-Whatua MAPO was established in 1996, and like all organisations, needed time to get up and running.

Explaining North Health’s Strategy

North Health were concerned about the evidence that Māori tend to under-utilise primary health care services (especially GP services), consequently leading to more serious illnesses and intervention in hospital services (Jackson, Kelsall, & Papa, 1996; Malcolm, 1996).

Despite reservations about the denominator population, the differences in the utilisation between the centres studied and the average New Zealand population are stark. This is particularly so when it is recognised that the patients being served by these centres are known to have poorer health status and therefore need to be using services more than better off, healthier populations. Almost universally, general practitioners working in the centres described the patients they were seeing as having multiple and complex problems requiring longer than average consultations. Patients deferred coming for treatment and often came with multiple problems saved up over a period of delayed attendance (Malcolm, 1996, p 358).

Furthermore, North Health accepted the orthodox view that the reason for failure to present for treatment to GPs earlier was because of cost (ibid). This reasoning will be examined more closely in the following two Chapters since recent research raises questions about whether financial barriers are delaying presentation for primary health care, or even if there is a delay in presentation at all (Tukuitonga, 1999).

What is not disputed by the research is that Māori have higher health needs than non-Māori overall, and that when this is taken into account, they are significantly under-represented in utilisation of GP services (Gribben, 1999; Malcolm, 1996; Scott, 1999).

Supporting choices for Māori patients in primary health settings was therefore seen as an integral part of a preventative strategy, in addition to overcoming barriers to utilisation of this service. These barriers were identified as service costs, communication difficulties, transportation difficulties, lack of choice and cultural factors.

Gwen Te-Pania Palmer from North Health explains the issue of choice as follows, They have a choice of Plunket or the Māori providers and in some cases they use both and one of the things that has been very difficult to get across to historical providers like Plunket is the fact that the independent

Māori providers provide a total service (Te-Pania Palmer interview, 23 April 1997, p10).

She is expressing a frustration informally reported from North Health staff in the new contracting environment around the practical difficulties of shifting resources from existing patterns to new providers who reflect new or different priorities in health services. Such a tension is escalated when one considers the decreasing amount of resource available within the health sector during the period 1991 to 1993 when the interim system was in place. It is significant that 'choice' became viewed as important for Māori as a result of the health reforms, because choice is a dominant theme in neo-liberal reforms. The increase of personal choice may have been at the expense of collective choices. However, choice was promoted for Māori clients because of the unavailability of Māori health providers in the newly evolved health market. In this way, Māori had been denied the 'choice' of using Māori health providers and Māori health professionals unlike their non-Māori counterparts who saw non-Māori providers and health professionals all the time.

Te Pania-Palmer's statement exposes a widely held belief that one of the distinguishing features of Māori providers is their more holistic approach to Māori health. They do whatever needs to be done to improve the health of their clients, including advising them on how to deal with Income Support, other health professionals and whanau issues. This is reflected in the appointment of community health workers, who were the major means of liaising with the Māori health provider's 'community'. This community includes iwi, hapū, and whanau associated with the patient and the provider's locality.

Te Pania Palmer explain the barriers identified as overcome by North Health's strategy of primary independent Māori health providers:

The issue of access, the issue of cost is not a barrier, professional skill and expertise is not a barrier, culture is not a barrier and they're given option choices (Te-Pania Palmer interview, 23 April 1997, p15).

Māori providers were funded on a different basis to most other primary health care professionals, although they were most similar to the Union Health Clinics established

during the late 1980s, in that they received capped funding on a population basis. A funded population was projected in contracts based on the expected number of registered patients with that provider. Staffing levels reflected this and allowed them to be salaried (or contracted in the case of doctors) because of the nature of the contracts with the funder. Again Te Pania Palmer explains:

All the services the way we have purchased are [a] budget for a capped set of population so in all our providers we have the philosophy of, if they haven't got the money it doesn't matter. Accept a koha, this is our fee, so there is a koha system. There is a small fee for those that are waged workers (Te-Pania Palmer, interview, 23 April 1997, p15).

MHDD staff believed that Māori providers were more responsive to Māori health needs. For example Māori provider services are mobile and go to where Māori clients are as well as providing clinic services. This included going into their homes.

Also in their favour, Māori providers are seen to have,

Strong linkages or points of contact [with] those agencies [in the community], so I think the cost first of all [is] the issue of access [which] is addressed by [going] into the homes [to] deal with whatever is there confronting them. If they're not contracted to do that service ... they ring and tell me [it's] outside their depth, like if its mental health and somebody is in a real crisis situation, they know exactly what to do (Te-Pania Palmer, interview, 23 April 1997, p15).

This concept of linking with both other providers and the Māori community was an important distinguishing feature of Māori providers. While all primary health care providers need contact with other health professionals and other services such as Children and Young Persons Service (now Child Youth and Family Service) or the Police, these relationships have a much lower priority than laboratories for testing, ACC and specialist services among non-Māori mainstream providers.

There is also evidence of a closer link between the purchaser (MHDD in North Health) and Māori providers - a relationship not replicated elsewhere in the purchaser. For

example Māori providers could ring MHDD Māori staff directly and tell them sometimes when they felt out of their depth, or were dealing with a series of crisis situations. Such behaviour demonstrated a slightly different relationship between Māori providers and their Māori health purchaser, from other mainstream providers. In effect MHDD were sponsors for these providers, having picked the winners in Māori health services. These providers then benefited from this largely amicable relationship.

The reason for this approach of picking winners is twofold. Firstly Māori providers required a closer working relationship of being able to talk directly to the other through *kanohi ki te kanohi* or directly by phone. Secondly, it was part of a risk minimisation strategy, which MHDD adopted to legitimise their choice of these 'winners'. They could not afford for Māori providers to fail. A key part of MHDD's strategy was to sponsor Māori providers mainly in the primary health environment, and encourage other North Health service teams to offer contracts for services to Māori providers (the same providers, or other Māori providers not contracted by MHDD). To do this they had to provide evidence that Māori providers could successfully take up a contract with North Health and deliver on that contract.

Criticisms of Māori providers were challenged by MHDD who had vested their credibility in these providers, and who claimed that Māori providers were actually made more accountable and demonstrated their performance more than other mainstream providers, and in particular CHEs, who are recipients of the largest slice of health funding. Te Pania Palmer explains.

We've actually monitored our Māori providers far more regularly than what the others have been monitored. Though I think it was about part of managing risk, but inadvertently what's come out is that our management of the Māori providers has actually been an auditing of ourselves, an auditing of them, very, very informal (Te Pania Palmer interview, 23 April 1997, p 12).

She goes on to explain why MHDD view their work with Māori providers as ground breaking in terms of accountability when compared with mainstream providers and expresses a view also expressed by other MHDD staff and Māori health providers.

My passion is we have to get performance from mainstream [providers] and we have to get performance in the CHE. They are the least performing out of all the providers in our region; the Crown Health Enterprises are the least performing. You know, one of the areas is that Unless they're paid money, more money, they won't do extra and what they interpret as extra. So, if you ask, if you say we're only getting your inpatient Māori data, what happens with people who front up just for day surgery. How many Māori people do you have? [How many] Māori people have you coming into A & E (Accident and Emergency) and then out again [They have] inpatient Māori data but we've got nothing about what they do in the community or the Māori community Health workers within the CHE. We've got nothing that actually gives us [anything] that separates out what they're actually doing, their performance levels. When you look at that in terms of the resources that are allocated to each of those organisations, it's already a great concern. It's huge resource begin invested and that's the point of tension in regards to Māori health at the moment [which] is between [the] nature of the independent Māori service provider [and mainstream providers] (Te-Pania Palmer interview, 23 April 1997, p13).

These concerns about mainstream providers and their ability to provide suitable services to Māori patients did not however address the depth of clinical expertise and experience that they had in respect of health services. Getting Māori providers to a stage where appropriate clinical depth and breadth would be available to a population burdened disproportionately with illness would take careful management of risk. Te Pania Palmer identifies this dilemma for purchasers.

At one time I thought that's all I'm doing is purchasing a huge amount of risk to bring about change. You know and it was about how do I continue to manage the risk as innovative and as exciting and as challenging as I

felt, there were times when I thought, how long do I continue to juggle like this and systematically begin to systemise some of the work (Te Pania Palmer interview, 23 April 1997, p11).

The Hon. Wyatt Creech (the Minister of Health in 1999) expressed similar reservations in respect of approaches from Independent Practitioner Associations and Māori health providers in transforming them into Integrated Care Organisations (ICOs). His concern was around the level of risk which new health bodies were willing to take on and the level of risk that they were actually capable of taking on (Keynote speech, IPA Conference, Awataha Marae, March 1999). This risk is multi-faceted and includes financial, clinical and organisational capacity to manage complex health problems for a defined population.

Reflecting Diversity: Ministry Of Health Review Of RHA Strategies For Improving Māori Health Status

This diversity in approaches among RHAs led to a variety of purchasing strategies and contract prices between various RHAs, a point that later became contentious with the Transitional Health Authority who sought greater consistency in contracts and pricing when the RHAs merged into one funding Authority in 1997.

The Ministry of Health undertook a review of the RHA strategies and since this is the only such review, it is worth quoting the findings at length. The report reviews these strategies because of the Crown's commitment to improving Māori health status so that,

In the future, Māori will have the same opportunity to enjoy the same level of health as non-Māori (Department of Health, 1992b).

Māori health was also a Health Gain Priority Area reflected in the annual Funding Agreement between the Minister of Health and RHAs, and it affirmed the relationship between tangata whenua and the Crown (RHAs 1996/97 Funding Agreements Section 4.1.6).

This analysis of the Ministry of health document includes North Health's response to these comments since their strategy is the focus of this research, but does not include comments from other RHAs.

North Health criticism about the Ministry report appeared to be concerned with two matters in particular, the lack of emphasis on the quality of thinking that went into the development of these strategies - in particular the lack of acknowledgement of the strategic nature of these ideas (that is that North Health believed these were truly part of a visionary process of change). Secondly, a concern that the Ministry of Health had overstepped the original terms of reference for the report by recommending changes to the Transitional Health Authority (THA). The THA was an unknown quantity at the time with considerable political clout (Dr Graham Scott as Chair, was an ex-senior Treasury manager and was Chairman of Midlands Health).

The review included,

Performance of the RHAs in respect of both Māori providers (by Māori for Māori and by Māori for all) and mainstream providers, including Crown health enterprises (CHE) and community providers (Ministry of Health, 1997, p iv).

The report explains that, "Each RHA has taken a different approach to purchasing services for Māori" (ibid).

All Regional Health Authorities responded to the tribal fabric of their respective regions, reflecting their relationships and understanding of the nature of iwi Māori politics, in their strategies for Māori health.

North Health's approach was a co-purchasing strategy with 'Treaty partners'.

It has established Māori Co-Purchasing Organisations (MAPO) in three geographical areas which are delineated merely for reasons of practicality [and] ... prioritising Māori health within the RHAs core business activity (Ministry of Health, 1997, pp iv-v).

This included input into decision making at governance and operational levels. In contrast Midland RHA relied on a series of,

Contracts with the thirty-five iwi of its region, through the development of four territorial joint venture boards (JVs) (Ministry of Health, 1997, p v).

These Joint Ventures encouraged participation of iwi in planning of health strategies and policies in health services purchasing for Māori. In 1997, they were still evolving consultation “structures and processes with Māori in the Midland region” (ibid).

Midlands Health also adopted an iwi-centric approach, choosing to work through established lines of communication with various Trust Boards, most notably Tainui. These Trust Boards represent beneficiaries of earlier settlements and therefore were in a strong position to legitimise their claim to speak on behalf of their iwi, and indeed, the other peoples of their area. In addition to Tainui representation on Midlands Health, and their support for MAPO, they successfully negotiated directly with Midlands for Tainui Capitation through Wayne McLean as CEO of Raukura Hauora. The Māori health portion of the budget was \$900,000 out of a total \$5,000 million. The total national health budget was \$5 billion (exclusive of GST)¹³.

Central RHA “adopted a traditional community-based approach to Māori health”. This approach was more eclectic, relying on, “direct relationships with each of the fifteen iwi in its region” (Ministry of Health, 1997).

Southern RHA had a series of ad hoc series of arrangements, but its primary relationship was with Te Runanga O Ngai Tahu. This Runanga had firmly established its position through the Treaty of Waitangi settlements process as the pre-eminent Māori authority in the Southern region. Southern RHAs strategy included consultation with Māori, an internal Māori advisory resource and statistical evidence focused on the Māori population (Ministry of Health, 1997, p vi).

¹³ GST is Goods and Services Tax, currently worth 12.5% of the value of the goods or service.

Two “high level strategies” are identified in the report with regard to each of the RHAs’ strategies, reflecting their policy and statutory responsibilities to Māori. These are described as,

Improving the responsiveness of health service providers to Māori health users, including the development of partnerships between mainstream providers and iwi and Māori groups (mainstream enhancement); and, encouraging the development of Māori providers committed to the provision of health services to Māori (by Māori for Māori, or by Māori for all) (Ministry of Health, 1997, pp vi-vii).

RHA purchasing strategies emphasised the latter, namely the development of Māori providers resulting in a significant increase in the numbers of providers.

Information provided to the Ministry of Health from the RHAs indicates that from 1993 to 1997 there has been a national increase from approximately 30 to over 200 Māori providers (Ministry of Health, 1997, p vii).

It is difficult to know exactly how many Māori providers there were prior to these reforms, as many Māori services existed under the mandate of mainstream services such as mental health or health promotion, or more generalised social services. However it is likely that those Māori who secured contracts, did so partly because of their previous experience of health or other social service delivery.

In commenting in the report on these various approaches the MOH made the following observations on Midlands Joint Venture approach, “[It] may not have consistently informed the operational activities of the RHA. There is some variability in the extent of interaction between JVs and the various service groups”. In addition, “Some providers visited by the review team reported that the JVs hinder iwi relationships with the RHA because they are essentially RHA structures which are not representative of the iwi” (Ministry of Health, 1997).

According to the report, Central RHAs approach “appears to have accommodated Māori health issues at both a strategic and operational level. However, those service groups

who have Māori dedicated positions and commitment of management and staff to targeting high risk groups, appear to have more successfully internalised the strategic directions for improving Māori health status, than other groups” (ibid).

Southern RHA established a Māori Health Development Unit which, “At this stage does not appear to be well integrated within the organisation. The review team was concerned that all of the RHAs service groups did not appear to be fully committed to improving the responsiveness of mainstream services to Māori” (ibid).

North Health submitted a detailed response to this report, many of their points emphasising the strategic nature of the decisions taken. There was a strong sense in North Health that the Ministry of Health failed to appreciate the nature or significance of orientation (Shea, interview, 12 May 1997).

The MOH acknowledged that some of these differences in approach might reflect, “the diversity of the regions’ Māori populations and different levels of organisational infrastructure in each of the regions” (Ministry of Health, 1997).

Factors Contributing To Variation Amongst RHAs

In the Northern health region (covering Auckland and Northland), there was an established way of working through the political sensitivities of Māori autonomy and service provision. The kind of political complexities of the 1990s, with the advent of large Treaty settlements and following the 1984 Hui Taumata, saw the debate around iwi and Māori emerge as a more central debate within Māoridom. There are a number of reasons associated with the policy environment that encouraged this emergence at this time. Many of these have been discussed in earlier policy Chapters, however it was the capacity of health authorities to engage meaningfully with Māori that is of interest here. Clearly RHAs engaged differently with iwi Māori according to their particular histories, analysis and experience of Māori, including concepts such as tangata whenua, mana whenua and manuhiri.

Relationships were already established with Māori organisations, including local marae and rangatira and kuia / Kaumātua. There was (and remains) considerable variation in the nature and strategies for dealing with these issues according to geographical location. This North /South gradient was most evident when RHAs were allowed to develop variable strategies under the new Health and Disability Services Act and consequently these variations were reflected in contracts with Māori healthcare providers. These strategies reflected the previous experience of both Māori and Crown agencies in negotiating with each other, the infrastructure available to deal with these negotiations, institutional memory of this and the particularities of the place and people involved in the negotiations. Auckland experienced the most complex environment with all iwi present along with major pan-tribal Māori organisations.

North Health demonstrated an ability to deal with the high level of complexity of Māori politics and was therefore better equipped to cope with this in the new arena. In particular, it was able to recognise the key leverage points with Māori, such as the drive for Māori autonomy and the need for caution in negotiating between Māori organisations, which were pan-iwi, and iwi representatives. Cooper's experience in development and Treaty issues was key to the development of North Health's grand vision and acceptance amongst the Māori community of their strategies.

The approach taken by each RHA became distinctive and reflected these elements. While attempts had been made to evenly divide the country into similar sized chunks, there remained major divisions and differences, as well as similarities between Māori in these regions.

Midlands Health benefited from its relationship with Tainui and other major tribes in its area such as Te Arawa. It was therefore able to relate to an established Iwi infrastructure that also had a history of delivering services and responding to policy advances. It also had individuals who had senior experience in mainstream health providers. A Māori health manager in Midlands Health indicated that there were problems with the Joint Ventures (JV) there. Some of these iwi JVs are extremely large and were creating

problems for Managers since they addressed the political control of health services through bureaucratic structures. Although the scale of these bureaucracies may be smaller, they still function in much the same way. Also, iwi and community consultation processes are time and energy consuming requiring resources that cannot then be transferred into direct service provision.

Some Māori health providers and MAPO pursued their own initiatives, sometimes independently of North Health MHDD. For example Te Kaunihera Hauora Tapui is made up of Ngati-Whatua, Tainui and Waipareira representatives and held a contract for public health services in areas such as smoking cessation for three years for \$800,000. This initiative followed the dis-establishment of the Public Health Commission and location of Public Health purchasing in North Health in 1995 and was funded by Public Health in North Health as part of their responsiveness to Māori (Lawson-Te Aho et al., 1999).

Unlike Midlands, North Health had more contentious ground to cover with regard to determining iwi legitimacy, which became an integral component of the North Health strategy. According to North Health, if Māori were to regain rangatiratanga then iwi would need to have authority vested back in them. This required careful negotiation and inevitably, some squabbles over who could claim this legitimacy emerged.

To this extent, health policy became a lever for clarifying unresolved issues around mana whenua. However these often rested on contentious decisions themselves, and were open to challenge both within iwi (from hapū) and between iwi (Waitangi Tribunal, 1998).

Nor did the dominant iwi occupying Auckland have an infrastructure or skill base sufficient to include them extensively in the development of this vision during the early phases of the health reforms. Operation of marae trusts reflected one aspect of a tribal organisation and many of these had become locked up in particular marae Committees or Trust Boards which had very particular beneficiary interests that were sometimes

criticised as non-representative of wider iwi/ hapū interests. These organisations were often dominated by personalities who came to define iwi identity and inevitably shaped iwi responses to health services.

Other Strategies: The Public Health Commission and North Health

It is worth noting that responsibility for public health services was initially given to the Public Health Commission (PHC), which had an even briefer life than Regional Health Authorities. The Commission came into existence on 21 June 1993 under the Health and Disability Services Act 1993 and was dis-established on 13 December 1994 (Hutt & Howden-Chapman, 1998).

Since the RHAs were charged initially with responsibility for purchasing only personal healthcare services, their strategies largely reflected this focus. Following dis-establishment responsibility for national public health purchasing was given all RHAs, but the bulk of public health purchasing went to North Health. When North Health became responsible for public health purchasing, little discernable change was made to the fundamental model for purchasing health services with respect to Māori health.

Consistency With Government's Approach

North Health's approach, while distinctive, coincided with key elements of the Government's reforms. Such a convergence of approach was timely and inevitable given the intent of the health reforms and wider public sector reforms. In particular the focus on expansion of choice is consistent with public choice theory, libertarianism and new right philosophies with the emphasis on the rights of individual Māori patients to expect a culturally matched service as evidence of quality in service.

Māori health strategies had to be sold to the North Health board with the support of key board members such as Harold Titter (Chair of North Health) and Denise Henare (Shea, interview, 1996).

The focus on access to services was also consistent with broader government policy that limited analysis of equity to questions of access. However access was broader in

meaning and effect. As Cooper explained the anticipated effect of Māori workforce development in the health sector should, “considerably improve ease of access to services - not just geographical access but psychological and cultural access” (O'Connor, 1998).

There was also a growing acknowledgement of the organic integration of social policy that takes place amongst Māori providers. Elizabeth Cunningham explained that, “Improving the health status of Māori requires the Ministries of Health, Education and Te Puni Kokiri to work together” (Cunningham, 1997).

She reiterated a theme identified by a number of Māori working with Māori health providers, that improvements in Māori health cannot occur in isolation from other social policy areas, in particular employment, immigration, education and housing. Cunningham goes on to say that this integrated approach is a Māori strength and that they have the ability to come together quickly around a particular topic irrespective of who they work for: Māori, “Have never seen themselves as competitors but as groups working together to try and improve the health status of Māori.”

Cunningham identified a dual strategy developed from the Coalition Government Agreement on health, which included providing appropriate services for Māori, “through culturally effective mainstream services and services from Māori providers” (Cunningham, 1997).

This opportunity was the result of a convergence of interests between new right government policies and Māori desires for rangatiratanga effected through contracting out health services delivery to Māori providers.

While the MAPO strategy may coincide in part with some of the aspirations of Te Tino Rangatiratanga, it is not ideologically driven. To iterate, the strategy is driven by an intelligent analysis of some of the underlying issues contributing to the negative aspects of Māori health status, namely the lack of effective Māori participation within the public health sector (Māori Health Development Division, 1997b, p1).

These initiatives are best understood as an extension of previous Māori health initiatives that reflected Māori interests in a developmental approach, particularly in integrating Iwi interests in development and health.

More often than not, Iwi participation in the reformed health sector did not represent a new or even renewed interest. Instead, the reforms simply allowed plans and programmes in place to find new expression (Durie, 1998c).

Durie argues that,

In the long run Iwi were interested in the health of their people within a context of Māori development. Of secondary importance was the shape of the health sector; it was, after all, only one aspect of the Māori development mosaic and certainly not the entire focus (Durie, 1998c, p164).

The government pursued a particular agenda for change with Māori that suited the purposes of a residual welfare state and reflected their interest in better managing the political risk of Māori health. They directed a form of development that had manifested in a particular way, locating services firmly within GP-like primary health services focused on individual and family changes, rather than on a broader critique of the impact of the range of social reforms on Māori mortality and morbidity. As such, there have been opportunity costs, which should be seen clearly as a trade-off for benefits to Māori under the 1990s health reforms.

Furthermore there were sound ideas already in existence, some of which were intended to provide the same benefits, but minimise some of the downsides associated with the current models. These downsides include the lack of sufficient clinical and business expertise in the health sector and need to develop these. Whether these initiatives would have been more beneficial to Māori, as a whole population, is difficult to assess. It is possible that Māori may incorporate aspects of a population-based approach, but as argued elsewhere in this thesis, this requires a re-orientation of thinking about the nature of health and health services.

What North Health Achieved

By 1997 North Health could boast some 20 independent by Māori for Māori providers within its region in addition to a number of other providers. These providers were made up as follows.

Table 14 Numbers And Types Of Services For North Health Māori Providers

Number of Providers	Types of Services Provided
20	For Māori by Māori clinical personal health services (Wai Health, Te Puea Marae Clinic, Orakei Health Clinic, Te Puna Hauora o te Raki Pae Whenua Clinic etc.)
6	Alcohol and drug services (including Putea O Pua)
1	Māori chaplain service (Amorangi)
1	CHE change management service (He Kamaka Oranga)
10	Community residential mental health services
5	Specialist community based mental health services, including 4 provided by Māori units with CHes
4	Disability Māori owned providers
1	Joint venture in public health (Hapai Te Hauora Te Tapui)
5	Regional public health
5	Other Māori owned national Public Health

	providers
3	Oral health (sub-contracted to non-Māori services, run under Māori auspices)
2	Primary care, bi-cultural services which included disability, long stay, acute and hospital care (e.g. Hokianga)
Total of 60 Māori Providers ¹⁴ (some providers appear in more than one category)	Across a range of services, encompassing personal, public, hospital and primary care sectors

Source: People in the Northern Region: A demographic Profile from the 1996 Census, Health Fund Authority, April 1998, Auckland (p 2).

¹⁴ Sharon Shea (Contracts Manager Māori Health, North Health), response to Ministry of Health, page 1997.

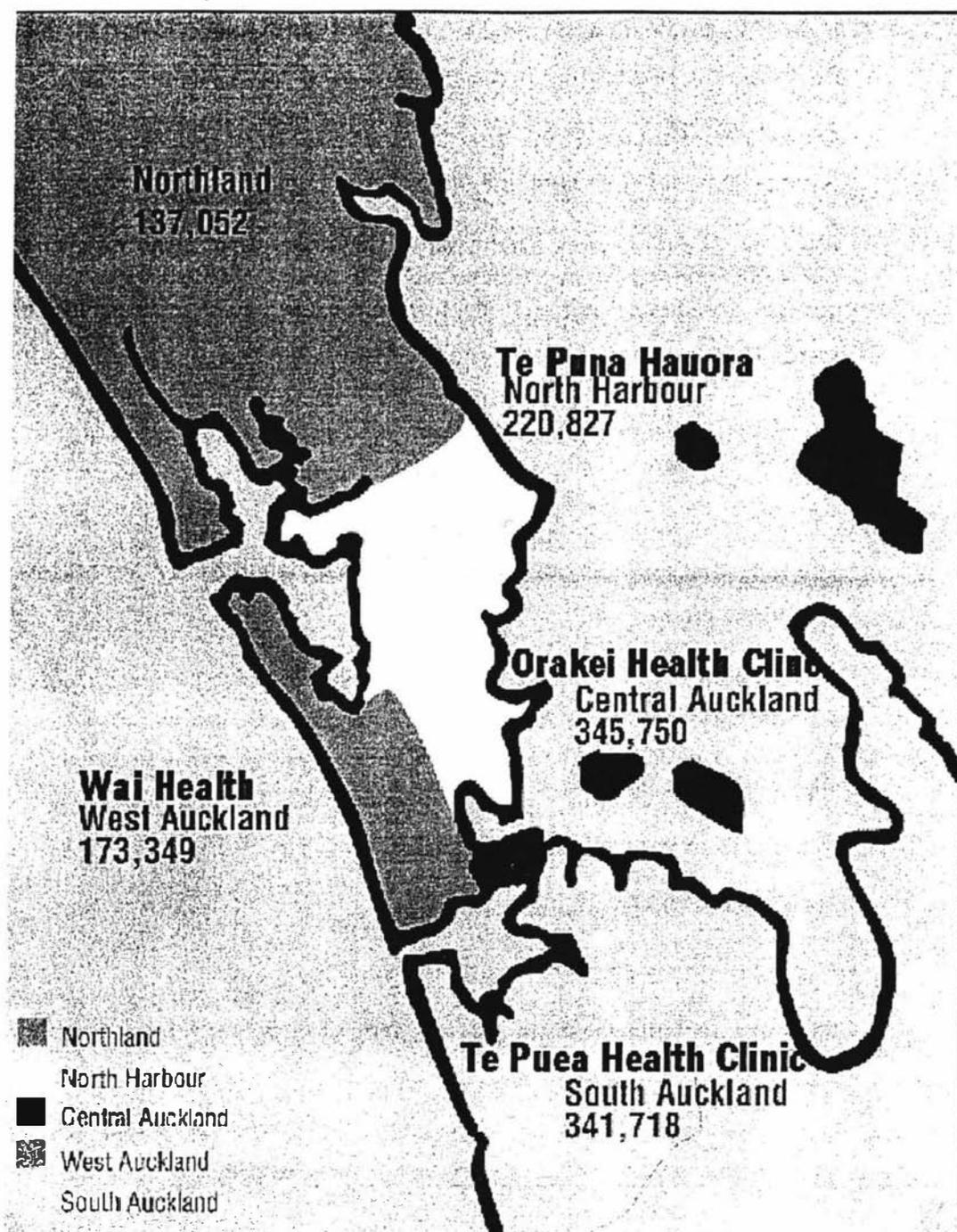


Figure 15 Maori Primary Care Providers by Population by Health District

North Health had also developed the Hauora Schedule which contained general measures of achievement in Māori health for all providers, particularly mainstream providers. MHDD work with mainstream providers such as CHEs and GPs to make them more responsive to Māori patients was very limited. This reflected the emphasis placed on

establishing new Māori providers (and thereby maximising the new market opportunity the enormous effort required to work with mainstream providers with a very limited staff capacity in North Health, and a view that other services' colleagues should make the providers accountable for Māori health gains. This lack of interest in mainstream providers can be seen in table 5.2 with only one contract in a CHE environment. Report called Service Level Cultural Quality Review, which evaluated four mainstream providers' ability to meet Māori health consumer needs, was not done until late 1996 during the period of the Transitional Health Authority. No independent review exists North Health's strategy apart from the much-disputed Ministry of Health Performance Management Unit and Te Kete Hauora called, Review of Regional Health Authority Strategies for Improving Māori Health Status (31 July 1997). An official information request by the author to the Minister of Health in late 1998 indicated no other reviews North Health's strategy.

Other RHAs also proactively supported the development of by Māori for Māori providers. For example the Central Regional Health Authority explained how a number of these had developed from previous Area Health Board contracts.

Originally there were 13 iwi who had contracts with the (former) area health boards. These contracts were transferred to CHEs on 1 July 1993. In the first year of operation, Te Ihonga Hauora had established a further 14 health initiatives. During this second year of operation, a further 20 Māori health initiatives were planned, however this target was exceeded and some 22 additional services were established (Ministry of Health, 1995, p 24).

Their services reflected a similar mix of primary care, alcohol and drug and community mental health services as those provided by North Health, although they describe the providers as "day services for turoro" (ibid, p 35).

Conclusion

North Health's strategy for Māori health reflected the Crown's objectives, including the crucial one of Māori participation in all levels of the health sector. North Health then developed a three-pronged strategy to address Māori health gain that included independent Māori health providers, mainstream enhancement and Māori provider development. Most of their energy and resources have been focused around the promotion of independent Māori providers.

North Health established 60 new Māori providers between 1993 and 1997. Some of these Māori providers did not directly deliver services but provided advice to either their organization, acting therefore as an internal consultancy, or to Māori providers and other health sector organisations as external consultants.

North Health developed a grand vision through their Māori Health Development Division (later known as the Māori Health Group). This vision was inspired particularly by Cooper and reflected his lifelong interest and commitment to the Treaty of Waitangi and Māori development. MHDD also relied heavily on core team members who remained during much of the reforms period within North Health, then the Transitional Health Authority and Health Funding Authority.

The grand vision gave preference to iwi through the development of MAPO and Te Kaunihera. This prompted tension, particularly with Māori Urban Authorities who viewed themselves as discriminated against on the basis of historical preference rather than merit. These tensions erupted in other Treaty of Waitangi settlement processes and Government processes throughout the 1990s.

The rationale for the creation of independent Māori providers included the promotion of choice of providers for Māori patients, greater access for Māori patients by locating them at marae and making them cheaper (especially with regard to primary care), more appropriate (cultural match between patient and provider), and more responsive to Māori health need because of their ongoing commitment to improving Māori health.

North Health as the purchaser of Māori health services in the Auckland region adopted an approach to managing iwi Māori relations in Auckland in a pragmatic, but also politically sophisticated manner. This reflected the political realities it managed which were considerably more complex than those faced by the rest of the country.

CHAPTER 9

Māori Health Providers Kawanatanga: Contracting, Governance & Management

Introduction

North Health's strategy for Māori health emphasised the Government's over-arching Māori health theme of greater Māori participation at all levels of the health sector as a means of addressing Māori health gains (Māori Health Development Division, 1997a). This was to be achieved through North Health's three Māori health strategies: Māori provider development, Māori mainstream enhancement and Māori co-purchasing (Shea, 1997a, p 1). These strategies were a reflection of government's Māori Crown objectives with respect to Māori health identified in *Whaia te ora mo te iwi: Māori Health Policy Guidelines to Regional Health Authorities and the Public Health Commission* (Department of Health, 1992a). These Crown objectives came closest to a Māori health policy of any of the policy developed during the early stages of the health reforms (Cunningham & Kiro, 2000). This report identified three 'directions' for purchasers: the greater participation of Māori at all levels of the health sector; resource allocations that take account of Māori health needs; and, culturally appropriate practices as integral to the purchase and provision of health services for Māori.

These North Health strategies relied on other tier strategies to make them work, including Māori participation in co-purchasing at the governance and operational levels (Shea, 1997a, p 1). While various Regional Health Authorities adopted different approaches with regard to purchasing of Māori health services to achieve Māori health gain, North Health adopted a co-purchasing approach that involved iwi representatives along with RHA Board members on *Te Kaunihera O Te Hauora Rangatira*. This body provided oversight of Māori health purchasing in their region as a sub-committee of the Regional Health Authority.

These strategies would be pursued through the MHDD and other North Health purchasing teams such as Public Health.

The operational arms of this Kaunihera were Māori Assisted Provider Organisations or MAPO. The MAPO co-purchasers were developed on the basis of historical iwi within the North Health area. MAPO would perform a number of roles as co-purchasers including contracting and monitoring of Māori health contracts with both mainstream and independent service providers (Shea, 1997b, p 3).

North Health's distinctive interpretation of government Māori health policy has been discussed in Chapter Eight. This Chapter, and the following two Chapters, shift the focus from a policy analysis to an analysis of how that policy was implemented through Māori health providers. This is described for the purposes of this research as the 'practice'. Thus practice in the following analysis is taken to mean two things; one, the way in which policy was actually implemented and its effects; and secondly, the way in which Māori health providers do what they do.

This concentration of energy by Māori as purchasers and providers in the development of Māori providers as the major strategy for North Health is shown by the emergence of 60 Māori providers in the North Health region by 1997. It is difficult to quantify the number of Māori providers prior to the 1993 legislation, partly because of a shift in emphasis that came to define those health services run by Māori for Māori within CHE environments as not Māori providers. Nationally Māori providers had increased from around 30 providers nationally in 1993, to over 200 by the end of 1996 (Ministry of Health, 1997). Prior to the 1990s reforms, there had been little interest in counting Māori health providers despite the existence of specific health-oriented services run by Māori for Māori.

The strategy of developing by Māori for Māori providers stemmed from a consensus about the poor state of Māori health and evidence of barriers to Māori utilisation of health system in both primary (Malcolm, 1996) and secondary / tertiary care (Jackson, 1999; Vaithianathan & Mutch, 2000). The tendency for Māori to present for more acute care in

hospital may be caused by a systematic failure of primary care as indicated in recent Pacific Island child health research.

Chapter Eight discussed the core case study, a purchaser called North Health that existed between 1993 and 1997. The following two chapters examine Māori health providers to understand how the strategies of the purchaser were operationalised. There were obvious sources of conflict between Purchaser and Providers, for example around the amount of resource available for provision of Māori health services. Another source of conflict between North Health and a large Māori health provider, centred around the iwi-centric strategy pursued by North Health under their MAPO strategy. However, there were obvious overlaps in approach between Purchaser and Providers irrespective of this conflict, with an emphasis on Māori ownership and control as a theme in both purchasing and health service provision. There has been little systematic evaluation of the quality of services during the time of the reforms, largely due to the focus on establishment and consolidation of these services. The 'evaluations' consisted of quarterly reports from providers to North Health, word of mouth from Māori to North Health MHDD staff, and reviews conducted by consultants that tended to concentrate on specific things such as how TAGs monies were spent. This information was augmented with statistical data of patient contacts, disease codings and similar capture in the North Health data from providers. A comprehensive evaluation of Māori health providers (including presumably the strategies adopted by North Health) never eventuated prior to the transition to a single funder in 1997.

While the common purpose of all involved in these reforms was Māori health gains, there were differences of opinion about how gains would be achieved, how much this would cost and who would best deliver this gain. These debates continue with contributions of increasing robustness presented through literature, hui, consultancy, and evaluation.

Chapters Nine and Ten consider the issues around establishment and consolidation for Māori primary care providers, and in particular the emphasis given by policy makers and Māori alike, to kawanatanga or governance. This includes feedback from respondents on

what they believe the health reforms intended and how they organised themselves to take up the opportunities presented by the reforms. The intention in these two chapters is to provide a narrative of Māori health providers' experiences, bearing in mind that these providers were the successful ones in securing contracts with the health purchaser. In particular, this chapter is concerned with Māori providers' own perspectives about their respective services, their relationships with the Purchaser and with each other. There are valuable insights about what could have been done better offered by both those working for the purchaser and for Māori health providers. The research has treated those working for the purchaser as Crown agents, while those working for Māori health providers are not Crown agents, irrespective of the fact that their funding comes from the Crown purse. Certainly, this was recognised by North Health staff and by Māori providers, although the extent to which it mattered to Māori providers differed enormously according to how well they felt North Health's Māori Health Development Division was treating them.

Chapter Ten considers the issues of consolidation and day-to-day practice of Māori providers. What are the philosophical considerations and values that underpin this work? How does this differ, if at all, to other primary care or community care providers? Does this matter?

Chapter Eleven describes and evaluates the other two North Health strategies of mainstream enhancement and Māori provider development (as defined in the early stages of the health reforms). This includes a consideration of the special characteristics of these services, their establishment and consolidation issues and relations with both North Health and other Māori providers.

Following on from this, chapter Twelve will consider the future of Māori health providers, as seen from the perspective of those providers working during 1997. This will then be extended to reflect likely scenarios for Māori providers in the near future, given the further reforms of the health sector in 2000-2001.

During the period of data collection, it was important to the Māori participants in particular, that the researcher had some familiarity with the experiences of Māori providers. They believed that only those who had demonstrated a basic level of understanding of their kaupapa and also a commitment to Māori development, could understand the nuances of their work. Because respondents were comfortable with the researcher, they sometimes revealed personal information that may not have been available to another researcher. It was especially important therefore to engage reflexively on what had been said, and to use other mentors, including supervisors to check appropriate types of information for public consideration. In all of these areas, commercially sensitive or private information was respected by the researcher.

Accessing these personal accounts was necessary to understand what happened for providers in Auckland during the reforms and to attempt to analyse what the effects of these had for Māori. The research methods emphasised the necessity for these personal relationships in gathering data, even when it created difficulties from an ethical perspective. Such ethical limitations however, are to be juxtaposed against the necessity to make sense of the significance of events attributed by the actors themselves, especially the Māori policy makers and Māori health providers during the period of the reforms.

The data collected during early phases of the research bear testimony to the value of this kind of 'inside' knowledge, for example, being able to identify the need for a developmental approach to the growth of Māori health providers in Auckland.

Rationale for Kaupapa Māori

The major strategy adopted by North Health with regard to achieving Māori Health Gains centred around the establishment of by Māori for Māori providers. This strategy resulted from a consensus about the poor status of Māori health, evidence suggesting a number of barriers to Māori use of the health system and Māori under utilisation of primary and hospital health care services (Jackson, 1999; Malcolm, 1996; Vaithianathan & Mutch, 2000). Possible barriers to accessing health services were identified as resulting from service costs, communication difficulties, distance and transportation difficulties, lack of

choice and cultural factors. The rationale for these reforms also included the experience of exclusion experienced under the existing health system and the historical suppression of Māori health perspectives. Penney reflects this commonly held Māori view, although this may not be historically accurate.¹⁵

The pre-European, Māori public health systems and healing practices had been largely dismantled through the processes of land alienation and overpowered by the control and delivery of health care by health professionals and state bureaucracies of the European government. The traditional leadership involvement in the maintenance of public and personal health then was disrupted. Tribal leaders were excluded from the decision-making forums of the State, and with the Tohunga Suppression Act of 1907 the practice by tohunga of traditional healing methods was effectively driven underground (Penney, 1996, p 22).

The health reforms of the 1990s increased the participation of Māori within the health sector as owners and workers within health services and also offered greater choice to Māori patients. Noticeably, the Purchaser used the development of Māori providers to flesh out its own purchasing strategy since little guidance was given to Māori providers in the purchasing guidelines as to what exactly a Māori service would be.

This is understandable given that no one really knew what a Māori health provider would look like under the newly reformed system of the early-1990s. A process of refinement occurred over the period 1993 to 1999, with early efforts focused on dealing with the attendant difficulties of this approach (Ashton, 1998). Establishing the business planning processes, including regular reports, followed this stage with an emphasis on developing information systems that would provide regular information back to the purchaser. This step also involved establishing human resource and financial processes within providers.

¹⁵ See earlier discussion about Tohunga Suppression Act that identifies the intention of Pomare in supporting the legislation. The concern of people such as Pomare, were to eradicate the practices of 'quacks' who incorporated elements of spiritualism and Māori theology in their treatments rather than as an attempt to eradicate traditional rongoa or practices.

Consolidation of providers was followed by a period (from 1998) concerned with demonstrating quality of care.

Reforms for Māori health providers reflected assumptions made with respect to other social services and indeed, the public sector reforms generally. Emphasis on personal choice, individual responsibility and competition dominated early thinking about the reforms (Cheyne et al., 1997; Easton, 1997a). This would be ameliorated by later experiences of providers who found that collaboration between themselves and other providers wasted fewer resources (Ashton, 1999; Ham, 1997) and allowed them to provide a wider range of services to their clients.

Earlier Experience of Māori Providers

Māori health providers are widely perceived as relatively new. Certainly, in their current form they have become a significant part of a newly evolved health market introduced by the National government in 1991. While Māori health providers were considered new, Māori involvement in Māori health occurred from the earliest period of New Zealand colonial society (Dow, 1995; Dow, 1999; Lange, 1999). This involvement took the form of representations to the colonial authorities for resources by both Māori and Pakeha, and also the provision of subsidised doctors to Māori communities. These subsidised doctors ended with the Social Security Act 1938, wherein services became available through a more integrated Pakeha / Māori system (Dow, 1998, pp 12-13). Nurses were an important resource within Māori communities and an important health education and promotion resource for many decades beyond the introduction of the Act.

Dow points out that reference to the Treaty of Waitangi was rarely mentioned in health discussions prior to 1940, with one exception in 1938 (Dow, 1995, p 14). However, the Treaty picked up momentum in health discussions from 1985 with the Board of Health's Standing Committee on Māori Health's reference to the Treaty articles as the foundation of good health in New Zealand (Durie, 1987). This was reiterated in other documents from that time including in the "pseudo Māori health policy" (Durie, 1999, p 241) titled *Whaia te ora mo te iwi*.

While the 1990s health reforms were credited with creating new opportunities for Māori to provide health services, it would be more accurate to consider Māori input into Māori health services as on a continuum on which it appears in various forms. Presentations of Māori history that rely exclusively on a few Māori heroes, such as Dr Maui Pomare, Te Rangi Hiroa (Peter Buck) and Apirana Ngata, underplay the efforts of many others in providing marae-based health improvement services (Lange, 1999, p viii).

Furthermore, health policy relating specifically to Māori also dates from colonial New Zealand society, and while some of this was self-protectionist on the part of Pakeha, some of it was also well intentioned and did lead to improvements in Māori health (Dow, 1995). The problem is that what was well intentioned has also often been dramatically ineffective in dealing with the burden of Māori illness and death, and to some extent this may be related to the unsuitability of ways of conceptualising and providing such health services. Furthermore, there has been an undermining of Māori health perspectives accompanying rapid and profound changes to New Zealand society that have impacted on Māori health and the ability of Māori to develop (Durie, 1998b; Durie, 1998c).

While Māori effort is to be celebrated in protecting our health interests and initiating beneficial changes for Māori, such as those undertaken by people of mana such as Princess Te Puea Herangi, Dr Maui Pomare and many others (Durie, 1999), an even greater number of Māori initiatives were due to the efforts of Māori and Pakeha advocates and 'ordinary' Māori working in their communities. Thus a rather a more complex picture emerges when considering the detail of any Māori health initiative. This was as true historically, as it was during the 1990s reforms where Māori health initiatives have required the support of Pakeha in positions of power (Shea, 1997a, p 2).

Case Studies of Māori Health Providers

Six Māori providers are examined in the case studies. They include four Māori primary care providers, one mainstream Māori provider and one Māori health consultant company. The researcher chose these case studies because they were representative of a

range of key characteristics of Māori health providers. Specifically, primary health providers were chosen because they were geographically dispersed across the Auckland region, they included iwi and pan-tribal providers, they provided a range of similar services, they were all established as a result of the health reforms, and they were all considered Māori health providers by stakeholders such as the purchaser / funder, MAPO, policy makers such as the Ministry of Health and other Māori health providers.

The following section presents a brief portrait of the providers studied. This research is then contrasted with national data regarding Māori health providers, to explain the characteristics of these providers and the rationale for their development.

Table 15 Case Studies of Māori Health Providers Auckland Region 1996

Wai Health	This is a pan-tribal Māori primary health provider. They are located in West Auckland and are also significant providers of other social services in this area. They employ around nine full time GPs in various clinics operating in their area, forming a network of clinics. This case study is of their parent health centre.
Te Paea Marae Health Centre	This is an iwi based Māori primary health provider. They are located in South Auckland on a marae and are part of a federation of similar providers who provide similar services in a network of tribal marae throughout this region. Their iwi also provide significant other social services. This case study is one of these providers.
Te Puna Hauora	This is a Māori primary health provider in the North Auckland region. They are located on a marae and are pan-tribal, enjoying a close working relationship with Orakei Health Centre. They have grown to encompass other social services, taking over some programmes previously run by the marae.
Orakei Health Centre	This a Māori primary health provider located in Central Auckland. They are an iwi provider located beside a marae. The iwi and marae

	run other social services located near their premises.
He Kamaka Oranga	This is a Māori service within a large Auckland Crown Health Enterprise or CHE. They are pan-tribal, but enjoy strong iwi relationships with both Ngati Whatua and Tainui, the two major iwi groupings of Auckland. They provided a policy framework for the CHE and have a change management orientation. This is a unique contract regionally and nationally. Their CHE involvement means they participate in services with a regional and sometimes, national, significance.
Awhi Health	This is a small, private, Māori-owned company located in West Auckland, but providing services to the whole of Auckland and also Northland. This company was established to provide consultancy advice to Māori health providers in the primary and secondary / tertiary sector. They have a contract for Māori provider development.

At least one key informant was interviewed from each of these providers and a number of recurring themes were identified. These themes form the basis for discussion in the sub-sections of this Chapter.

The inclusion of four Māori primary care health providers was deliberate. The majority of Māori providers were established in this area of primary healthcare. Furthermore, the choice of four allows some basis for comparison, with two iwi-based services and two pan-tribal services included in the case studies. They also span the whole of Auckland geographically, and this acts as another dimension in comparing their development and commonalities across the whole of Auckland.

Wai Health

Wai Health is a Māori primary healthcare provider established in October 1994, and represents one of the earliest North Health contracts with Māori health providers. Their experience with other social service provision and strong presence and advocacy for Māori within West Auckland, were also factors in securing a contract for Māori primary

health provision. Their service is located at Henderson and initially included two GPs, one of whom was Māori, the other having had Union Health experience. As with all other Māori providers, GPs are highly mobile which leads to changes in staff within providers. Wai Health aligned itself with a group called The Doctors located in New Lynn in 1997 and has further developed a series of strategic health relationships with the local IPA, Pacific Islands health group and CHEs.

Wai Health is the health provider arm of a Māori Urban Trust in West Auckland. This Trust represents the interests of urban Māori and delivers a range of social services in education and training, Kaumātua roopu (elders council), social work and counselling, health, community development, justice, employment and foodbanks. They aim to provide comprehensive services for Māori and have developed strong relationships with other key organisations in West Auckland including their local City Council. They have a strong relationship with a pan-tribal local marae that acts as its turangawaewae. They also maintain ongoing relationships with other iwi groups in Auckland and many other government and social service agencies.

This Trust was in a strong position to take up the opportunities of the 1993 legislation, with a team of full-time staff, lawyers, accountants, Kaumātua / kuia and community supporters. This level of infrastructure and link between community and organisation ensured a rapid uptake of a new opportunity for accessing government funds. While advocating for Māori in West Auckland, they have also embraced non-Māori and anyone who supports their kaupapa of “Kokiritia i roto i te kotahitanga” (translated as Progressively act in unity).

By the end of 1997 patient registrations had reached 9,000¹⁶ reflecting mainly, but not exclusively, Māori patients. They employed 5 General Practitioners, 7 Nurses, 2 Community Workers and a Manager.

¹⁶ John Tamihere (CEO Waipareira Trust) public statement, April 1998, at Hoani Waititi Marae to Massey University

They started with a capitated contract from North Health for approximately 4000 permanent patients. However it was preceded by a number of health initiatives run through the Blockhouse Bay Medical Centre (Tamihere, 1996, p6), and eventually through their Trust initiating a health service by purchasing a building and hiring a doctor.

We hired our first doctor and that was Dr Crengle, and she used to work at the back of the administration block. So, the community then knew that Waipareira had a 'quack in the back' of its administration block. Yeah, we grew our patients from there, and we had, overnight, two thousand registered patients through the Waipareira network. We started on our own money. We developed our own clinic. We developed our own knowledge base and then we put our hand up to say that we're a Māori provider, "Can we get some?" (Tamihere, 1996, pp 6-7).

These early initiatives were funded entirely from their own money, differentiating them, they believe, from other Māori providers who secured funding by virtue of their iwi status.

Wai Health used the accumulated cash reserves to invest around \$250,000 in health in 1992/93 so that they could also be eligible to benefit from opportunities in the health reforms (Tamihere, 1996). In contrast to other providers they believe, they established *themselves* in the new Māori health provider marketplace in 1992.

That [we] are there on the basis of our own pinga's, lock, stock and barrel ... without [a] significant handout mentality and without any political support of some significance (Tamihere, 1996, p9).

They also saw the local CHE, Waitemata Health, as an ineffective answer to Māori health, tying up valuable Māori health resources estimated at around \$1 million through their Māori health unit and treating those who are already ill. However, Tamihere does concede that they were good at their core business of secondary and tertiary services.

I believe that secondary, tertiary services they're good at and the reforms meant that you should be looking at what you're very good at in terms of our core trading activities (Tamihere, 1996, p12).

The Trust secured a contract in 1993 and began their health service in 1994. Their contract has been continuously ‘rolled over’ like all other Māori primary healthcare providers, without adjustment price for inflation. The manager explains,

This has grown each year and the funding has not increased until our third year of review (October 1997) when after lengthy negotiations the HFA refused to increase our funding although we had reported our client base increasing to approximately 9000 clients. We walked out of the negotiations threatening legal action and invited an audit team out of the HFA to check over our numbers if that was what was causing concern. At some stage the HFA had indicated that their information showed that Wai Health had 1200 clients. Sometime later the HFA did take up the offer to audit our numbers and subsequently confirmed the numbers in the vicinity of 8000. Funding was increased to increase the doctors from 2.5 to 4.5, the nurses from 4 to 7, the addition of a clinical manager and operating expenditure (Ratahi, 1997).

Wai Health employed six community health workers and provides services to a predominantly lower socio-economic group with the poorest health outcomes. This tends to be a young population. Three-quarters of their clients are community cardholders, “suggesting a large number of beneficiary, low-income people ... 85% of them are Māori, 15% of them are non-Māori” (Tamihere, 1996, p19).

Table 16 Percentage of Patients’ Ages Wai Health 1998

Under 16 years	44%
Over 16 years	56%

Source: Ratahi interview, 1998

Their contract was capitulated (in 1998) for an agreed population of 8000. The frustration expressed by this provider about the continual roll over of contract funding is shared with other primary healthcare providers such as Independent Practitioner Associations who also have disputes with the purchaser / funder over numbers of registered patients. The

lack of confidence in registration numbers stems from a history of poor information technology application within the sector, leading to duplications and being funded twice for the same thing, inadequate targeting of health service to need.

Te Puea Marae Health Clinic

Te Puea Marae Health Clinic is an iwi-based primary healthcare provider. It has a number of sites and operates an extensive network of health clinics and health promotion programmes based in various tribal marae. This Case Study is based on a marae in South Auckland close to a major arterial route. It has a close working relationship with a MAPO, and an extensive network of providers in primary healthcare, public health and even some secondary care services.

Te Puea Marae Health Clinic's Clinic is focused around personal healthcare. It has a community outreach service that undertakes health promotion type work. It is, "one of six primary health services under the [iwi] provider organisation." (North Health, 1997c).

Like other Māori healthcare providers, Te Puea Marae Health Clinic has an extended primary health service with community education, with their community health worker playing a key role in negotiating between the provider and tribal community, MAPO and purchaser.

The providers in this network have a high profile within their community in South Auckland and have an intimate relationship with their MAPO. This iwi has a well-developed infrastructure that enabled it to respond to changes and opportunities from the earliest period of the health reforms. It was able to quickly capitalise on these opportunities, employing policy analysts, managers and other staff who had been in key positions with the Purchaser during the period of implementation of the health reforms between 1991 and 1993.

The Provider has an intimate relationship with the tribal umbrella health organisation. This relationship has changed over time with the establishment of MAPO and clarification of respective purchasing / funding and service provision roles requiring

shifts with the umbrella organisation. Prior to MAPO the umbrella organisation effectively acted as the co-purchaser until the formal establishment of the MAPO. Relationships between the umbrella organisation, MAPO and Te Puea Marae Health Clinic have remained close over the period of establishment until the present. This can be explained in part because of the historical significance of this marae to this iwi, and also by the involvement of key personnel from the provider in iwi business. No figures were available to the researcher on numbers of registered patients, ethnicity or socio-economic background of patients for Te Puea Marae Health Clinic, although personal communication suggests registered patient numbers were approximately the same as other Māori primary health providers at around 2000 to 25000 patients in 1997.

Te Puna Hauora

Te Puna Hauora is a Māori primary healthcare provider located in North Auckland. The provider was established in April 1995 with a contract from North Health. They service a diverse socio-economic community with extremes in wealth and pockets of poverty. They are located on a multi-cultural marae site in offices that have been adapted for primary healthcare use. The original purpose of this space was office space for the marae.

Primary health services are provided to anyone wanting to use the service. Patients are encouraged to register, but are not pushed. 2,800 patients were registered in September 1998, although registrations increased at a rate of 80 to 100 per month as the clinic advertised its services. Ethnicity is diverse among this registered population (see Table below). The age group was mixed from very young to very old.

The clinic changed its name in 1996 to better reflect the area serviced by its Health Centre and to separate the Centre more clearly from the marae. It was awarded a prize for quality in primary health care in 1996 from North Health, as an acknowledgement of its staff's achievements in primary healthcare. In 1998, it was the first Māori primary provider to systematically plan for a quality of service accreditation or best practice model.

During the establishment phase of the Health Centre, there were ongoing difficulties in the relationship with the marae, including disputes over how the financial accountabilities and resources would flow between the marae and clinic. These were effectively resolved with the Centre's expansion that incorporated running aspects of marae operations, thereby taking over some financial responsibility for marae facilities according to their expanding service needs. Such an arrangement suited both parties.

The target was for around 4000 registered clients by the year 2000 (Marsden, 1996). During the period 1995 to 1998 their contract has changed not just with the funder, but also with the original contractor (the marae).

Te Puna Hauora was assigned a contract by Awataha marae [in] April 1997. [Its] contract [was for] 2 years until April 99. [It] has evolved into an internal I.C.O. [and is] heading for comprehensive services (Marsden, 1996).

Te Puna Hauora's patient population were predominantly community cardholders¹⁷ (around 70%). They are also ethnically diverse although most were of Māori ethnicity.

Table 17 Ethnicity of Patients Te Puna Hauora (September 1998)

Māori	74%
Pacific Islands	14%
Pakeha	10%
Other	2%

Source: Marsden, interview, 1998

Orakei Health Centre

Orakei Health Centre is a tribally based primary healthcare provider located in Central Auckland. It is placed adjacent to a traditional marae and owned by an iwi who have a leading role in Māori politics in Auckland. They service an extremely diverse socio-

¹⁷ Community cards are available as a form of government subsidy for those on low incomes to enable them to access higher subsidies for social services such as health.

economic population with extremes in wealth and poverty. Most of their patients are Māori, but like all other Māori providers, they provide a health service to anyone who registers with them. They have a close working relationship with Te Puna Hauora, which includes offering advice and support to each other. They also participate occasionally in joint training sessions. Their site is purpose built as a primary healthcare clinic.

The legal entity for the health provider is an extension of the marae Trust Board. The Health Centre Trust Board was initially appointed by the marae Trust Board. The Centres Trust Board appointed a Clinic Manager to run the service (North Health, 1997d, p8). The provider has numerous external and internal relationships including with the marae social services, other health providers and other Māori organisations (North Health, 1997d, p9). Like all the other Māori providers, they operate a Well Child Care programme necessitating preventive primary health checks with children. Staffing is comprised as follows,

Six staff are employed: 2 clerical administrators, 2 practice nurses, an independent midwife, a clinic / service manager and a doctor (North Health, 1997d, p 5).

Table 18 Percentage Ethnicity of Patients for Orakei Health Centre

Et	Māori	Pakeha	Pacific Is.	Other
96.1	80.1	8.3	5.8	2.0

Source: Peter Crampton, National Health Committee Report, Third Sector Primary Health Care, 1999, p25.

Other Case Studies

These two case studies are dealt with separately in a brief Chapter 10, as they are different from these four Case Studies and from each other since they originate from different North Health strategies and are sited in secondary and tertiary services or as a consultancy service. They will be discussed within the context of other Māori health providers and structures that arose as a result of the health reforms such as Hapai Te Hauora and Ngangaru.

Māori Health Providers: New Expertise, New Challenges

Māori providers brought many new skills into the health sector including an intimate knowledge of their local communities, wider social commitments through joint programmes with iwi and other community organisations, experience with health promotion activities, cultural expertise including appropriate use of te reo and tikanga within the health sector, and a strong commitment to making positive Māori health gains. Part of this new expertise in health also stemmed from the more systemic view of Māori with respect to health.

Tribal (iwi) authorities were in a position to bring fresh approaches to health. Sectoral divisions (for example health, education, welfare, housing) often imposed barriers to integrated development. Iwi development on the other hand retained close links between social and economic policy areas and between the various social policy sectors ... In the Māori development model, sharp distinctions between different social or economic activities were not drawn; nor were they separated from a cultural context (Durie, 1998c, p 154).

There was also rapid learning about new roles, although a high turnover in management staff amongst some providers highlighted the high demands placed on these positions during the early years between 1993 and 1996 of provider establishment. Shortages in Māori clinical and management expertise led to educational institutions attempting to increase recruitment of Māori into medical and nursing programmes through innovative new programmes such as the Health Sciences course at Auckland Medical School. Māori health providers also gave many Māori opportunities to learn new skills in these new health provider environments, including in roles such as governance, management, negotiation, liaising with other health professionals and health education such as with nutrition and anti-smoking campaigns. Such expertise would have inevitable spin-offs for other non-health services promoted by iwi Māori organisations.

Despite this experience, there were shortcomings in this expertise that needed to be addressed through long-term workforce development strategies and through strategic

alliances with other providers, thereby allowing Māori to expand the clinical and business skills available to Māori providers. Furthermore, this kind of collaboration increased the likelihood of transparent quality of care systems that protected Māori clients.

North Health needed Māori providers who would succeed in the reforms, but they also needed their priority health need areas addressed. Addressing these needs was hampered by the different stages of development of Māori providers.

Structurally we needed robust, sound business organisations with competent health professionals and that we would focus on the quality of trying to get those services established. There is a whole number of things to do and like establishing; I guess the basic business practices that you have in a small business. We looked at it [as] trying to establish a small business. Then we looked at recruitment, selection and recruitment of staff, of professional staff (Te Pania Palmer interview, 23 April 1997, p 9).

North Health's strategies for Māori health - increased Māori participation, Māori provider development, and mainstream enhancement - were based on ways of conceptualising strategies for Māori health development identified in a paper for North Health by Durie and Doherty in 1993¹⁸. These goals related to socio-economic advancement, Māori self-determination in health matters, and a more responsive health sector. Attempts were made to incorporate these goals in subsequent policies at national and regional levels throughout the reformed health sector. They reflected the beginning of an interest in socio-economic advancement advocated by Durie¹⁹ and also self-determination for Māori in the health sector²⁰.

Any evaluation of the success of these North Health strategies has tended to focus on the increase in numbers of Māori health providers rather than on evidence of qualitative improvements in health gains. The reason for this is in part the lack of adequate information captured coupled with inadequate measures to determine the success of these measures. This was not unique to Māori providers. Indeed, North Health Māori Health staff stated that Māori providers were more systematic and comprehensive in respect of health information captured and given to the funder, than other providers, including very large providers such as CHEs. Even by 1999, many hospital services did not have accurate information on the numbers of Māori staff and patients, complicated no doubt by the variation in institutional practice in recording ethnic data and the added difficulty of inconsistencies in official recording of data amongst government agencies.

The reforms were premised in part on increasing individual choice for health consumers in the use of services. A major assumption of the reforms was that Māori patients would use those providers who better met their needs by providing a more 'appropriate' service. Appropriateness would include the following factors: being visibly Māori (located on

¹⁸ M.H. Durie and G. Doherty, 1993, Policies for the Advancement of Māori Health, Northern Regional Health Authority, Auckland.

¹⁹ See Te Rerenga Hauora by Cunningham and Durie for discussion of these goals developed more fully during the 1990s in Health and Society, Davis & Dew (Eds), Oxford University Press, 1999, p235-254.

²⁰ See Durie, Māori Participation in a Reformed Health System, Health Manager Journal, September 1996.

marae or similar 'Māori' environment, Māori staff, signs in Te Reo Māori, recognition of whanau as part of the healing process, and involvement with local Māori community); being cheap (many rely on koha or small co-payment charges); and operating under kaupapa Māori (although this remains undefined, it could include things such as Māori ownership of the provider, more consensus decision-making, involvement of kuia / Kaumātua in the service and in governance, expectation of community involvement in governance), amongst others. Many themes would emerge through this research identifying elements in common with all Māori providers, particularly those providing primary health care. These themes include a commitment to tino rangatiratanga for Māori, adaptiveness, innovation, quality of service, workforce development, kaupapa Māori service, collaborative efforts and relationships with other providers. Māori providers tended to organise around a primary care team strategy, rather than relying on a single practitioner approach common to most General Practice services.

North Health's Main Strategy: Independent Māori Providers (By Māori for Māori Providers)

The major strategy pursued by North Health was the development of independent (by Māori for Māori) Māori health providers. These were established because of an assumption that existing healthcare providers were not taking sufficient cognisance of Māori health needs and prioritising these, despite the overwhelming evidence concerning the disproportionate burden of Māori illness and premature death. Māori and low income New Zealanders utilise primary health services less frequently than other New Zealanders (Malcolm, 1996). There were also assumptions made by funders that access to primary care for Māori patients was blocked because of financial and cultural factors. Māori are over represented amongst low income New Zealanders and this may limit their use of primary health services because of the cost of using these services. This cost includes not just the consultation co-payment charged by the GP, but also the prescription costs for those not covered by the community services card subsidy and possible transportation difficulties to attend clinics.

The Growth Of Māori Health Providers

By 1998 North Health had 32 Māori providers within its region, out of a total of just over 200 nationally. This compared with around 30 Māori providers nationally in 1993 (Ministry of Health, 1997). Most of these had been established between 1993 and 1995. Despite frustrations with the contracting process while North Health's overall strategy was being worked out, many of the frustrations reported by Māori providers reflected concerns in common with other mainstream providers who were dealing with other service teams in North Health. These frustrations included a lack of clarity around the nature of the contract early in the negotiations process (that is that both sides were learning by doing), the length of time it took to get responses to queries from North Health, and whether or not you were in the favoured group and therefore eligible for contracts. Those favoured were identified as a priority group in North Health's Grand Vision and included criteria of previous track record in social service delivery and credibility within their specific communities.

Rangatiratanga Māori Control And Ownership

An important impetus to the emphasis on rangatiratanga in health (and other areas) for Māori was the recognition that,

Māori have a right to good health and to quality of life not because of government charity but because Māori rights to shape and influence the policies and politics of New Zealand were never extinguished under the Treaty of Waitangi (Lawson-Te Aho et al., 1999, p 78).

Thus Māori rights to good health are guaranteed under the Treaty and furthermore, Māori perceive that rangatiratanga was an essential ingredient for judging the success of health initiatives. This latter is because rangatiratanga is an essential ingredient of Māori development, which is so integral to Māori health and well-being (Durie, 1998c). Māori ownership and control of health initiatives was viewed by all Māori interviewed for this research, as an important sign of goodwill and success for the health reforms. This applied particularly during the early phases of the 1990s health reforms when Māori goodwill was required to secure buy-in to the health reforms by establishing Māori health providers.

A core expression of rangatiratanga for Māori health was in the degree of Māori ownership and control over health services, and further, in the degree of Māori participation in purchasing, planning, delivering and monitoring of such services. Cunningham and Durie (1999) describe this as, “underlying issues of objectives, context, control, management, and access” (Durie, 1999, p 247). Certainly one of the objectives of the health reforms was greater Māori participation in the health sector.

There were a number of objectives I think on the reforms. For Māori it was to create an environment where they could participate far more extensively than what they had traditionally done, through the Area Health Boards (Maniapoto, 1996, p 2).

While support for Māori ownership and control remains constant over time, there are questions emerging about the evidence for judging the success of these health providers (Lawson-Te Aho et al., 1999).

A more objective assessment is required when considering health outcomes, such as life expectancy and smoking rates, that nearly a decade of health reforms have had on Māori health. What is required therefore is evidence of improved health outcomes despite the inherent limitations currently within the health sector for being able to identify these. Critically, this also involves a rigorous appraisal of existing and past health strategies and how they have had an impact on Māori health.

Any Māori health development strategy should be open to critique if it is to achieve the best outcomes for Māori health ... funding management impacts directly on service provision and therefore, on Māori health. There are significantly greater issues than the politics of Māori health strategy design. These are big picture issues about the relative position of Māori in New Zealand society and the causes of Māori illness and deprivation. These issue[s] will always impact on any strategy that the HFA (Health Funding Authority,) designs (Lawson-Te Aho et al., 1999, p 81).

Such an analysis includes a thorough understanding of the context within which this development strategy and critique occurs, along with a consideration of the evidence of the outcomes of such strategies. The link between rangatiratanga and governance will be examined more fully later in the Chapter.

Hauora

The philosophical orientation towards wellness amongst Māori health providers is a common theme emerging from the literature and this research. Each of the Māori providers interviewed had an expressed commitment to Hauora Māori. It was sometimes difficult however, to identify what this specifically meant because it seemed to encompass doing whatever was needed by the client to address their health needs. Specifically, hauora seemed to emphasise relationships between health professionals, allied professionals, and patients and their whanau.

This orientation toward hauora can be seen in the way in which Māori services are configured, the emphasis on assisting those in most need, irrespective of ability to pay and the strong community development and health promotion orientation of Māori providers. While budget-holding or capitated funding allowed Māori providers greater flexibility in responding to low socio-economic patients, they also had a philosophical orientation that promoted intervention with these patients and viewed them as their target group.

The difficulty for health services was in untangling those aspects that could properly be under their control and those aspects that are influenced by socio-economic determinants for health. There is a possibility of providing a wide range of social services to Māori patients via the health service (for example transportation, advice on income support from government, ACC entitlements) that are tangential to health services but important for well-being. This poses potential difficulties for funders of such services. In the 1990s reforms the purchaser / funders approach was to treat these social elements of the service as an essential component of a Māori service because it *enabled access* to occur for Māori patients. There was also wide acceptance of hauora as being a more

encompassing definition of health, similar to the concept incorporated in the Ottawa Charter. This broader definition facilitated more generalized responses in health services for Māori patients.

Commitment to Māori Development

Māori health providers viewed health services as an integral part of Māori development, and visa versa, development was considered an essential part of health. This was for two reasons, firstly, because Māori need to be healthy to participate in their culture and society, and secondly, because health services are an expression of Māori self-determination. Thus Māori providers needed to prove their ability to provide complex services to their own population in areas of high health need in order to gain credibility for further services.

Māori community health workers had a key role in promoting healthy lifestyles, liaising with other agencies around Māori clients and explaining medication regimes to ensure compliance. They became the arms and legs of the Māori health provider, with an ongoing presence inside their communities. They also raised the profile of the provider by attending hui at the marae, at iwi events, and at community events. The practice of community workers is examined in more depth later.

Involvement with Marae

Involvement with marae was another distinguishing feature of Māori health providers that emerged from the research. However, this relationship was not without major problems for health providers. Māori politics centre on their marae and these therefore become the site of many political debates and struggles. The establishment of Māori health providers required Marae Trust Boards to behave differently, sometimes recognising that they lacked the specialist knowledge necessary to run a health service and would need to bring this expertise 'on board'.

Substantial differences were also apparent between the two iwi providers and between the two pan-tribal Māori providers in the research. One iwi provider had a number of services throughout the area creating a network of linked marae clinics. The other

essentially had one main clinic that operated on their central marae. This became the locus of primary health for their Auckland population, although their iwi had expanded to their boundary with a public health provider. Similarly, one pan-tribal provider had developed an extensive network of clinics throughout their community through various alliances with other health professionals and with non-Māori agencies, while the other was centralised on one site with a network of relationships out from that site. All enjoyed an essential relationship with at least one marae, or a network of marae within their area. Personnel were often in common to both marae Trust Boards and Health Trust Boards during the early phases of establishment for providers, but this membership would gradually change during the consolidation of the Health Centre. Notably, more experienced managers, clinicians and health sector people would come on to these Boards lending greater credibility to the activities of the provider.

Barriers to Access

Two underlying assumptions that drove the development of health strategies in North Health which promoted by Māori for Māori providers were the perception that Māori under-utilised GP services and that financial and cultural barriers prevented access by Māori to GP services. These assumptions made about low utilisation provided the strongest rationale for the creation of by Māori for Māori health providers. Barriers to access were identified as arising from service costs, communication difficulties, distance and transportation difficulties, lack of choice and cultural factors (Cunningham & Taite, 1997; Durie, 1995).

North Health also had evidence of an unequal geographical distribution of GPs within Auckland. Such an unequal spread of doctors was seen as contributing to possible inaccessibility to primary care with high need populations. Furthermore, there appeared to be no relationship between health need and this distribution of doctors. Those areas with high health need had fewer doctors, while those with low health need had more doctors.

Table 19 General Practitioners By Population Per Auckland District

District	GP FTE	Population	GPs/100,000	Pop/ GP
Auckland Central	399	377,900	106	950
North Shore & Rodney	212	258,000	82.5	1,215
South Auckland & Otahuhu	285	382,000	75	1,340
Waitakere	105	173,349	61	1,651

Source: Medical Council, The New Zealand Medical Workforce 1998, Medical Council May 1999.

Māori live disproportionately in South and West Auckland and these are the areas that are most poorly serviced by GPs with an average of 75 GPs per 100,000 in South Auckland and Otahuhu and 61 GPs per 100,000 in Waitakere City. Māori are over-represented in lower-socio economic groups based on NZDep (a model of socio-economic deprivation for New Zealand used to identify areas of high need according to key indicators such as income, employment, access to a car and other similar factors). Areas with this population profile therefore have higher health needs. While Māori nationally visit GPs more frequently than non-Māori, they have higher health needs and when GP utilisation is adjusted for this health need, then they can be considered to under-utilise GP services (Scott, Ministry of Health, personal communication, November 1999).

In addition, the experience of exclusion for Māori under the previous health system and the historical suppression of Māori health perspectives added weight to the creation of by Māori for Māori health providers. Such patterns of alienation of Māori as an indigenous population originate in colonial experiences shared in common with other peoples (Kunitz, 1994; World Health Organization, 2000).

Penney's earlier comments about the Tohunga Suppression Act reflect a common belief among Māori, namely that this Act was an expression of European imperialism and a direct attempt to suppress Māori practices and knowledge. This view is historically misleading because it ignores the promotion of the Act by Māori MPs and health advocates at the time who were keen to eliminate unhygienic practices in Māori villages, promote sanitary conditions and rid Māori communities of charlatans such as those self-identified Tohunga who practiced a form of new spiritualism mixed with traditional

Māori medicine (Belgrave, 1985). The effect of the Act however was to suppress Māori practices and knowledge and therefore it did have an assimilationist effect on Māori society. Noticeably, the Act was not repealed until 1962 (Dow, 1995, p 235).

The 1990s health reforms increased the participation of Māori within the health sector as owners of services, as workers within health services, and also offered greater choice to Māori patients, all of which were consistent with the principle of rangatiratanga. This greater choice offered to individual Māori patients may have given them greater access to affordable primary health care but it also gave the purchaser more leverage in contract negotiations because the purchaser was now able to compare the performance of Māori providers with non-Māori providers. The presence of Māori providers allowed North Health to threaten to remove services from one provider to another. Sharon Shea illustrates this point when theoretically considering how her thinking might be swayed as a Māori health consumer.

From an economic perspective, we can say that we are not getting value for money here. Let's put our money elsewhere. Nothing that they have done over the last year has improved my health status, so where should I put my money? (Shea, 1997a, p 4).

Such increased choice is a key ingredient of the contestable market envisaged in the early 1990s health reforms and is therefore consistent with the ideas of neo-liberal government policy.

The threat to terminate contracts did not occur however for either mainstream or Māori providers. Instead a more incremental approach was adopted wherein resources were reallocated at the margins of health expenditure or reallocated within portfolio areas. The reasons for this more incremental approach are many and varied. They include the political leverage exercised by large mainstream providers such as CHE with the public, and therefore with politicians; the inability of Māori providers to provide some of the services either because of technical, medical or equipment constraints; or because of geographical constraints. All of these factors identified for non-termination of contracts carried high risks that were politically unacceptable and were therefore not implemented.

The strategy adopted by Māori health providers to increase revenues was an increase in contract price funded through an extension in the range of services offered. These services were in addition to their core general practice services. Thus the addition of gynecological and antenatal clinics, pediatric clinics, diabetes clinics, health promotion programmes such as keep fit classes and other services, are a reflection of this strategy. These extended the original roles of health workers, although they were clearly aligned, and included an increased range and specialisation in medical care.

From around 1997 there was an increased emphasis on collaboration between Māori health providers, but also notably between non-Māori health providers and Māori health providers, in the formation of strategic alliances. This period followed the early health reforms when Māori providers had gained a considerable degree of experience and confidence, and when competition was being downplayed within the health sector following the Coalition government of National and New Zealand First. Thus Māori providers formed clinics with CHEs, local GP networks through IPAs and with other local health services and services such as Plunket. These relationships will be examined in greater depth in Chapter Eleven.

Evidence of under-utilisation of primary care by Māori is also seen in access to hospital services in Auckland. A study done at South Auckland Health by Jackson (1999) and another carried out for Waitemata Health by Vaithianathan and Mutch (2000) (Jackson, 1999; Vaithianathan & Mutch, 2000) found that despite higher Māori morbidity, discharge rates and resource use in South Auckland and West Auckland appear lower than non-Māori. This could be due to undercounting and misallocation in the hospital data, or it could be due to genuine access problem of Māori not seeking or not being referred to the help they need.

Contracting

Contracts became the major mechanism for specifying work between purchasers and providers. This orientation towards legalistic and contractual mechanisms is a direct

reflection of the health reforms (Ashton, 1998), and wider public policy reforms consistent with neo-liberal policy. Early contracts reflected the inexperience of the purchaser in that they were extremely mechanistic. Later contracts would be more relational and process-oriented reflecting learning by the purchaser during the years between 1993 and 1997. However, contracts were by their nature broad and while clauses about performance expectations of both parties were present, they were rarely, if ever enacted.

A Hauora Māori schedule attached to all contracts in North Health was amended to incorporate more directives in respect of Māori health after a period of trial, but the failure to evaluate providers regularly or carry out the threats made some of these mechanisms for accountability to Māori health gain somewhat hollow because of inadequate enforcement and evaluation regimes.

North Health invested considerably in an approach that needed to demonstrate success. MHDD therefore adopted a more mentoring approach with Māori providers to address 'issues' identified in their quarterly reports or by word of mouth amongst Māori providers. This included the use of consultants and joint training through North Health or MAPO or through other providers. No Māori health provider contracts were withdrawn however between 1993 and 1997 because such a withdrawal would be clearly viewed as a failure and might have jeopardised the Māori provider development strategy. North Health chose their 'winners' in Māori health provision, and then supported them (within certain constraints) to deliver their contracts. This gave them the 'runs on the board' needed within the purchaser (Cooper, 1997; Shea, 1997b).

Ironically such an approach was intended to minimise the worst excesses of the new contestable health environment where competition and mistrust were commonplace among providers. Rather, North Health's approach was more consistent with a community development approach with Māori communities identified and funded to work within their areas. Such an approach was a pragmatic approach needed to make their strategies work.

Each of these phases of development of Māori providers contained different pressures. For many providers the emphasis during the contracting stage was in proving their credibility to the RHA. This required a consideration of their track record in social services provision and their credibility among the Māori community within their region. The next stage of establishment was concerned with establishing basic systems, employing staff, and practical matters such as locating their service (usually at a marae), establishing boards, networking with marae committees, iwi authorities or corporate bodies of their governing Māori organisation. Reports to the RHA reflected a preoccupation with complying with contractual responsibilities. Most providers complained of short contract timeframes with annual contracts that required extensive re-negotiation every year. This was extended to bi-annual and three yearly contracts by the late 1990s.

Transitional Assistance Grants

Funding for development and capital investment was made available to Māori providers through two main sources of additional Vote Health spending - TAGs (Transitional Assistance Grants) and Māori Provider Development Service Funds (MPDS). TAGs became available in 1995, while MPDS became available from 1997. TAGs were grants for training and development with most monies granted for the purchase of properties, equipment. North Health invested heavily through TAGs funding in establishing new Māori providers. It shared this investment jointly with the Ministry of Health and both organisations were involved in deciding who would receive such funds. MHDD explicitly supported 'their' providers (that is those that held an MHDD contract) because otherwise the financial barriers to entry of the health market would have been too great for these new Māori providers and thus would have prevented them from competing with other providers for contracts. These funds were significant and may well have appeared as a 'lolly scramble' for the brief period in which they were available.

Some providers benefited considerably more than others, and only those with contracts were eligible for consideration. These funds were a grant and providers became

accountable for ensuring they were spent according to proposals. It would be 1997 before these grants were evaluated to ensure compliance with original proposals (that is that the properties, equipment and training proposed had taken place). Few discrepancies were found during the evaluations of these providers between what was applied for and purchased with the monies. There were some recommendations for improvement of systems or security in these reports prepared by an independent consultant (Muir, 1997a; Muir, 1997b).

Despite these financial advantages, Māori providers had difficulty securing and operationalising contracts. Much of this early difficulty (1993-95) was attributed to the embryonic nature of the organisations (RHAs and providers) and the need to work out their strategies and policies. Being amongst the first of the new Māori providers was important as one provider explained.

First cabs off the rank, very important, and so, in the re-marshalling of the health reforms, the old boys network stole a significant march (Tamihere, 1996, p 4).

MHDD admitted that it picked “winners and losers”, and that those Māori providers who secured contracts in the early days (1994-1995) would benefit from having gone through the learning curve of being a Māori health provider. MHDD chose providers for a number of reasons including a political resonance with their grand vision of tino rangatiratanga and mana whenua. Such moves were widely interpreted by those on the outer of these machinations as the ‘old boys network’. Other factors for selection included the track record and infrastructure capability of potential providers, their network and likely population profile and whether another provider had been identified within that geographical area.

Māori Provider Development Services Funding

The Māori Provider Development Scheme was a key government strategy announced in the 1997 budget and reiterated in a letter from the Minister of Health, Hon. Bill English to the RHAs on 13 October 1997 (English & Delamere, 1997), which stated that,

The Māori Provider Development Scheme is designed to accelerate the development of the Māori health and disability workforce, as well as Māori providers. This dual focus will enable Māori providers to more effectively deliver quality health services to Māori, so improving the health and well being of Māori ... The Māori Provider Development Scheme was first announced in this year's Budget. Funding for the scheme is \$6.7 m (excluding GST) in the 1997-98 financial year ... Funding has been committed for the two following years (English & Delamere, 1997).

Priorities for funding were identified as these items.

- ◇ Māori health scholarships,
- ◇ Provider assistance,
- ◇ Workforce and service development pilots; and,
- ◇ Best practice and procedure models.

The tendering process was contracted to Ernst Young on behalf of the RHAs and MOH, and subsequent contracts would be monitored by MOH. Some grants were considerable for example an IT project for \$25 million funded by Central Health.

Capacity of Māori Health Providers

With a few notable exceptions, Māori were inexperienced in health service provision by the start of the health reforms. Where existing health initiatives did exist such as with Tainui in Huntly, they were relatively isolated and existed in the absence of a comprehensive framework of policy or resources to support them.

Concern was expressed about the ability of Māori providers to be good employers, and staff turnover for many Māori providers (both clinical and administrative) remained high. The last phase during the late 1990s witnessed an expansion in many services, and an emerging interest in quality considerations beyond simplistic consumer satisfaction surveys. Such surveys provided the only qualitative assessment of Māori services. Piecemeal attempts were made by the RHAs to address concern about Māori provider

service quality, by employing consultants, offering advice and support directly by Māori staff of RHAs to Māori providers, or providing access to training.

Māori Provider Size

The size of Māori health providers in this research extends from small with contracts of around \$50,000, to large with a contract, for example, of around \$1 million over three years. The average budget however is in the hundreds of thousands, with increases in contract prices related to an expansion in the range of services offered by Māori providers rather than by increases in the contract price per se.

Since contracts were paid to Māori primary health providers on the basis of registered population size the enrolment and 'registration' of patients, as well as their health need status, became important to providers. The average size of the providers became larger than most other primary health providers within a few years of their establishment. One Māori Provider claimed to have as many as 9,000 registered patients by the end of 1997 (Ratahi, 1997) with five full time doctors. Another claimed to have 2,500 registered patients by 1998 with numbers increasing by around 40 per month following an active recruitment campaign by the provider (Marsden, 1998b).

These recruitment campaigns took one major form, namely the use of their networks to encourage patients to use their service. The low cost of doctor consultations, the wide range of services, provision of support services such as transportation, community outreach and health education, along with cultural appropriateness were promoted as attractions to potential patients within these networks. These networks included iwi hui at various marae, word-of-mouth, local community newspapers and alliances with local GPs and Union Health Centres.

The average size of Auckland GP practices (per GP) was around 1200-1500 patients, which compared favourably with the rest of country which had average practices of fewer patients (Stone, President GP Association, personal communication November 1997). Thus Māori providers had larger practices per GP on average than other GP practices

within a short period of establishment. Such figures are open to question however, since there is no guarantee that duplications of patient numbers across practices does not occur. Patient contact is difficult to measure despite payment of GMS to GPs because of the ineffectiveness of information technology in the New Zealand health sector. In short, Māori can not be absolutely confident about the figures, but the trends point to slightly larger practice numbers in Auckland because of population size and faster and larger growth of patient sizes among Māori providers because of their active marketing and other attractive benefits.

The use of Community Service Cards by patients was used by researchers, North Health and Māori providers as a de facto proxy measure for health need based on socio-economic deprivation. Ethnicity is also used as a proxy for socio-economic need, which in turn is used as a proxy for high health need. All Māori health providers reported around 80% of their patients as of Māori ethnicity. For example, a Māori provider, Orakei Health Clinic, reported ethnicity of 80.1% of Māori ethnic descent amongst their registered patients, 5.8% Pacific Island, 13% Pakeha and 2.0% other (Crampton, 1999, Table 4., p 25).

The ethnic and socio-economic patterns of these patients have obvious implications for the managing of such complex health needs. This includes a greater emphasis on early, proactive and preventive medical and general healthcare.

Māori Providers' Perceptions of the Health Reforms Opportunities

Māori providers expressed considerable support for the health reforms because they were viewed as promoting Māori health and opportunities for Māori to provide services directly for their own people, and because Māori were viewed by both purchaser and providers, as playing an active role in policy formulation on Māori health. Their reasons also included the possibility of iwi development.

It's [the health reforms] a positive opportunity for iwi development in terms of providing services that are integrated and within the many ongoing iwi (Hiini, 1996, p 1).

While another provider expressed the opinion that this focus on iwi enhanced iwi development at the expense of wider Māori development, there was widespread support amongst Māori providers for the positive contribution that this type of iwi development could make to Māori. However, problems were also perceived with the contracts. The head of one provider commented that problems became more apparent as time wore on:

I think ideologically it was tremendous. So, from an ideological and conceptual framework it provided huge opportunity in terms of a philosophical capacity. Yeah, now that we're a bit down the track there, the reality [has come home and] the shine's gone right off it (Tamihere, 1996, p 2).

He identified other implications for iwi and pan-tribal Māori providers from these health contracts.

Firstly, you've got to understand what the expectation was. Yeah, and the expectation was that there would be a range of opportunities for Māori participation for the first time in the health industry, other than being a patient of it...There was the opportunity, we thought, of actually getting into provision of health care. Now, what you've got to understand from the economic model is that what you see in industry is only arguably 30 to 35% of it. What I mean by that [is that] health is an industry on its own. ... There's huge service related industries that are connected into it, everything from baseline cleaning, security, all the way through to the provision of supplies.... So, it afforded us for the very first time, a window of opportunity that we'd previously been precluded from (Tamihere, 1996, p 3).

Four of the six Māori providers complained about inadequate resources to do the job, recognising that Māori were a high need population and that providers were entering a new market.

In terms of realistic resources for Māori people, I think that there [are] some basic problems and difficulties, and they are mainly to do with workers and resources, financial resources and infrastructure (Hiini, 1996, p 1).

There were also other frustrations.

I'll tell you it was a five year old getting loose in a lolly shop in terms of expectation and capacity. There's also an expectation that if we put our hands up to provide services, that there would be the developmental and capital funds up front to ensure a robust and worthwhile system so we could conduct ourselves on some merit [with] people (Tamihere, 1996, p 3).

As noted above, the need for developmental and capital funds was addressed by the government through two funds provided centrally through the Ministry of Health. These were Transitional Assistance Grants (TAG) and Māori Provider Development Funds (MPDF later MPDS). TAGs funding was available earlier in the reforms process during 1996 to assist Māori health providers to establish their services through capital purchasing of buildings, cars, computer equipment and other similar equipment. MPDF monies became available from 1997 to assist with more developmental needs including business plans for expansion of services, quality assurance evaluation and information technology projects. North Health was very successful in securing funds from these central funds paid through the Ministry of Health for Māori providers, with higher 'hit rates' than other RHAs for successful funding of their applications.

Major Themes Emerging From The Māori Health Provider Literature

Recently, there has been a growing interest in Māori health providers. This interest has been due in part to the perceived success of Māori health providers in delivering effective, quality health services to high need populations. A growing body of literature has resulted which has identified themes that have also emerged in research for this dissertation. The literature reflects a more considered view of the historical experience of Māori in the health sector through the work of Lange (1999) and Dow (1995 and 1999). In addition, Cunningham and Durie (1999) have written *Te Rerenga Hauora* in *Health and Society in Aotearoa New Zealand*, which supplements work done earlier by Durie in his second edition of *Whaiora* and Cunningham and Kiro (2000) have a Chapter on Māori health policy appearing shortly. In addition to this literature, there are a number of ad hoc articles including Ruakere's comparison between an iwi general practice and

mainstream general practice(Ruakere, 1998). Enigma’s Healthcare Review Online has published a number of articles by Māori related to Māori health services and policy. These cover topics such as Te Raukura Hauora O Tainui, Wai Health and Māori Integrated Care Organisations.

A National Health Committee commissioned report on Māori Health Providers by Dr Sue Crengle in 1999, identified many themes in common with this research. Some of these themes will be discussed in Chapter 10 because they are about defining characteristics of Māori providers. A number of these themes have already been discussed in this chapter. They include the importance of rangatiratanga ownership and control including tino rangatiratanga, which has been expressed more as iwi or whakapapa based ownership and control among Māori providers because of purchaser support. There is also a questioning of barriers to access for Māori patients, particularly to primary health care (Crengle, 1999; Ruakere, 1998).

Crengle identified a number of key issues for Māori providers. These are shown in the following Table.

Table 20 Key Issues For Māori Health Providers

Funding Authority issues including contract specifications that are inconsistent with Māori models and approaches to service delivery, inappropriate monitoring frameworks, changes in the nature of relationships between funders and providers, absence of preferred provider status, absence of national standardisation of contracts

Special needs of Māori which makes the services more costly to achieve the same health gain

Funding levels that may be inadequate to address the high health need of Māori

Enrolment and registration problems including; two year limit for active patient status; highly mobile patients and the potential for claiming twice for the same patients or events between providers; informing the community

Information requirements including; lack of feedback from the HFA, the need for rigorous information on socio-demographic information, health status, and provider management

Workforce development issues including the high demand for certain workers and the increasing knowledge and skill base required of workers

Information technology: capability of software and the need to support IT capacity within providers

Source: S. Crengle, Māori Primary Care Services, A Paper Prepared for the National Health Committee, August 1999, pp 2-3.

The issues identified in Crengle's report overlap considerably with the views expressed by Māori providers in the research for this research. However, there tended to be less of a focus on the appropriateness of contracts according to Māori models during the early and mid-phases of the research as suggested by Crengle, and more of an emphasis on securing developmental funds, establishing contracts and extending prices and services. The interest in Māori models arose in part, out of a consideration of quality of service models appropriate for Māori care that occurred later in the health reforms.

Monitoring of providers was implemented much later for Māori primary providers and has tended to take the form of a more mechanistic evaluation approach, such as the review of the use of TAGs monies by Muir and Associates in 1997²¹.

Almost no critical evaluative work was done on Māori providers until 1999 when Te Aho Associates reviewed Hapai Te Hauora. Even then, reservations around this evaluation meant that the report is not publicly available. Hapai, however, have given this researcher permission to quote extracts of the report.

²¹ Jeff Muir and Associates reviewed all providers in 1997 that had received TAGs funding to determine if they had complied with the conditions of their grant.

Understandably, the focus around Māori providers was around describing and understanding what they were doing within an environment of rapid and continual change. Nor is this experience unique. Other evaluations of mainstream providers done sporadically by the purchaser / funder have rarely seen the light of public scrutiny. Many of the reports' findings are disputed by providers, or purchasers, or by both. It does raise questions however about the robust nature of the monitoring of contracts that occurred during the health reforms and what we learned from our mistakes and successes during this time.

What Distinguishes A Māori Provider?

There were two crucial assumptions with respect to purchasing Māori health services associated with the health reforms: firstly, that existing health services had not met the needs of Māori adequately in primary health and secondary and tertiary environments; secondly, that there was a difference between Māori providing these same health services and non-Māori providing these services because of cultural subtleties that Māori providers were able to act on. This intangible 'Māori' quality has been extremely difficult to clarify. However, when asked, most providers identified some common things as evidence of cultural appropriateness. These things are listed in the following Table.

Table 21 Aspects Of Cultural Appropriateness Identified By Māori Health Providers

Staff are Māori
Staff understand Māori culture and respond to cultural cues such as te reo, respect for Kaumātua / kuia, manaakitanga
Services provide support such as transportation, referral to specialist services, accompanying Māori patients to such services where needed, home visits by Community Health workers, liaison with Kura Kaupapa, Kohanga Reo and marae
A hauora orientation that focuses on prevention including proactive health promotion campaigns such as immunisation, diabetes clinics, exercise and nutrition
Networks into their community, participation in areas of Māori development within their communities including involvement with iwi and key Māori organizations

Crengle (1999) identifies a number of key features of Māori primary care providers, many of which appear to overlap with those identified above. These are summarised in the Table overleaf.

Table 22 Key Features Of Māori Primary Care Providers

Services are by Māori for Māori	Governed and operated by Māori organisations or groups
Philosophical approaches frame the services	<p>Operate according to kaupapa Māori</p> <p>Māori cultural values, beliefs and practices (tikanga Māori) are used in the development and delivery of services</p> <p>Mechanisms exist to ensure accountability with their community</p> <p>Māori staff wherever possible</p> <p>Services are high quality, affordable, accessible and acceptable to clients</p>
Demography	<p>Positive Māori development</p> <p>Māori health and well-being</p> <p>Predominately but not exclusively Māori clients</p> <p>Higher numbers of young and fewer elderly people registered</p> <p>High proportion of low socio-economic clients</p> <p>Client health status reflects the evidence about high health need of Māori</p> <p>Traditionally Māori have received less primary care and are over-represented in secondary care services</p> <p>Clients face many of the barriers to care that are described in the international literature</p>
Description of Māori primary care providers	<p>Variable size, small to large</p> <p>Some providers have a preferred provider status with</p>

	<p>funderson, others do not</p> <p>Size of client base varies from several hundred to ten thousand</p>
Location	<p>Within a variety of Māori organisations including iwi, hapū, urban Māori groups and independent groups</p> <p>Geographical location varied from urban to rural</p>
Services / programmes provided	<p>Community health programmes covering health promotion, health education and screening</p> <p>Intervention / clinical services such as general practice, midwifery, counselling, dental etc.</p> <p>Mental health services</p> <p>Traditional healing services</p>
Methods of delivery of services	<p>Training and workforce development</p> <p>Within kaupapa and tikanga Māori</p> <p>On site at health centre</p> <p>Wide variety of community locations</p> <p>Mobile and suitcase clinics</p> <p>Have informal and formal relationships with other providers who offer services they are not able to provide</p> <p>Referrals made to employment, training and other social service organisations to ensure clients needs are met</p> <p>General practices may or may not be part of the Māori primary care service programmes – those not providing primary care services may have good relationships with local general practitioners</p>
Māori integrated care organisations	<p>May be part of pilot for MICOs or similar arrangement, or may be orienting provider to integrated care</p>
Staffing	<p>Wide range of staff</p> <p>Community health workers / kaiawhina essential</p> <p>Workforce development critical</p>

Source: Crengle, Māori Primary Care Services, A Paper for the National Health Committee, August 1999, pp 1-2.

Since most Māori provider contracts were in primary health care, the most appropriate comparison is between general practice and Māori primary health providers. However, it is important to also distinguish between primary health and general practice. Dr Julia Carr explained a possible difference between providers in terms of the underlying model they adopted. Carr said primary health care was about the Alma Ata declaration which promotes active involvement of communities in planning and delivering their health services compared with General Practices which are largely run and owned by individual medical practitioners as a business (interview, 11 August 1998). In New Zealand an example of the primary health care model is the Union Health Clinics where there are elected Boards with consumers also represented. Similarly many Māori providers have elected Boards that reflect the community serviced by this provider by inclusion as Board members or Trustees. They also share much in common with their orientation toward a more community development and integrated service delivery approach: that is, that there is a willingness to address matters of income support, subsidization of co-payments, health promoting activities and screening demonstrated by these providers.

So what characteristics do Māori health providers have? Again there are similarities between certain kinds of providers such as Māori, Union Health and community owned services with their focus on building relationships with a wide range of patients, to the active involvement of their community in organisational, clinical and educational services and a staff orientation towards self-knowledge of patients. There is an assumption, for example, that patients can heal themselves, rather than an emphasis on 'dis-ease' which is seen as so prevalent in general practice (Carr, interview, 11 August 1998, Wellington). There were also other similarities.

There is a focus on relationships with clients and taking into account community expectations. There is an expectation that [patients] can heal themselves. This compares to primary care and individual GPs that are a business. [Union Health Centres and Māori Providers] communities are actively involved in planning, for example having consumers on their Boards. An example of this is Ngati Porou Hauora, which has an elected Board (Carr, 1998).

Keefe-Ormsby also identifies similar qualities of Māori health providers with those of other Māori social services. These include all of the following characteristics; i) kaupapa, ii) collaboration with key players and advocates, iii) appropriate location (e.g. near major transport routes for easy access and near other services likely to be used by these clients), iv) timeliness (available when needed), v) communication, vi) flexibility in policies and style of management, vii) a positive outlook, viii) and a love which reflects a passion and commitment to the people they are working for (Keefe-Ormsby, interview, 11 August 1998, and also “Mauri Tu Tomoana Resource Centre” pamphlet by Te Roopu Rangahau Hauora a Eru Pomare, Wellington, July 1998).

Thus Māori providers have more in common with third sector primary care providers than with other mainstream providers. This can be seen from the analysis of political theories, their legal structure, and governance and their targeting of high needs populations (Crampton, 1999).

Community Development and Community Outreach

The community outreach is a unique feature of Māori healthcare providers. This role has been performed slightly differently amongst various Māori providers, often reflecting the stage of their development or their particular philosophy as an iwi or Māori organisation. Most of the responsibility for this community outreach has fallen to community health workers and Chief Executives of Māori providers.

Community health workers were used to recruit patients during the establishment phase, the objective being to get patients from their whanau and hapū and local community on the register. This was required to justify provider budgets in negotiation with the RHA but also to begin servicing Māori patients. Some providers never used community health workers for this role, relying instead on all workers within their organisation to recruit patients for the register.

Accountability

Another major feature differentiating Māori providers from other primary health providers is in their form of governance and the way in which they are made accountable

to their communities. This additional accountability has been described by key informants as occurring in different ways, for example by being members of their local communities and therefore being identifiable in shopping centres, at hui and in similar community or iwi fora.

Māori clients sometimes approached health workers to discuss their health problems or other difficulties they are experiencing with health services in any forum, both formal and informal. Thus the boundaries between private and professional often overlapped and consumers saw workers as being available to them at all times.

Another accountability mechanism is through the formal mechanisms of their respective communities, such as through marae activities, marae committees, which are an expression of their iwitanga - that is that those mechanisms that reinforce cultural identity are also sources of accountability for health service performance. These mechanisms for accountability are far over and above those of other providers who were also required to submit regular reports on expenditure, statistics around disease coding and consultations, and other ad hoc requests.

Contracts With Māori Primary Healthcare Providers

Māori primary healthcare providers were contracted on a different basis to most other primary healthcare providers. They received capitated funding for a registered or projected registered population. This capitation included the cost of General Practitioners, nurses, community health worker(s) administration and management staff. They also received financial support through the TAGs funding that allowed them to establish premises and buy equipment, including computers, furniture, medical equipment and vehicles.

Other similar contracts are those of the Union Health Clinics established in the late 1980s and a few IPAs spread throughout New Zealand. These providers also required enrolment of a registered population and shared a different orientation to primary healthcare from many GP practices.

There was, however, a difference with respect to contract negotiations with the Purchaser. This was in the requirement that Māori health providers go through the MHDD, while all other primary care providers went through the primary care group and, for secondary services, went through the CHEs service groups in North Health according to specialty services offered. This requirement was to ensure a high degree of control exercised by MHDD over the Māori health development strategy of North Health. Any Māori provider was referred to MHDD, irrespective of the willingness of other services to fund them or their willingness to go through this route. This protocol was relaxed somewhat after 1995 once the bulk of Māori providers had been established, and indeed MHDD encouraged other service teams within North Health to actively find and support suitable Māori providers in their specialty areas such as mental health, disability, medical-surgical and public health.

These contracts with Māori providers included a number of attached schedules as new contracts were added to core contracts such as Well Child, Health Protection and Clinical Assessment, Health Promotion and Education (Crengle, 1998; North Health, 1997b).

The Case Studies included in this research share many things in common, but there are differences between each. Their relationships with their 'parent' organisations vary, but are usually more intimate than with other similar non-Māori organisations. This reflects the fact that staff may be family members within these various organisations. There are also differences in relationships between providers and other Māori organisations such as local Kohanga Reo, North Health and other health providers.

Legal Entity

A key element of the establishment of new Māori health providers was the transference of ownership from the Crown to Māori-owned entities. This legal identify was necessary as the government required legally identifiable entities that could be sued or legally held to account, and who would also become responsible for financial and clinical risk of Māori patients. This required Māori healthcare providers to ensure that their governance and management structures were established and functioning adequately.

This legal ownership has been associated with evidence of Treaty commitment, since Māori have an autonomous legal identity and it thus appears to be an expression of rangatiratanga. However, this arrangement also made Māori organisations vulnerable to legal enforcement if contracts failed. Such failures could be due to a multitude of problems including inadequate resourcing, inappropriate training or expertise (that is that the wrong provider was chosen), failure of other allied providers to perform, or failure of the Purchaser themselves, to perform.

All four of the primary health Māori healthcare providers examined in this research had constituted as a Trust - some independent of their marae Trust. These other Trusts were either iwi Runganga, or offshoots of these Runganga, or alternatively, operated under other Māori Trusts. The bi-cultural Māori provider examined in the secondary health sector, exists as a separate unit within a larger Crown Health Enterprise, while the last case study studied is a limited liability company.

Governance, Management And Leadership

Governance of Māori health providers has been a site of conflict in a number of primary healthcare providers. One reason for this during the early phases of the health reforms may have been the lack of experience of those with governance responsibility and consequent problems in differentiating between a management and governance role. This was further complicated by the overlap in roles between the governance bodies of Health Trusts and other Trusts or Committees in Māori organisations, all of which have a vested interest in the health contract. There was also the added difficulty of being able to recruit experienced people available to perform in governance because of limited resources for remuneration and opportunity costs in more lucrative directorships available during this period in public companies.

Half of the case studies studied cited examples of problems with governance particularly during the early stages of establishment. The fact that the other two did not cite such problems may be for reasons other than not experiencing these difficulties. However, it

does appear that two of the four primary care Case Studies experienced fewer teething problems over governance than other providers. These providers had the strongest identities within their regions at the start of the reforms and were extensively networked throughout, providing broad services. It may have been that their organisational experience obviated any challenge to the way in which they worked because their position within their community was already well understood along with well-established processes and structure. In comparison, the other two providers have had to work harder to demonstrate their credibility in service provision. Despite this, all providers clearly learned as health organisations and the establishment of health services in every instance enhanced their standing within their communities.

A number of Māori providers reported a range of different problems related to governance. These included interference in management by those responsible for governance; failure to act on problems when family members of those with governance or management responsibility were involved; or a lack of insight by governance of the needs of a health organisation.

A further criticism voiced during the research was the degree to which the parent Trust siphoned off resources from the Health Centre for other uses. Two of the four primary care providers made this complaint. This issue is complicated by factors such as the investment made by parent organisations, their risk exposure for the health services contract and their own internal pressure for further development, all of which may contribute pressure to drawing on health resources for wider development purposes. Furthermore, such 'development' may be an essential component of the hauora-oriented service. For example, marae development may be essential in order to have adequate resources to run health promotion programmes, training for staff, expand health administration offices.

Another delicate issue for providers was the involvement of whanau in disputes surrounding marae-based services. Such disputes are inevitable in that this broader involvement of people from other services around the marae or Trust occurs, as staffing

becomes a public rather than private matter for discussion on the marae or in Trust meetings. Everyone associated with the marae knows who works at the Clinic and what their job is. The inclusive nature of whanau, hapū and iwi, militates against confidentiality and privacy in these situations, making the job of managing personnel disputes immensely difficult. Furthermore, many on Boards are themselves new to this role and have not always found it easy to distinguish between appropriate or inappropriate intervention in operational management or determine what is sufficient guidance in strategic management.

A reason for possibly over-prescriptive behaviour by, for example, the Māori Committees or Iwi Trust Boards who own Māori health providers, is the degree to which these bodies have been responsible for the totality of service operations in the past. In a way, the health clinics imposed a new discipline on these governance structures that took time to settle in. The charismatic leadership attractive in so many Māori organisations, may not necessarily provide the kind of operational expertise necessary to run such complex service organisations. There is a relative lack of experience amongst managers in running these services, especially as businesses, and predictably, clashes arise from this relative lack of experience on all sides of the governance, management, and community equation.

The successful implementation of health services also lead to an embedding of the leadership within these providers. In every Case Study, in primary and secondary care, managers had cemented their positions of leadership within the wider iwi Māori community as a result of their involvement with the health service. As the Health Centres became a regular source of funding, they became increasingly important to cash starved Māori organisations. They also provided tangible benefits to their communities and were therefore recognised accordingly. These rewards were seldom in monetary terms, although larger providers paid their senior managers more, but were more in terms of the mana of these people and their subsequent integration into their organisations' other businesses.

Although Māori providers are keen to emphasise how well their governance systems work, in fact they were complicated and required considerable settling in time. Lines of accountability were blurred by personal relationships that interfered in accountability, performance and transparency of decisions among some of the case studies (although in differing ways). This was not helped by a multiplicity of services arrayed around marae or Trust Boards. Nor are these problems limited to a few providers. All of the interviewees expressed some frustration with governance, although these took particular 'forms' according to the particular provider.

Management

Management amongst Māori providers differs, with people from vastly different backgrounds managing these services. Te Puna Hauora has an experienced practice nurse now as a nurse manager. Orakei Health Centre has a psychologist as manager, and previously had a manager with an information technology background. Wai Health has a manager with a community services and consultancy background, with a previous manager also having a community services background. Orakei Health Centre has a de facto manager who has community development experience and Māori political activist background.

North Health identified the lack of managerial expertise early on in the reforms process as an issue resulting from the absence of experienced Māori health managers within the health sector. The period of the reforms has allowed Māori managers to gain experience in new roles of purchasing, consultancy and health services delivery. There is now a more experienced pool of Māori health managers available to work for Māori health providers and as consultants to Māori health providers.

Early management issues were concerned with establishing information and reporting systems and managing staff (Awhi Health quarterly reports to North Health, 1996-1997). These human resource functions were particularly problematic for many Māori health providers because of the lack of managerial expertise and also the changed nature of employment between employer and employee under the newly introduced Employment

Contracts Act. While training in management and human resources could address some lack of expertise, such learning would take time and experience to build up within providers.

The network of relationships used by Māori health service providers further complicated the management of Māori health providers. An extensive network of marae (with the marae politics that accompany this), their local community or iwi politics (particularly active during the period of Treaty negotiations and settlements during the 1990s), familial relationships between workers and Board members and consumers and their communities and iwi, relationships with other health providers such as IPAs, CHEs and private laboratories and pharmacies, and with the purchaser / funder, all added layers of complexity to their business dealings.

The human resource implications for managing staff in this newly restructured health environment, were particularly vexing for a number of reasons. Firstly, staff were recruited to new roles. Some of these roles were configured in new ways, such as practice nurses having a more active and expanded clinical and managerial role. Some of the newly recruited were inexperienced in the health sector, or inexperienced in other roles such as managing other staff. One provider explained that this related to the exclusion Māori had experienced in the health sector for so long.

You've been locked out of management for a hundred years you know; your leadership's been decimated in the Second World War ... What do they train you for then? They train you for both seamstresses and wharfies and freezing workers. We have no management ethos or class. People budget in our houses on the basis of whether the water gets cut off first or the power. You know, we then know what the priority bill is. I mean, you know, people can't understand that, but that's the reality (Tamihere, 1996, p 25).

There was also the additional burden of trying to meet community expectations and being available to health consumers who were members of your community or iwi, on a continuing basis. Lastly, there was a difficulty in managing a complex web of personal

relationships between staff, those responsible for governance, the local community or iwi to who the provider was responsible, the purchaser and other health professionals.

This high level of commitment by staff to their kaupapa of improving Māori health by whatever means necessary was identified by all of the providers.

Working for a non-profitable organisation means that those people are really committed to working for a kaupapa in terms of taking the initiative, a community initiative, to providing those services. So, it's almost like these people are here because they have, are committed to improving Māori health status, but also because ... they have a lot of skills and experience to offer (Hiini, 1996, p 2).

Recruiting and retaining staff became a key establishment issue for Māori providers during the early stages of the reforms.

Working for a non-profit organisation means that there are also a number of difficulties in terms of incentivising, trying to keep those people here. It sometimes means financial remuneration and trying to pay them what they're worth, I suppose. And again, [this] relates back to funding issues and resourcing issues (Hiini, 1996, p 2).

The problem with not being able to remunerate staff appropriately for their efforts was also identified by another provider when talking about community health workers.

So, even if they didn't have a wage as far as I was concerned, I was already tono (told to) and I came in contracted as the community health worker for [x] (Davis, 1997, p 6).

While lack of payment in the period of contract negotiation during the very early stages of the reforms was a reality for many Māori provider workers, they would face lower levels of remuneration for similar work than in mainstream providers once contracts were confirmed. Furthermore, some of this early work was subsidised by contract work done in other services.

While health contracts were generally more generous than other social service contracts devolved from government on the cheap, remuneration for Māori provider workers was still relatively low when compared to those working in mainstream Pakeha providers. This is particularly noticeable when Māori providers are compared to CHEs, whose remuneration included other non-salaried components such as access to necessary resources like computers, training and cars.

Well, it all comes back down to resource, bottom line ... Our darlings. We had to start them here on \$15,000 a year. They had to work twenty hour weeks to pay them on that, but they worked forty hours, [person x] and [person y] and the rest of them, for the belief in their community. Well, why should I, you know, why should I treat them as third class citizens and slaves when just up the road, people are running around in flash cars? All the back up equipment and everything else and getting \$38,000 for doing half the work? We had to go through that to prove ourselves, but we're not going to subject ourselves to that nonsense for much longer (Tamihere, 1996, p 28).

It was common for Māori staff in one provider to know a great deal about what was happening with staff in other providers, because of the close nature of the Māori community within the Auckland region. This proximity raises questions about boundaries associated with ethical implications of who has knowledge about whom, and how they use it. One manager explained it as follows.

Being a community health worker however for the whanau of [x] is greater than any job description because I first have a commitment and accountability to my whanau, to my hapū and to my iwi, then to the organisation and so this is what the organisation had to acknowledge was, if they take me on board with that acknowledgement then I was prepared to work for that organisation and so we fit together quite well (Davis, 1997).

Working Boundaries

This type of commitment raises questions about boundaries. Many Māori providers adopted similar protocols to other social service or primary health care providers.

I'm evolving [policies], some of which are yet to be identified to the management. Most of our policies are, when it comes to ethics, we accept a lot of the mainstream ethics in terms of, for instance our GPs. Those are sort of accepted No, even, within their whanau unless the client, the specific patient brings those people with them and is told by the GP that, with their permission he will share information [would the information be disclosed]. For instance, my mother is a patient of our clinic. I've rung up and said to the practice nurse or to the doctor, 'oh, have you had word from the specialist when here appointment is?' And, they've said, 'yes, but we've rung her', and I go, 'Oh, that's good because she wanted me to get in touch.' Now, just because I'm the community health worker, I don't have access to medical files I then have to gain permission from the person who is the record keeper for our organisation. So, I've set some guidelines up for myself that doesn't mean that we've instituted them yet (Davis, 1997, pp 8-9).

While professional boundaries are recognised by many staff working for Māori providers, those participating at all levels of the organisation may not necessarily understand these. For example, personal relationships between those responsible for governance and clinic staff, or between a purchasers' staff and providers' staff, may colour what information is shared and how much value is attributed to differing narratives. Furthermore, staff believed that this lack of confidence in professionalism might colour potential consumers views of their service, despite considerable effort by providers to address these ethical concerns. One provider describes it thus,

It's also been a barrier for a lot of Māori whanau wanting to access Māori services, as they think, 'oh well', just the fact that I see them there. 'I'm gonna go to the clinic', well, I don't. It's part of my training as a family therapist that I've learned to observe people's privacy, people's confidentiality (Davis, 1997, p 10).

Māori providers were understandably keen to dismiss this perception of a lack of health professionalism.

We've got to get in there and do the damn work and do it as good or better than Pakeha. And, we've got to be prepared ... We can't awhi any other way except by the quality, both tikanga and professionally. I believe we've got a huge responsibility [for] Māori nurses and Māori workers, and I don't think a lot of people have realised it (Marsden, 1996, pp 7-8).

This view is not just preciousness. Māori initiatives are subject to Pakeha veto through political intervention and public opposition to funding of such. Because of this Māori are vigilant about the possibility of being seen as lacking credibility or breaching rules for funders.

Reporting Mechanisms

While informal accountability mechanisms were applied to Māori health providers, such as those described previously, there were also a series of formal mechanisms for reporting required by the purchaser, North Health. Māori providers were required under their contracts with North Health to submit regular reports on their contract (either quarterly or monthly). However, most did not actually comply with this requirement providing instead more intermittent reports. This pattern was common to most other health providers who also held contracts with North Health.

In addition, primary health providers went through two reviews between 1996 and 1997. These reviews covered those providers who received a Transitional Assistance Grant. A private company did the reviews on behalf of MAPO (Tihi Ora, Tainui and Te Tai Tokerau) and North Health in late 1997 (North Health, 1997b; North Health, 1997c; North Health, 1997d). The other reviews covered a selected group of providers and covered matters such as management, administration, human resources, consumers and services. The author of these reports are not noted, nor are they dated, but they were written for MAPO and North Health and reviewed overall performance of these providers. Most importantly, there were a number of informal review mechanisms including regular meetings between providers and MHDD and MAPO staff. This included meeting at hui and specific meetings called at North Health or MAPO. One

contested area between providers and purchasers is the extent to which MHDD and MAPO staff were available to meet with them on site.

All Māori providers reported other informal mechanisms for accountability and reporting to consumers and members of their iwi and community.

We're having our first whanau meal this evening at [x]. First one ever. We're expecting about forty with our extended [whanau] So, we've grown from that little nucleus to a real strong whanau, committed. And you know, it's the service that we deliver. It's just a gem and it's just been breaking through so that the iwi know it for real. They've seen so many things fall. It's for real. It belongs to you and we're here to serve it and it's a two-way thing. We believe that Māori expect professionalism (Marsden, 1996, p 21).

Informal accountability mechanisms also consisted of whanau meetings, hui and the opportunity for Kaumātua or kuia to attend Board meetings.

Conclusion

Māori health providers are a political expression of Māori desire to address the high Māori health need evident in the statistics on mortality and morbidity, and more generally, on Māori well-being. Māori organisations have entered the health provision market created in the opportunities of the 1990s health reforms and have taken up the challenge with gusto.

There have been considerable frustrations amongst Māori providers with North Health. These frustrations centered around the short-term annual contracts (these were extended from the late 1990s to become bi-annual and tri-annual contracts), inadequate capital and developmental funding (despite the availability of one off funds such as TAGs and MPDS) and the capping of contract prices for operational service contracts during a period of moderate economic inflation. North Health was similarly frustrated by the time taken to deliver on contracts and the beneficial contracts enjoyed by Māori providers, who seemed to constantly complain about the inadequacy of these.

These Māori health service contracts differed from most other providers in significant ways, providing salaried staff while also allowing GMS and ACC claims. Despite this, Māori provider contracts are likely to be unsustainable in their current form because of low subsidisation for services from patient fees and high health need patients with multiple diagnoses (co-morbidity). Such conditions make it even more difficult to manage Māori patients adequately.

These contracts with Māori providers had to be established quickly but also, needed to be sure of success, since it was of great political importance that Māori providers didn't fail. There was an enormous burden placed on both purchasers and providers of these services as a result. If non-Māori providers fail, then it can be attributed to poor business practice or some other matter. When Māori fail this is attributed to other factors like incompetence and is generalised to other Māori providers.

There has been enormous difficulty in establishing these contracts, not least because of the serious shortage of trained and experienced staff to take up these new positions in purchasing and providing services, thus other tier strategies such as workforce development have been an essential part of the overall health gain strategy.

Ethical dilemmas also arose as staff moved between RHAs and providers. Māori staff are insiders to a Māori polity and therefore had access to a considerable amount of information that circulates within it. Attendance at hui, organisational information and personal networks are the most common means of accessing this insider information. Thus it is common for other Māori to know what is happening within particular Māori providers and within the purchaser. Such unrestricted access to information raises questions about boundaries, particularly for the purchaser who is supposed to make their decisions on objective information. Similarly, it belies the inherent secrecy of early competition between providers, since many knew a great deal about each other's business dealings and internal management. This has become less important as providers have established themselves and the competitive underpinnings of the reforms have been

eroded. Māori providers adapted to the less competitive environment that emerged between 1997 and 1998 with alliances between themselves and other providers.

Management of Māori health risk in financial and clinical terms was a new challenge for Māori providers, and while this learning was shared with other new independent and primary care providers, Māori providers have had to learn on the job rapidly.

Systems for Māori providers have also had to develop rapidly, including the demand for information from the purchaser driving information technology. Such investments in equipment, training and further development required major capital investments with risky outcomes. These have largely been partly funded independently through the purchaser and through the Ministry of Health, but the bulk of costs are met from within the resources of providers.

Lastly the early emphasis on competition between providers during the early phases of the 1990s reforms, meant that collaborative efforts with other providers including IPAs, CHEs, other Māori providers, and allied health professionals such as Pharmacists and Laboratory services, have all taken much longer to develop effective working relationships that will benefit Māori patients.

Inexperience with the new health sector and the constant changes to the health sector further complicated the environment for Māori providers with differing versions of purchaser / funder, ACC, CCMAU, Treasury, Te Puni Kokiri and various other agencies, all involved in the mix. Māori providers have shared this learning with other new providers as everyone grappled to come to terms with the environment.

Despite innovative contracting and enormous efforts by Māori providers, they remain price takers rather than price setters in the health marketplace created by the 1990s health reforms.

CHAPTER 10

Māori Health Providers: Kaupapa Māori Services & Community Primary Health Care

Introduction

Māori health providers have entered the primary and public health care 'market' with a number of innovative responses to this opportunity for Māori participation in the health market. These responses will inevitably influence these 'markets'. In particular, the tendency to adopt a community development orientation, focus on health promotion and work with high need patients, provides a benchmark for work with other primary care providers. Their entry was intended to shift resources from large CHE providers to others as a means of increasing contestability and creating a more efficient market in healthcare services. While Māori providers were understandably enthusiastic about marginal shifts in resources, mainstream providers were understandably muted in their responses to the providers' entry into the market. Open hostility between IPAs, for example, and Māori providers, was avoided in the early stages of the 1990s health reforms and by the end of the reforms they saw themselves as having more in common with each other against the secondary / tertiary provider section, than they had against each other. Interestingly, the 2000 reforms may serve to cement the interests of all of these providers within a District Health Board structure. This latter possibility will be examined more closely in Chapter 12.

There is no question that Māori providers have achieved an enormous amount in a short period of time. What is less clear, however, is whether there is a distinctive 'practice' associated with these providers, and indeed, with other types of Māori health providers.

A growing body of literature on Māori health providers (Crengle, 1999; Jones, 1997; Kiro, 1997; McLean, 1997; Penney, 1996) has been largely uncritical of the political strategy or achievements of Māori providers. One reason for this is the widespread

support for the growth of Māori providers within the health sector and the perception that they have achieved an enormous amount within a short period of time. However, further robust development requires an honest critique of these efforts as a means of improving services.

Chapter 9 discussed those aspects related to Māori provider establishment, including a list of characteristics that define Māori health providers. It focused on by Māori for Māori health providers because of the emphasis on such providers in the purchasing strategy and policy development during this period. This Chapter will consider issues of consolidation for Māori health providers and elaborate on what makes Māori providers distinctive in healthcare.

Māori Healthcare Providers

During the 1980s Māori healthcare providers operated with contracts under many guises, depending on where funding could be secured. It may therefore be inaccurate to quote increases in the number of providers from 30 in 1993 to over 200 in 1997 (Ministry of Health, 1997), because this suggests that it is possible to definitively describe who is a Māori health provider. What Māori can say from these Ministry of Health figures is that it reflects the number of Māori healthcare providers holding contracts with the RHAs and Transitional Health Authority between 1993 and 1997. However, even this figure is debatable, as some providers included in the figure are not direct service providers, but provide support services, or co-purchasing services, or consultation / brokerage services to RHAs and Māori providers.

Any suggestion that this kind of overlap with social services stopped with the 1991 health reforms is erroneous. Some projects funding by CFA, Lotteries, ASB Community Trust and other philanthropic Trusts may also fall into the category of healthcare providers. The key is obviously in how one defines health, and again, a telling characteristic of Māori providers has been the tendency to be encompassing rather than exclusive.

Consequently, the lines were considerably more blurred than is currently postulated between new Māori health providers and those who existed prior to the health reforms and provided health related services while being funded outside of Vote Health. There has been a consensus amongst Māori about the significance of housing, employment and education as a factor in health outcomes evidenced in holistic Māori definitions of health (Department of Health, 1984; Durie, 1998c; National Health Committee, 1998).

The rise in by Māori for Māori providers may also reflect a new realism that Vote Health funding for Māori health services is one of the few available sources of funding given the closure of Māori Affairs funding following mainstreaming of government money directed at Māori. These health initiatives were also to be supplemented by funds from other sources such as Treaty settlements, Vote Education, and justice or business development. It is therefore not surprising to find Māori transferring their energy to health services as a means of promoting their development. Resources and services are needed in the Māori community and Māori have adapted to providing them. Who funds them is almost irrelevant.

Role Expectations, Cultural Sensitivity and Social Distance

Recent studies in New Zealand suggest that systemic failure by health professionals may be at least part of the problem leading to higher rates of acute admission to hospital rates for Māori and Pacific Island families. For example a 1999 study of Pacific Island caregivers showed that many had visited a GP before their child was hospitalised, but a mis-communication between caregivers and doctors led to inadequate care necessitating hospitalisation (Tukuitonga, interview, 8 October 1999). Similar questions can also be raised concerning Māori caregivers and their children.

This kind of mis-communication during primary care consultations, where caregivers identify behavioural patterns such as “they are off their food” or “they’re not playing” while doctors are concerned with medical symptoms such as “they have a high temperature” or “they have a body rash” (ibid), may be related to a role conflict between clinician and patient exacerbated by a wider social distance between clinician and patient

with Māori and Pacific Island patients. Literature suggests that the greater the social distance between patient and doctor, then the more likely it is that the patient will view the interaction as unsatisfactory (Fraser, 1994). Such views have implications for compliance with respect to following medication regimes and lifestyle changes. Furthermore, the clinician may view their interaction with patients as consistent for all patients and not even be aware that there is a problem of miscommunication based on cultural difference or socio-economic distance.

Māori providers have experienced rapid development, learning lessons that other health professionals have had decades to bed down. Despite this they have continued to expand the range of services available to patients and to latterly, proactively seek alliances with other health professionals as a means of expanding their services. These achievements are however compromised by the relative lack of clinical depth and ongoing reliance on non-Māori expertise – given the limited skilled and trained Māori medical workforce. Māori providers are aware of these limitations and have sought to overcome them at times by ‘brokering’ services on behalf of their patients, for example by organising specialist clinics for diabetes (Te Puna Hauora) or negotiating access to CHE services in hospital settings (Te Puea Marae Health Clinic).

There has also been a tendency for some Māori providers to describe themselves as operating under Kaupapa Māori, while making little effort to understand what this means in practice. This is not to question whether they are indeed operating according to Kaupapa Māori, because clearly many of them are, however, what constitutes kaupapa Māori services has been given little thought. Rather, it is assumed that they are already kaupapa Māori providers purely because they are Māori providing services to Māori. Rather than externally testing their approach, there is a tendency to embed existing behaviours and ascribe these values to Kaupapa Māori.

The use of consumer satisfaction surveys prescribed by contracts with the purchaser does little more than scratch the surface of the relationship between patients and the provider and may reflect more about favourable price, location and other less qualitative factors.

More meaningful indicators of the quality of the provider / patient interaction are left begging. The retention rates of patients once enrolled may provide better evidence of the quality of service, along with the extremely low number of complaints received by Māori providers. These suggest that Māori providers were able to meet or exceed expectations of patients.

Furthermore, there are questions about the extent to which providers actually did conduct such consumer feedback surveys. Providers tended to adopt an ad hoc feedback system from patients. This consisted of occasional comments by patients or personal contact with patients in public places such as the local supermarket. A more systematic collection of data may have provided valuable insights into the quality of service and the nature of the interaction between provider and patient, whereas such an ad hoc approach adopted by providers may present a skewed picture of this interaction.

This more ad hoc feedback, albeit from multiple sources such as hui, interviews, survey questionnaires, may reflect a pre-occupation with more pragmatic considerations during this period of establishment and consolidation. Energy was concentrated on securing contracts, establishing basic services, enrolment and registration of patients with their services, convincing other purchasers, politicians and sometimes their own people, of the validity of their service, and developing relationships with other health providers to expand the range of services available to their patients.

These pragmatic considerations have focused Māori efforts on providing tangible and immediate evidence of their benefits to policy makers, purchasers and political decision-makers. Their survival and expansion depended on this. However, as a consequence less attention was given to population health strategies and public health approaches. The exceptions to this have been the immunisation programmes (in personal health) and nutrition and healthy lifestyles programmes (in health promotion). There is a question as to whether this alone constitutes a population approach, as identified by Rose, who recommended shifting the whole risk profile for the population by shifting it to the right of any mortality curve (Rose, 1992).

As explained earlier, a population approach coupled with the socio-economic and cultural determinants analysis, suggests that health indicators are interwoven with other social and economic indicators such as labour force participation, educational achievement and tenure of housing. These may provide more compelling evidence of outcomes for Māori in conjunction with health status evidence, since health is often the culmination of life experiences in other areas.

The practice of Māori providers has come to define the policy of Māori providers. For example, the extent to which MAPO have been allowed to operate as autonomous entities remained almost entirely dependent on the goodwill of MHDD staff despite the formal agreements and MOU. Even as late as 1999, MAPO staff were sometimes included in key consultations, and sometimes not. This improved considerably by the time of transition to the Transitional Health Authority (THA).

As Māori providers bedded down in the health sector and information systems improved, the quality of information collected at the individual patient and population level also improved. Māori can expect providers to provide better evidence of the quality of their interventions in respect of Māori health gains, as will other mainstream providers. Clearly a considerable confidence about the contributions and value of Māori providers already exists within the sector.

The extent of change in the area of iwi-based services is profound. The finance and support provided for the development of Māori primary care services may be judged as one of the principal successes of the reforms of the past decade, although success is more evident in iwi-based rather than urban non-iwi based services (Crampton, 1999, p 15).

While the basis for Crampton's favourable view of iwi rather than urban Māori services is not explained in the report, it may reflect the fact that iwi providers are more numerous and are also members of Healthcare Aotearoa, which was the basis of his report. Such support is understandable because of the disadvantages faced by many Māori providers

with their high need populations, newness to the field and complexity of arrangements with marae, iwi and communities of interest, making their job an even more difficult one.

However, other primary care providers have also achieved substantial improvements in patient care during the same period without being heralded so frequently as successes. Examples include improvements in patient information systems, control of laboratory and pharmaceutical expenditure without adversely affecting health outcomes and investment in new community health promotion programmes with patients among GPs.

Grappling With Competence

A *learning while doing* philosophy is also evident with the purchaser as well as with providers. While the major strategies in respect of Māori health remained constant during the 1990s, refinements were made to policies that elaborated on, or amended in some way, the original intention of the policy. These refinements tended to be highly operational and specific in nature though, rather than a shift in the strategic nature of these policies.

A major challenge for mainstream providers under the health reforms has been to improve the quality of their cultural competence in delivering services to Māori. This has been heightened by the entry of Māori for Māori providers into the market, thereby theoretically at least, offering the purchaser and patients a choice of providers. For Māori providers the challenge has been to improve their technical (clinical, managerial) competence through staff recruitment, experience, consultancy and education and training.

In a report written by North Health in 1997, the progress of mainstream providers in improving their cultural competence was called into question. The Cultural Quality Review made damning observations about the failure of CHEs and Disability providers to implement comprehensive improvements to services for Māori patients and staff. Within the RHA concerns were expressed about the lack of accountability of mainstream providers for Māori health, despite the fact that they received the greatest amount of

money. Sharon Shea (Māori Contracts Manager for North Health) explains the difficulty faced by the Purchaser.

Politically it has been really difficult managing, or asking for information from the CHEs, major providers who have such a hold on the market, and anything that has a hold on the public. A lot of things that they have done haven't come to light for CHEs, and also the same for GPs (Shea, 1997a, p 1).

The bulk of RHA expenditure went to mainstream health and disability providers who also provided services for Māori patients. The Māori Health Development Division calculated that around 13% of North Health's budget was spent on Māori health (in the 1996/1997 financial year) (Shea, 1997b). This is not money spent specifically on Māori providers, which was said to be less than 1% in North Health according to Hudson, but rather, the money spent on Māori patients across the total spend of North Health.

Similarly, audits conducted during 1997 of Māori providers who received Transitional Assistance Grants showed that some lacked even basic information or other administrative systems. Things like asset registers, knowledge of employment legislation and similar items (Muir, 1997a; Muir, 1997b). These shortcomings were addressed by contracting the services in some cases or by working directly alongside the MAPO or a consultant.

The heavy emphasis on information collection, contract negotiation and relationships communication with the purchaser, other health professionals and their own Māori communities of interest required a larger administration relative to other primary care providers. However, there have been suggestions for economising on this administration, both within providers through things such as joint administration staff shared with their marae or Trust, or alternatively, by consolidating administration within an umbrella organisation in much the same way that IPAs have done for GPs.

Risk Transfer

Underlying the legal transfer of ownership from the Crown to health providers during the reforms was the notion of risk management. This risk shedding by the government was an underlying driver for the government in the health reforms, and indeed the social policy reforms generally, during the 1990s. Certainly New Zealand Treasury promoted the need to move to risk shedding by government and the allied responsibility of return based on the degree of risk borne by providers. Contracting was the main mechanism for establishing terms between parties of health purchasers and providers (Ashton, 1998). These contracts reflected a higher level of risk and legal responsibility borne by the provider for the delivery of contracted services. This idea is crucial to the way in which the reforms have subsequently been implemented with Māori providers. It would be misleading to suggest that government has transferred risk. They have been able to transfer a level of risk, but retain the ultimate responsibility for health outcomes and issues associated with resource allocation.

Māori providers are not just responsible for clinical or operational risk, but they also bear financial risk. Their total risk is often greater than that of other health providers.

Māori providers are more exposed and vulnerable than other providers in terms of financial risk because most providers are in the form of a Trust and unlike CHEs do not have powerful, politically influential shareholders. When a CHE is not financially viable, it can agree with its shareholder to inject capital. It therefore has a strong fallback position, because their shareholders are the government and the government has access to cash, and it has political leverage because the government need to be seen to be putting in money to this sector. Māori don't have this fallback position. They only have the option of getting a better price through the contract. This option is also available to mainstream providers (Hudson, 1998).

This is due in part to the fact that Māori providers are small, localised and may offer fragmented health services without the resource base in terms of money or skills to diversify. Their lack of size and relative lack of influence in their sectors make them

vulnerable and unable to diversify their services without significant backing from a large parent organisation, or health funder.

Mainstream providers are able to use certain services to leverage support because of their clinical clout, for example, acute services within CHEs. These have political and professional clout ... Māori providers operate in a tiny portion of the primary market and don't have this clinical clout. They find it hard to recruit and keep experienced Māori clinical staff (Hudson, 1998).

A reason for their inability to recruit and retain Māori clinical staff is in part a product of the small number of Māori with this expertise. The providers are therefore unable to leverage the professional power of their staff, as other providers or provider organisations such as IPAs do. Māori health professionals are also more likely to choose to work for mainstream organisations (both funders and providers) for a number of reasons. Firstly, they have access to training and development money and a structured career development. Secondly, they have professional peers who are similarly trained. Thirdly, they are able to engage in more complex interventions rather the highly routine work of a GP clinic. Therefore Māori providers have to appear more attractive to draw these same staff. Human Resource policies are often under-developed with Māori providers and staff often work beyond their job descriptions in ways that may well lead to burnout.

Other risk factors can also be identified: Māori are a high risk health group experiencing very poor health outcomes; Māori providers are small, new services in a well established industry - primary healthcare; and, the contract prices are based on imperfect information and are likely to not accurately reflect the true cost of establishing health services. The difference between the price of the contract and the service is therefore made up of Māori staff "sweat equity" (Reid, Keefe-Orsmy, & Robson, 1996).

Māori providers' financial risk exposure is high because they often lack financial integration with other large services to adopt the 'swings and roundabouts' effect of

being able to carry an under funded service through over funding in another area for a limited period until other things kick in to sustain it. An example of this would be CHEs, who employ large numbers of staff, some of whom can be reassigned to high-pressure areas, or who can offset some expenses against other services. This option is not available to Māori who tend to work in cash-strapped environments with little capital.

Distinctive Approaches In Māori Healthcare

Māori providers' service configuration and practice reflects a commitment to more holistic care. Thus while clinicians are very important for Māori primary care providers, clinical roles are part of a team which also emphasises health education and prevention. This team includes community health workers, administrators, counsellors, doctors and nurses. These services may also include alliances established between primary health providers and other health providers with counselling services, youth development programmes, iwi or community development programmes, and health promotion programmes through marae or community centres such as health aerobics and nutrition.

Māori providers also formed alliances with CHEs (now Health and Hospital Services or HHSs) and other Māori providers according to their particular expertise. These alliances occurred later in the reforms. During the early phases of the health reforms emphasis was placed on competing with all other health providers for contracts and favour with the RHA. Signs of a softening of this approach amongst Māori providers began to emerge in 1996/7 when contracts had been secured for a few years and providers had established their core services. In addition, evidence was gathering momentum about how undermining a competitive model was in health, curtailing necessary co-operation between health providers and health professionals. This convergence prompted Māori providers to seek alliances between themselves and other providers.

While integration and a developmental approach, along with an encompassing definition of health, are widely associated with Māori health there were other distinctive characteristics amongst the Case Studies of Māori primary care providers. Most notably, all the providers enjoyed intimate relationships with significant Māori organisations

within their locale. Indeed most of them were established by these very organisations. This became a crucial consideration when North Health decided with whom to contract. While there were some concerns about nepotism because of the proximity of Māori staff in the purchaser to particular providers, all providers chosen complied with the broad criteria established by North Health for selection of Māori providers for primary care.

McLean identifies different kinds of Māori health providers.

I think we have to be quite careful [when we use the term ‘by Māori for Māori’] because I think we can define ‘for Māori by Māori’ under three categories. The first one which I would just use the term tuturu Māori, you know traditional healers for example. The second one is you know for Māori by Māori services where the patient is mainstream for a non-Māori organisation – and we have many of those, you know they’ve sprung up all around the country side...and the third one you now, [is] by Māori for Māori and you know Raukura Hauora is a good example of that. Now what’s so unique about Te Puea, the Te Puea marae service, [is that] one, it is owned and managed by Māori is the first thing. Two, because that it brings all of those added dimensions that makes that service culturally safe (McLean, 1996, p 11).

The use of terminology ‘by Māori for Māori’ providers is clearly associated with what McLean identifies as the last category of provider, which is those owned and managed by Māori and which provide services to Māori patients. However, it is useful to remember that there are two other categories of providers, including those who are part of mainstream services and those who are traditional healers. Traditional healers maintain a low profile in the health sector but are sometimes used by both mainstream and by Māori for Māori providers. For example, mainstream providers may allow tohunga or Māori chaplains to conduct karakia with whanau in hospital settings. Mainstream providers remain the dominant providers of health services to Māori, and yet relatively little effort among most has occurred to affect or improve their practice and responsiveness to Māori.

Patient And Clinical Characteristics Of Services

There are many similarities between Māori primary care providers and other primary care providers, noticeably the Union Health Centres and GP Clinics. The clinical team consists of the General Practitioner(s) and Practice Nurse. These core services may be supplemented in clinics with other services or by specialists from CHEs dealing with nutrition, cervical screening, and immunisation programmes. These services continued to expand to include mental health or counselling. The extension of these services and the linking with CHE specialist services, provided a clinical depth and breadth otherwise unavailable to most providers.

Māori providers were interested in challenging some entrenched clinical behaviours, for example the tendency to prescribe drugs rather than 'green prescriptions' or tendency to have shorter consultations, provide detailed explanations of medication regimes or health risk factors. The potential problem of having Māori patients unable to pay for necessary medication was an issue for Māori providers.

- Some of them [Māori patients] don't quite get to the chemist 'cause they find out that the cost is about \$50 and that's the difference between you know getting some pills or whatever, and putting some food in their pukus. Now that's the kind of plaster approach... sending fat people down to the chemist, you know with a prescription to deal with hypertension, you know is just masking over the issue and he says (the Chairman of Raukura Hauora) that [what] they need is to send them off to the gym (McLean, 1996, p 17).

While 'green prescriptions' by GPs are being increasingly encouraged, Māori providers were quick to identify the potential of these and apply them. Again McLean explains.

- I think if we come back to you know the real Māori health needs, I think a lot of our ailments can come back to one of three principle reasons; nutrition, behaviour [and] lifestyle (McLean, 1996, p 17).

As new providers in the primary care market, Māori health providers had fewer preconceptions about how they should interact with Māori patients. Rather, their interest was on creative solutions to Māori illness. If that meant paying a year's gym subscription

or swimming fees, then this might be considered more useful than paying large pharmaceutical bills. In practice however, these approaches were rarely implemented. Part of the reason for this may have been the difficulty in selling the New Zealand public the legitimacy of spending Vote Health monies on individual gym subscriptions while hospital waiting lists grow.

Payment and other aspects of care also marked Māori providers as different from other mainstream primary providers since they relied on a koha system. This was true for all primary care Case Studies. For example,

A koha system operates for unwaged clients, particularly beneficiaries. Services to children under 5 years are free. Informal networks are relied on to give feedback and information to service providers on access for clients to their service and responses are made accordingly. Already, the service has been able to identify and respond to barriers to access for their clients... Children and whanau access the practice register through the providers i.e. GP, practice nurse, receptionist and / or community health worker enrolling them into the service when they attend the clinic or require the marae-based health promotion and education services (North Health, 1997d, p 5).

Tikanga Māori

Tikanga Māori or kaupapa Māori was seen by all providers as essential for distinguishing Māori providers from other providers. Tikanga is a complex concept however, since it may require responding to a particular tribal kawa. Overall principles appear the same however. Some of these have been identified in both mainstream Māori providers and amongst by Māori for Māori providers. McLean explains the significance of tikanga for Māori providers as, “Tikanga Māori in its broader sense [is what] makes that service culturally safe” (McLean, 1996).

Tikanga Māori is considered to be those behaviours and values that are particularly Māori. They come to define who Māori are and what Māori believe in as Māori. For example principles such as manaakitanga (hospitality), whakapapa and whanaungatanga

(family belonging), respect for elders and knowledge of appropriate behaviours around death and birth. Tikanga is associated with a correct way of doing things to ensure that Māori principles and values are reflected in our actions. Therefore the translation of this into the health sector means behaving in ways that reflect and preserve Māori cultural beliefs.

Tikanga Māori may also dictate where some services can be located. For example, it may mean locating services on one particular marae because of its significance to iwi within that area, as opposed to another marae within that area. McLean explains,

You know in terms we still have our protocols I guess. We still have to work within those and I'm talking about our Tainui protocols and that you know being mana whenua still dictated, or continues to dictate you know the extent to which [you can] and where you put your services (McLean, 1996, p 13).

Involvement with Marae

Three of the four Māori providers considered in the Case Studies were located on or adjacent to a marae. Two were affiliated with a particular iwi, while two were pan-tribal.

All of the Māori primary health providers had strong relationships with their local marae. The only one not based on a marae, was near its marae and was in constant contact with it. Those that were located at marae all reported having to deal with the 'politics' of the marae, necessitating education, regular communication and often participation in marae activities. In each case, these relationships were considered distinguishing features and a key expression of their Kaupapa Māori.

Commitment To Whanau, Hapū And Iwi

Whanau, hapū and iwi are the basic social units of Māori society and they continue in the present time, although in changed forms. An explicit commitment to whanau, hapū and iwi is something shared in common with all Māori providers. Wai Health were more concerned with the social support networks of their patients, which may, or may not include those who are related. There is a much greater focus on whakapapa with tribally

based providers. Whanau were viewed by all providers as the basis of Māori well-being and therefore were seen as an integral part of any person's treatment. This meant that all Māori providers in the research worked with whanau as well as the patient wherever possible. There were issues of confidentiality raised in respect of their practice, but this an unusual complication. In most cases, patients either chose to bring their whanau or did not. Certainly, all providers indicated that they would respect the individual wishes of the patient in respect of informing whanau of treatment, thus protecting their role as health professionals.

While all providers expressed a willingness and commitment to hapū and iwi (including the pan-tribal providers), this was less tangible and often took the form of participating in hapū or iwi hui discussing Māori health, formulating health plans according to the identified needs of a hapū or iwi or working with marae or community organisations owned by hapū and iwi. The practice of Māori providers therefore recognised whanau, hapū and iwi as the basis of social organisation for Māori. All also acknowledged that social support systems such as friends and neighbours play a crucial role in healing and all dealt at the level of whanau and individual patients in their day to day work.

Kaupapa Māori In Healthcare Service Provision: Strategic Considerations

There is a link between health services and other strategic Māori objectives, namely the reinstatement of tino rangatiratanga under the Treaty of Waitangi, and thus the link between Māori health and other forms of Māori development (Durie, 1998b; Durie, 1998c; Durie, 1992). While the Treaty provides a basis for a constitutional expectation of service, it is the appalling health outcomes experienced by Māori that provide the momentum for action on Māori health. This was expressed in the Crown's objective "Whaia te ora mo te iwi" to address the health status disparity between Māori and non-Māori. This has provided the policy backbone for much of what has been developed as Māori health policy during the 1990s. This includes improvements within specific areas of Māori health and also a focus on the long-term outcomes of Māori development and its integration with health.

The political influences that have legitimated some interests over others within Māoridom, such as a few dominant iwi, is reflected in preferential policies developed under the health reforms. These preferential policies were intended to address the mana whenua or rangatiratanga of iwi over Māori within their rohe. Such an approach has understandably given rise to grievances from those excluded from this process. What is surprising is the degree of consensus and lack of conflict from Māori that accompanied so much of the reforms. This can be explained in part because of the success in selling the reforms to Māori opinion leaders, and in contracting these opinion leaders (and therefore co-opting them) into the process of the reforms. One informant explains it as follows.

Firstly, you've got to understand what the expectation was. Yeah, and the expectation was that there would be a range of opportunities for Māori participation for the first time in the health industry, other than being a patient of it. And so, there is the opportunity to aggregate our populations who were committed to some form of Māori contribution for their health and that was those health care plan capacities. There was the opportunity, we thought, of actually getting into provision of health care (Tamihere, 1996, p2-3).

Māori interest in the reforms did not mean Māori had not relinquished interest in Health Care Plans first promoted in the late 1980s. The 1990 to 1993 phases of the health reforms were seen as a means of implementing elements of these plans. These plans identified a population-based approach to care for Māori in their region, or tribal area.

This positive view of the reforms is reinforced by yet another key informant.

Well, ... there were a number of objectives I think on the reforms. For Māori it was to create an environment where they could participate far more extensively than what they had traditionally done, through the Area Health Boards ... No one really knew at the time whether it was going to happen or not because like, we were only implementing it. So, I had the framework from the providers who put the framework in and they had done studies on it (Maniapoto, 1996, p2).

The influence of the providers on shaping the outcomes of the health reforms, was identified by another provider. Another informant saw providers as driving the policies based on their day-to-day experience of health services. Providers were relatively considered information rich since they had the health interaction with the patient and providers also enjoyed the loyalty of their patients (Hudson, interview, 1998). However, providers were reliant on funding from the RHA and many of the most experienced senior managers remained in the purchaser at the time of the purchaser / provider split in late 1992. Another informant explains why the largest health providers were advantaged in the reforms.

They had the historical vote coming in. The purchaser/ provider split meant that the purchaser was so far behind it wasn't funny and was virtually held to ransom on issues, particularly by the bigger providers, be they called CHEs, Plunket or whatever else, because they just had to keep a retention of service going whilst they understood quality, efficiency and effective type deals (Tamihere, 1996, p4).

Kaupapa Māori In Healthcare Service Provision: Operational Considerations

Māori providers have had to establish and operate health services within a very short period of time. This challenge was increased because of the complexity of the health sector. This complexity has been exacerbated by the 1990s health reforms with the accompanying fragmentation of health agencies and changes to purchasers / funders. The establishment of these services depended upon a number of factors, not least of which is securing a contract with the purchaser. Other factors included finding appropriate staff with requisite expertise.

The most difficult recruitment challenge was in finding staff with medical and nursing competencies and managers able to run small businesses. Managers have been crucial in establishing these services and often led development of these services by maintaining relationships with the purchaser, forming and maintaining strategic relationships, and co-ordinating activities with other providers, including other Māori and health providers. This has been hindered by the absence of sufficient management expertise for these kinds

of enterprises, requiring many to learn on the job. The results have been variable and have included high turnover of Māori managers between Māori or health organisations; significant personnel difficulties and grievances that have required intervention by Boards; difficulties arising from inappropriate intervention by Boards in management; and too prescriptive an approach to the health service, reflecting a Board's highly parochial interests.

There have been reported clashes between different governance structures such as Marae Committees, Runanga and Health Centre Trust Boards. Health funding has provided a significant, regular source of funding for marae or Māori organisations, used to providing services to Māori with minimal resources. This more secure funding, which while being inadequate in many cases, has been highly desirable for Māori organisations:

Community Health Workers, Community Outreach And Development

The degree of community outreach, involvement, direct accountability and commitment to development is a defining feature of Māori providers and has been part of their vision since they were established. At times, community health workers have felt marginalised within the Health Clinic. Despite this, they are integral members of the health team. In some cases, the community health worker is the lead worker in terms of negotiating with authorities or formulating the development plans and tribal networks on behalf of the Health Centre.

This form of community outreach may take many forms from practical support such as providing transportation to Health Clinic appointments, to transportation for patients and their whanau to specialist or hospital appointments, to pharmaceuticals pick ups and other such activities.

[She] also transports patients to hospital appointments or GP appointments if they can't transport themselves (Marsden, 1998a, p4).

Availability of transportation was confirmed for the provider Case Studies and Te Puna Hauora. Orakei Health Centre also provided transportation if necessary. The community health workers are primarily responsible for this. The purpose of community

health workers is to encourage Māori whanau to use their health and social services. A community health worker from Wai Health explains the advantages.

For our whanau to have somebody working in the health system, preferably a Māori I suppose. And because our whanau are really shy and they don't want to be a hoha to anybody. When they get sick they wait and wait and wait till the last minute before they'll come in and see a doctor but having somebody there that they know or somebody that they've been able to build up some sort of rapport with regardless of who it is. As long as it's Māori, they can at least ring them up on the phone and you can korero with them and just help them to make that decision for themselves to come and access the services. Some of them, because being in the area, living in the area, you get to know them and meeting them in the clinic you just sort of, because you're Māori you say "kia ora" you know, and you start talking away to each other or some of them will just ring up because through word of mouth or something, through whanau, talking to each other. They've heard about our services and then they'll [say], "... [so and so] said to ring you. "Can you help me?" (Makiha & Graham, 1996, pp 1-2).

Their work includes education in areas such as women's health, children's health, medication compliance and public health. Again this same community worker explains.

My main area of work was within women's health and that was seen as mainly an education role on health issues to Māori women as well as non-Māori, although our target group was for Māori women. And, also looking at, in a supportive advocacy role ... But, because your contract is specifically education and a little bit of support, when you meet with women in the community, they would have other health problems within the whanau itself, for themselves that really needed like, someone outside of the [Wai Health] services to actually work with them (Makiha & Graham, 1996, pp 2-3).

This explanation is backed up by the community worker for Te Puea Marae Health Clinic who describes a similar role, but one which is more linked through the various iwi marae

and has the benefit of multiple iwi health providers who can network amongst themselves. Their umbrella organisation is the employer, not the marae or Health Centre. It employs 10 community health workers spread around a network of marae in their iwi rohe. These community health workers have regular meetings. At these meetings they discuss their work and workload management. They have a firm commitment to community development as a philosophical expression of empowerment for Māori communities and they use the strength of their own experiences in working with the Māori whanau they come into contact with. The community workers have “walked the journey I have” (Davis, 1997). A community worker explains that their role is to, “know who to talk to and how to get resources [for their clients]”. They also need to see, “the macro as well as the micro”. She maintains contact with her kuia and Kaumātua through various tribal hui and provides education, support and a link to the clinic through these various hui - where she is seen, and they know they can talk about their health needs with her.

Another community worker explains how broad this mandate may be.

A lot of homes that I've been into, the housing has been very poor in relation to heating, dampness, which causes ill health, what we all know. And, to be able to work with that you had to know a key person at Housing Corp. or knowing things about Land Board issues ... so that's another example and also a child with a, you know, getting asthma ongoing and other health problems and you're looking at the bedding and the, you know, the issues within the home and it's really hard to say, well, you know, you promote all these good messages, dust free homes, airing your blankets when they may only have, you know, very minimal [things] in the home ... and if one child has headlice and here you are gong with these wonderful messages, shampoo their hair weekly, check their hair, and it's just an ongoing thing. It feels like you're just doing a band aid service (Makiha & Graham, 1996, p3).

A characteristic of Māori primary health care services is their use of community health workers for community liaison and education. This kind of outreach enables greater engagement with their communities of interest than occurs with GP practices.

This community development orientation is in keeping with the orientation of other indigenous communities who have experienced dispossession of their lands and who bear a disproportionate burden of illness in their population. As such, any programmes aimed at improving health status operate within “the context of colonisation history and the contemporary cultural renaissance whereby indigenous populations are asserting their rights to self-determination” (Voyle & Simmons, 1999).

Community development is reflected in two respects for Māori health providers: in their philosophical orientation towards developmental aspirations for their communities of interest (iwi, organisation or community of residence), and in the reflection of community development principles in their practice. This can be seen in the explicit pursuit of empowerment of their communities in health promotion activities, by involvement of their communities in governance, and by their commitment to a more team-based approach amongst workers.

In summary, community development is an essential component of a Māori health approach to health. Voyle and Simmons identify this as,

Community development strategies incorporating empowerment as both means and end are consistent with the aspirations of the renaissance and reflect the principles of the Ottawa Charter for Health Promotion (Voyle & Simmons, 1999).

Alliances With Other Primary Care Providers

Māori providers were not the only initiatives established under the health reforms in the primary care sector. Integrated Practitioner Associations (IPAs) also arose during the health reforms. These grouped General Practitioners to budget hold for the delivery of primary care. Early efforts of IPAs were in finding cost savings that could then be reinvested into health initiatives directed by shareholders, protect the professional

interests of GPs, influence primary care strategy and provide professional medical and nursing training for primary care practitioners. In some IPAs there was a greater emphasis on community collaboration, while others emphasised the business and profit outcomes promoted under the 1990s health reforms. This budget included pharmaceuticals and laboratory spend for their registered populations (comprising GP's patient populations), in addition to some special budgets around administration support, computer grants and information technology developments, training and specific disease programmes prioritised by the RHA / HFA.

During the early part of the health reforms, IPAs and other community health providers such as Plunket saw themselves as in competition with Māori providers. This tension eased considerably under the new more collaborative approach fostered towards the late 1990s when new providers had established themselves and were bedded into the health sector and when a new political environment in government encouraged this. Competition was no longer seen as delivering superior results in the health sector.

Relationships between Māori health providers and these other providers developed over time. Sometimes new relationships were forged with older services such as hospitals, for example, the joint venture Superclinic at Middlemore Hospital sponsored by South Auckland Health and Tainui. Other examples such as Westkids arose in the late 1990s, with diverse community partners starting with Starship Children's Hospital (Auckland Healthcare) and Integrated Primary Care Service (IPCS), then broadening to include Wai Health, Pasifika Fono, Plunket and Waitemata Health. These new initiatives marked the high tide of the success anticipated by the early health sector reformers because they encouraged local innovation and responsiveness to patient need. The problem is that they were limited in number and were still very difficult to launch, taking many years to come to fruition. Such long lead times led to inevitable frustrations within providers, including Māori providers.

There were also serious concerns held by Māori providers about joining forces with non-Māori providers. Some providers believed that this was surrendering the hard-won rangatiratanga of Māori providers for small gains under other providers' control.

Similarities And Differences Between Third Sector Primary Care Providers And Māori Health Providers

Māori providers appear to share a considerable amount in common with other third sector primary care providers. In particular, they share an orientation towards community development and health promotion and a commitment to broad public health definitions of primary care (Crampton, 1999, p 3). Arguably, they also choose to work with vulnerable populations, such as those who are low socio-economic or those who are ethnically Māori or Pacific Island. Crampton identifies commonalities between members of Health Care Aotearoa (HCA), a not-for-profit umbrella organisation of community based healthcare providers in New Zealand. This analysis by Crampton could easily be extended to include almost all Māori providers. These are summarised by him as,

Governed by management committees that include community members and patient representatives, and tend to adopt population approaches to funding and provision of primary care services. In general, population based approaches are adopted in the following four areas: targeting of high needs populations; geographical location of services; population based funding; and, denominator management of health problems. The populations of HCA are largely non-European, and live in deprived areas (Crampton, 1999, p 3).

While Crampton's analysis is about the work of HCA, including iwi providers, there are obvious overlaps between the ideas and values driving these services – or their kaupapa.

One possible difference however, is the extensive use by Māori primary care providers amongst the Case Studies in this research (both iwi and pan-tribal) of community health workers and the requirement for location on, near or with a marae. The widespread use of te reo amongst Māori providers and also the extension of services to include things such as transportation reflect a willingness to go beyond the 'normal' primary care

service. This expanded service may require additional work by the provider, for example two checks to make sure patients visit specialist referrals, or physically taking them to the specialist, or explaining lifestyle changes within their whanau environment, or looking after their babies or children for a period while they visit the doctor or ante-natal clinics or indeed, whatever is needed to assist the patient to get appropriate treatment. Community health workers amongst the Case Studies cited all of these as examples.

The 1990s health reforms gave greater control for third sector organisations and Māori providers in some areas. For example these providers could contract for services previously provided exclusively by CHEs, such as immunisation and other specialist services. Despite this, however, many of these services remained at the periphery of mainstream services because most of these services remained firmly within CHEs despite the early promise of transparency and competition. The size and history of CHEs in providing such services and the risk of transferring services proved too difficult an equation to solve in a decade of reforms.

The orientation of Māori health providers to community development has been discussed earlier. This orientation is aligned with an integrated social policy approach including training and education, and welfare services as a means of promoting iwi Māori development. Such an orientation fits neatly with the growing interest of Māori providers and policy makers in population health approaches. This has gained momentum somewhat in the international literature around the debate on socio-economic and cultural determinants.

The significance of population based approaches for Māori is that they are premised on the importance of the collective as opposed to individual interests. This is more congruent with traditional Māori values. Furthermore, it necessitates interventions irrespective of the ability of the population to meet its needs. This is important for Māori since evidence suggests that Māori are probably net beneficiaries of universal systems. The evidence about who uses these services is still unclear but it may be that those who experienced increased choice as a result of the health reforms and access to Māori

providers, may also be beneficiaries of other Māori specific programmes such as Kura Kaupapa Māori.

Crengle (1999) summarises a by Māori for Māori provider as having the following characteristics;

- Operated by Māori organisations / groups which are governed by Māori
- Based on kaupapa Māori and utilise tikanga in the development and delivery of their services / programmes
- Accountable to the Māori community
- Utilise (where possible) Māori staff
- Provide the Māori community with high quality services that are affordable, accessible and appropriate (Crengle, 1999, p 8).

Some of these characteristics are not shared with other third sector primary care providers. In particular, the commitment to Māori participation at all levels in the health sector is an obvious difference. This is at the heart of the Māori health gain strategy identified by the Crown and North Health. It remains a key part of their strategy even through the various transformations from North Health to Transitional Health Authority, to Health Funding Authority to Directorates and District Health Boards. Crengle goes on to identify two philosophies that underpin the work of by Māori for Māori providers, “the use of a Māori model of health and positive Māori development” (Crengle, 1999, p 8). Durie identifies both of these as resulting from the sea change in Māori approaches to health from the Hui Taumata of 1984, when Māori decided that they would no longer be passive recipients of health services, but active partners in these services. This was extended to cover governance and management of services as a result of the 1990s reforms because of the then government’s commitment to devolving risk and responsibility to such communities.

Population Based Healthcare

Population healthcare requires an analysis of the health of populations and recognition that this may be more than the simple aggregation of individual ailments. For example, understanding that Pacific Island patients are subject to high levels of obesity and

diabetes may mean the health professional involved needs to promote a more a proactive campaign of diet and exercise. At another level, population healthcare can be seen as considering where the best changes can occur. Does it make more sense to treat the ailments such as the common flu that generate more days off and involve a greater burden of illness or to treat those conditions that are more infrequent but result in more serious and long term interventions for the individuals who suffer them? Furthermore, are these conditions amenable to treatment such as pharmaceuticals, changes in lifestyle or wider social influences such as employment and education?

The theoretical basis of population based healthcare is gaining ground around the critique of the impact of inequalities on health (Lynch, 2000; Marmot, 1995). In particular, the work of Wilkinson on his relative income hypothesis theory (Wilkinson, 1996; Wilkinson, 1997), while criticized, appears to be galvanizing disparate interest in the relationships between biological and social processes that affect health (Berkman & Kawachi, 2000; Kawachi & Kennedy, 1997; Kawachi, Kennedy, & Wilkinson, 2000).

A commitment to gathering information by the purchaser may be derived from different motives such as the desire for fiscal control which requires accurate costing of services (something that had not existed before the reforms), monitoring of compliance with contracts for delivery of specified contractual outputs such as surgical procedures, throughput, consultations and immunisation rates. Information is a powerful management tool and an essential ingredient for a transparent and competitive health market. Information Technology could also improve our ability to measure health outcomes such as life expectancy, disease state management, referrals and discharges including handover between primary and secondary care physicians, utilisation data for hospitalisation, attendance at health promotion activities and a host of other potential measures. For example, detailed data collection allowed much closer clinical monitoring of variances in individual clinician behaviour. For example, amongst IPAs comparisons in pharmaceutical and laboratory spend could be tracked raising questions when different clinical behaviour occurred for different populations.

Māori Nurses: Lynch-Pins In Māori Providers

The significance of Māori nurses in the development and maintenance of Māori health providers cannot be underestimated. A Kai Tiaki article states that,

Māori nurses have a pivotal role to play in improving Māori health and the Health Funding Authority wants to make sure they're in a position to do so (O'Connor, 1998).

This was a view supported by the MHDD of North Health. Cooper explains,

We want more effective primary care and we need more practitioners than are available now. So we will push and pull funding levers in ways designed to benefit Māori need (Cooper, 1997).

Cooper sees this as encouraging a greater responsiveness to Māori need and,

Wants a situation where any nurse is capable of dealing with the needs Māori people present with. I don't have any doubt that that is not the case at the moment. It is an issue for the [nursing] profession to deal with (O'Connor, 1998).

In response to this, the HFA funded a workforce development strategy for Māori nurses, investing millions in their education over a few years.

Māori nurses are at the forefront of a movement occurring elsewhere in primary health care whereby nurses have an expanded clinical role, screening patients for blood pressure, weight, family history and other important medical history factors. Rather than undermining doctors' roles by taking over some activities such as cervical screens, immunisation shots and routine blood checks, it could be seen as the development of a primary care team including the nurse, doctor, administrator and community health worker. Such changes are occurring worldwide and may reflect growing public interest in holistic health care which coincides with debates around dealing with the structural and political roots of ill health rather than simply treating symptoms of illness (Wilson, 1998, p 18).

Wilson (1998) has argued that the allocation of government subsidies to GPs as providers and gatekeepers consolidated the position of doctors over other health providers like Māori healers, nurses and homeopaths. Furthermore she stated that the proposed solutions such as managed care, might not deliver the benefits in the way intended. Rather such organisation of healthcare may implement a form of “surveillance medicine” where the boundaries between healthy and ill people become increasingly blurred as all are targeted for intervention. This is particularly so for those families considered “at-risk” such as Māori and Pacific Island families.

Critics such as Wilson contend that this increased medical surveillance excuses health professionals from participating in difficult discussions around the structural and political implications of illness. Navarro presented a critique in 1986 of,

The role of capitalism in creating ill health and the demand for social and medical services, [he] talked of the depoliticising nature of medicine (Navarro, 1986).

This is of concern if, as one study suggests, medical care may contribute as little as 6% to health, and in the USA, and may have contributed as little as 3.5% to some specific infectious diseases (Grace, 1989; McKinlay & McKinlay, 1977). The study suggests that our greatest opportunities for health gain lay outside the dominant drivers of the health sector. Again, Wilson (1998) finds that poverty overwhelmingly underlies the various risk indicators identified by programmes such as Family Start²² and she criticises the targeted approach that individualises these families and their care.

Health promotion type programmes are also suspect because they rely on individuals taking responsibility and changing their lifestyle. Again Wilson using Lowenberg, explains the implications of this.

Individual responsibility pervades the discourse of health promotions and warns of the dangers of the “ideology of choice” rhetoric, which targets

²² This is a government sponsored national programme aimed at targeting at risk families and intervening early by community based agencies.

those with the scarcest resources and the most profound needs (Lowenberg, 1995).

While Māori nurses are leaders in many Māori health providers, their value lies in expanding a more individualist approach to primary care and promoting a more team based approach. Such an approach was apparent among all of the Māori primary care providers and therefore Lowenberg's criticism was somewhat mitigated by this more inclusive and health promotion orientation of Māori providers. However, the inexperience of Māori nurses in working in this environment, means that it may be some time before the best combination of clinical excellence, expanded scope of services offered and community health team approach can be realised.

Problems in Paradise

Māori health providers have acknowledged having start-up problems associated with new organisations, such as inadequate experience in human resource management and business skills. These can be accepted as an inevitable part of growing new organisations and developing new models. However there are underlying tensions amongst Māori providers that sometimes disempower Māori health workers within these initiatives. For example, multiple accountability is both an advantage and an additional responsibility for those working within such providers. There is also intense pressure to be part of the collective, with little room for individuality amongst some providers. Efforts to introduce continuous quality systems will allow some of these issues to be addressed within a structured framework for change but more is needed.

These problems also afflict everyone in the primary care team. For example some community health workers reported feeling "the last to be considered" by their provider. They were the "add-on at the end". Contracted doctors reported mixed feelings with relief expressed by some that they did not have to worry about the administration which was taken care of by administration staff, but concern expressed by others about their ability to continue training and up skilling. Some of them did this by working part-time at other Health Centres or by undertaking further training. Similarly, nurses also reported problems. In a Kai Tiaki: Nursing New Zealand article about Helen Taiaroa, a Māori

nurse with 25 years experience, worked for a marae based iwi provider in the Hawkes Bay but left within a short period of time. She describes a number of features also identified in this research. These features include the nepotism of an iwi-based service where members of one whanau were on the interview panel and were administrators for the iwi health provider. She found that this made it difficult to raise issues, once employed without offending someone. A Māori provider employee also expressed this view during the research that found the “whanau dynamics a little hard to take”. He explained that a few whanau members dominated the marae committee and also came to dominate their health Trust at times frustrating efforts to achieve fundamental changes in governance, management and staffing. Such matters were especially difficult to raise without major confrontations.

The Kai Tiaki is also critical of the lack of experience of those required to manage or govern health professionals.

They had no idea of the professional standards required of a registered nurse (RN). They had no knowledge or understanding of the legislation governing nursing or health. I was to provide an immunisation and asthma education service but my employers could see no need for me to do training in those areas (Unknown, 1998, p 27).

This lack of understanding of health was not raised by any of the case study participants, although again, health professionals did talk about this informally. In particular, the more clinically specialised they were then the more tenuous their understanding and greater the likelihood that their professional development would be inadequately supported by the provider (such as continuing medical education or continuing nursing education). Māori providers usually had no budget for staff training despite the high need by staff for such ongoing training largely because they prioritised other more consumer focused activities. This problem is not unique to Māori providers. Many other primary care providers also report major problems with upskilling staff, particularly nurses, for new roles. Joining IPAs that provided ongoing medical and nursing training was one way of resolving this problem. These providers also lacked sufficient budgets for training and education and when money was available it was prioritised for doctors.

Also, Māori providers did recognise the limitations of their staffs' skills and were mostly careful to provide only those services they could cope with at the requisite level of quality. Where expertise was lacking, it could be brought in by purchasing it (McLean, 1996, pp 15-16).

Two difficulties in particular affected this research, the first was that the initiatives were often so new that it was difficult for any form of outcomes based evaluation to have taken place. This also meant that staff were sometimes reluctant to express critical opinions during formal interviews, although freely expressing them outside of these. Within hui or other more informal gatherings, they were much more forthcoming. Secondly, the health reforms were seen as empowering for Māori and there was a strong desire on the part of the individuals interviewed to avoid undermining these. They were apologetic about raising difficulties and largely identified the problems as personally located rather than systemic. This is ironic given the empowering mandate of the changes.

Helen Taiaroā goes on to identify another issue expressed by one Case Study interview, namely the absence of suitable qualifications amongst those responsible for evaluating her performance. She also believed that the service was at times unsafe because of the absence of suitable qualifications amongst staff to deliver the services for which they were contracted.

Other human resource issues were identified as a, "poor rate of pay for my skills and qualifications. They were getting a cheap nurse" (ibid). These poor practices in human resources were also recognised amongst North Health Māori providers. North Health attempted to deal with this in at least two ways, the first was by contracting Awhi Health, a Māori health provider development company, to provide training to Māori provider managers on human resource management, and by encouraging further training and mentoring. This was of limited success because few Māori provider managers believed that they needed to change their practice as 'staff were happy with their jobs'.

Māori Health Development staff were occasionally asked to intervene directly with Māori providers to avoid major disruptions within providers. MHDD staff had authority because of their role as purchasers. It also meant that Māori Health Development staff were susceptible to being seen as overly interventionist by some Māori provider critics, or unavailable (because of the additional demands placed on them by more direct personal engagement with providers).

Another article in *Kai Tiaki* identifies similar issues.

This situation is compounded for some iwi provider employees by a real reluctance to raise any issues of discontent because they are employed by their own whanau (O'Connor, 1998).

These issues include pay rates, employment contracts, working conditions and coping with pressures caused by budget constraints. Taiaroa's concerns lead her to a view that, "I can do so much as a Māori nurse for Māori clients in this non-Māori environment" (O'Connor, 1998).

Criticisms Of The Purchaser

Criticisms of the Purchaser among Māori providers have centered around its underestimation of the true cost of providing services (bearing in mind that little accurate data exists about the costs of health services in New Zealand, or indeed internationally). More often however, providers expressed frustration with the continual rollover of contracts, with little or no opportunity to negotiate increased prices in the contract. These rollovers occurred at the expiration of contracts, which were usually bi-annual, or annual. Such short time frames meant that providers invested considerable personal resources in contract negotiations usually requiring significant management time. Many of these contract negotiations were amiable and therefore reflected the quality of relations that existed between the Māori Health Development Division and the Māori provider themselves. This is not surprising since many of the provider's contracts were based on the personal assessment of MHDD staff about the ability of these people to deliver quality health services to Māori patients or clients.

Following the euphoria of securing a contract, realities of providing health services started to hit home for Māori providers. This included the necessity for ongoing negotiations, staffing, provision of appropriate services and negotiation with other primary care providers.

Māori providers were funded by capitation, bulk funding or fee-for-service for their services by North Health according to projected patient numbers. This allowed them to pay staff, including their GPs, regular salaries. They were also entitled to claim GMS and ACC for patients, partly to offset the patient profile of high Community Service cards amongst patients and koha for those patients not working full-time. Despite this, many providers believed the funding levels were inadequate (Crengle, 1999, p 3).

Conclusion

Māori health providers have a number of defining characteristics identified in Chapter 9. They have also developed a distinctive way of working with much in common with other third sector primary care providers, while retaining core features of primary care in common with GPs. In particular, the kaupapa of Māori providers stresses the importance of accountability to their communities of interest, either their iwi or their specific geographic region and the people who live in them. In this respect they are more naturally inclined towards a population approach in health services, although the absence of population strategies in the rest of the health sector makes this more difficult. They are also more inclined to a holistic view and try and incorporate this in their practice by doing 'whatever is necessary' to assist the patient with their problems. They also have more blurred professional boundaries since they often interact with patients in settings other than the clinic.

Māori providers have an expressed desire to work with Māori for Māori. This commitment forms the basis of a Māori kaupapa integral to the strategic vision of the organisation, and is reflected in their operations wherever possible. Whether this constitutes a kaupapa Māori service is another question altogether. Māori providers' commitment to whanau, hapū and iwi and / or Māori communities, and the use of

community development as the key means of developing their health services, are all distinguishing features of Māori health providers.

This next phase of Māori provider development between 2000 and 2001 will include a continuing focus on quality of service. Unfortunately few tools are available against which measures of such quality of service can be determined. He Mahere Whakamua is a Māori model of quality of services for community health services and is based on Donebedin's model (Martin, 1997). It remains the only Māori quality of service model to date.

Did North Health pursue a political strategy as a means of achieving improvements in clinical outcomes? Certainly the approach is consistent with the theme of development as integral to health improvements. However, is there evidence that such strategies work? There is certainly evidence that the reverse is true, that is that health services with little Māori participation result in poor health status for Māori (Pomare et al., 1995). A definitive answer to the question of whether such strategies work to improve the health status of Māori is still some way off as health outcomes tend to be longer term measures of changes in society. There is also the additional problem of linking policy changes and health services to health status and health outcomes. Greater clarification about how all of these interact is required from future research, particularly with regard to how they affect vulnerable populations such as Māori.

Understanding how and if Māori providers can lead to improvements probably requires a much deeper understanding of the nature of New Zealand society and the type of development necessary for such improvements to occur. Any expectation that political strategies will alone improve Māori health outcomes seems optimistic.

Māori healthcare providers examined in this research shared many things in common with each other, including similar client profiles, experiences of similar marae and iwi politics and similar practices with respect to primary care. During the early stages of the health reforms Māori providers were often in competition with each other for contracts.

By 1998 this had changed considerably, with many establishing supportive joint relationships with other providers, including other Māori providers.

By the late 1990s Māori providers had begun establishing joint relationships with other health providers such as IPAs, CHEs and other community health organisations. The initial competitiveness promoted by the health reforms (believed to lead to greater accountability, transparency and efficiency) would be replaced by a more realistic and collaborative approach by 1996 following the election of the Coalition government.

Many iwi providers still expect preferential treatment in securing service and other contracts and this has been reinforced by North Health's successor, the Health Funding Authority, which has continued the commitment to mana whenua through their Treaty Relations policy that has prioritised iwi funding.

The Māori Health Development Team of North Health promoted policies that supported the rationing and public choice ideals widely promoted by successive National governments during the 1990s. However, their views were tempered with a strong commitment towards the need to engage Māori actively in all aspects of the health system and a desire to have success with 'their' Māori providers. These 'successes' were essential for convincing a new bureaucracy of the workability of by Māori for Māori health provision. Particular Māori providers chosen by North Health through the contracting process between 1993 and 1995 were significantly advantaged in the following years, securing regular roll-over in contracts and preferential tendering for other contracts. Other funds became available to support the enormous infrastructure needs of new health providers, including workforce development, information technology and asset purchasing. These funds consisted of TAGs funding and Māori Provider Development Funds.

During the late 1990s Māori providers consolidated their primary health services, offering an increased menu of services to an increasing number and range of patients. In some cases Māori providers came to specialise in particular areas such as family services

(sometimes associated with other contracts secured by the parent organisation), mental health, diabetes clinics, and pediatric services. This specialization has enabled Māori providers to move peripherally into new areas and expand their services. They are also able to offer a form of sub-specialisation within community settings that is consistent with other developments in primary care (Minister of Health, 2000b).

However, fundamental questions need to be asked about the nature of the risk being taken on by the Māori community in Māori health; the take-up of population approaches to health for Māori; the effectiveness of such approaches in the context of the overall reforms of the government; the sustainability of Māori health providers, and the quality of services provided.

CHAPTER 11

Mainstream Enhancement And Māori Provider Development

Introduction

The development of by Māori for Māori providers was the major strategy pursued by North Health resulting from the Crown's objective to achieve greater Māori participation in the health sector as a means of ensuring Māori health gains. Two other strategies were also employed; mainstream enhancement and Māori provider development. The Māori provider development strategy pre-dated the national initiatives of the Ministry of Health and Health Funding Authority between 1998 and 2000 that resulted in funding for the Māori Provider Development Scheme (MPDS). While the previous two Chapters examined by Māori for Māori providers in the primary care sector, this chapter examines these latter two North Health strategies.

Only one contract was agreed for each of these other strategies in Auckland, one with a mainstream Māori provider in a large Crown Health Enterprise (CHE), and one with a wholly Māori owned limited liability Company which provided consultancy services to those Māori providers referred by North Health. Both of these contracts have been regarded as unique in New Zealand (Te Pania-Palmer, interview, 11 March 1999). These contracts were unique because they were the only contracts of their type nationally, and because they provided services that were different to those offered by other Māori providers.

With regard to the CHE provider, while there were other contracts with CHE to provide a Māori presence through cultural advisory units, neither of the other two Auckland Māori units had the change management focus of this particular provider.

A bi-cultural contract was also approved in Northland with Te Hauora O Te Hokianga, followed soon after by a public health contract with Te Hauora O Te Tai Tokerau (known

as THOTT)²³ and a Tai Tokerau MAPO during the phase of MAPO development. These contracts are not dealt with within this research as they were not among the Case Studies.

Case Studies

As indicated above, there are two Case Studies in this section with one example of each one of the remaining three strategies (that is the mainstream enhancement and Māori provider development strategies) adopted by North Health with respect to Māori health. These two case studies are He Kamaka Oranga from Auckland Healthcare and Awhi Health. He Kamaka Oranga is the sole example of the mainstream enhancement strategy and Awhi Health is the sole example of the Māori Provider Development strategy.

Mainstream Enhancement Strategy: He Kamaka Oranga

Mainstream enhancement means improving mainstream providers' services for Māori patients. This can be achieved in a number of ways, but essentially means making services more appropriate (that is, more acceptable, relevant and responsive). There are two assumptions made here, firstly that many mainstream services are not appropriate and therefore do not meet Māori health needs (therefore relating to outcomes for Māori), and secondly, that it is possible to improve the quality of mainstream services by making them more responsive, relevant and effective.

He Kamaka Oranga is a bi-cultural CHE-based service responsible for Māori Health Management. Their Kaupapa / Mission Statement is;

To provide sustainable Māori Health management to improve the quality of life for Māori and all other people in Tamaki Makau Rau - while preserving those visions and qualities unique to Māori (He Kamaka Oranga, 1994, p 2).

He Kamaka Oranga has had a contract with North Health from 1994. Its contract was an acknowledgement of the need to do something within the Crown Health Enterprise environment and the desire to adopt a more strategic approach in turning around a large

²³ Te Pumanawa Hauora completed an evaluation of THOTT for the Health Funding Authority in 1999.

and complex organisation to become more responsive to Māori patient needs. Both the provider and purchaser recognised that this would be a big job and that it would probably take some years to achieve direct benefits for Māori patients who used these services. The goal was to change the CHE environment so that it was better able to respond to Māori patient need, thereby improving Māori health status.

The patient using these services, as opposed to by Māori for Māori services, was inevitably involved in a more acute or serious illness episode. This is particularly so for Māori patients who present with more co-morbidities and in more acute states than non-Māori, making it more difficult to treat them. Despite this, they often have less money spent on them in hospital interventions than non-Māori (Jackson, 1999; Vaithianathan & Mutch, 2000).

He Kamaka Oranga also provided a safety net from Māori politics for the CHE by deferring things Māori to the General Manager. They could identify with a broad spectrum of Māori, from mana whenua iwi to urban Māori groups. In particular General Managers' close relations with iwi Runanga would enable them to benefit from the iwi-favourable policies of the Purchaser which dominated purchasers' strategies with regard to Māori health from the mid to late-1990s.

Māori Provider Development Awhi Health

Awhi Health signed a contract with North Health in October 1995 after approaching it in 1994 initially for another type of service. North Health's Māori Health Development Division identified a gap in the market and suggested that the skill mix of the new company might be better suited to supporting Māori providers, particularly with management and business advice. The contract negotiated was for a limited budget working with Māori health providers subject to MHDD approval. While these providers initially included all those within the North Health catchment area, including Northland, this was subsequently changed in 1996/97 to specify only Auckland based MHDD funded providers (as opposed to any provider irrespective of their being funded by other service teams in North Health such as mental health, disability or public health).

This Case Study also performed work on behalf of the Purchaser itself, in the primary care and secondary care environments also. This work included business planning, applications for funding and general management advice and training and also evaluations of health providers.

During the establishment phase of Māori health providers (between 1993 and 1996) this development role consisted of writing business plans, providing small intensive training courses for managers on human resources, the role of governance and management. Later during the consolidation phase (1995-1998) topics for training included integrated care and quality of service accreditation.

While not working directly with Māori patients as the 'by Māori for Māori' providers did, Awhi Health nevertheless worked with providers who delivered services to these patients and thus maintained a commitment to improving the health of Māori patients and their whanaū through the provision of quality healthcare services in common with all other Māori health providers.

This role of working with both the Purchaser and providers led to some confusion among providers about what Awhi Health was there to do: to gather evidence of performance for the purchaser or to meet their needs in an area of difficulty. Such confusion and skepticism about the ability of the provider by other Māori providers, led to under-utilisation of the contract during the first two years. Interestingly, Māori providers were keener to use outside large consultancy firms such as KPMG, Ernest Young and Arthur Anderson, in preference to this low-no cost Māori alternative.

Working In A CHE Environment

He Kamaka Oranga's contract allowed for shared funding between the host organisation and North Health with 50% provided by the CHE itself, and 50% from North Health as an addition to the CHE budget for funding this service. According to He Kamaka

Oranga, the rationale for this contract with Auckland Healthcare and North Health reflected

The elevation of an integrated Māori Health Management function to corporate status. This movement symbolically signaled the importance of Māori Health and Te Tiriti O Waitangi within Auckland Healthcare. It also enabled Māori Health Managers to gain a comprehensive strategic overview of the whole organisation for the first time, and its performance relating to Māori Health Service (He Kamaka Oranga, 1994, p5).

Following the appointment of a new Chief Executive to the host CHE, a review was conducted of He Kamaka Oranga and following a substantial staff turnover, the service was restructured during 1998. This restructuring falls outside the time period of this study, so the discussion here is primarily about what occurred between 1994, when the service was established and 1997, when the Case Study period ends. However, some reference is made to subsequent changes as with other sections to improve our understanding of how this strategy unfolded.

He Kamaka Oranga's service was organised for both corporate liaison and service liaison within each hospital and CHE community health setting. The General Manager of He Kamaka Oranga was a member of the senior management team of the CHE until 1998 when a restructuring established a separate Manager's position for the service and a new role for the General Manager as an advisor to the CEO. The Manager of Māori Health Services remained a member of the Executive Management Group. He/she enjoyed a close working relationship with the position of General Manager established as a result of the first restructuring.

He Kamaka Oranga is a Māori change management service established to assist the CHE to implement Māori appropriate services. The development of Māori providers was intended to improve the access of Māori clients to "culturally safe and effective health care" (A Plus Newsletter, Auckland Healthcare, March 1997, p3). Specifying exactly what this meant has taken considerably longer than anyone anticipated. Part of the

problem is that much of what was considered kaupapa Māori related to primary care, while little had been developed on this within the secondary and tertiary sectors. It was compounded by an historical approach within CHEs to advisory units who tended to be the 'dial-a Kaumātua'²⁴ arm of the organisation, rather than contributing to substantive decision-making in the organisations.

A review of He Kamaka Oranga conducted by the purchaser in 1997, concluded that the mainstream enhancement strategy had been worthwhile, but it needed to find a new direction if it was to continue to be effective. This direction included reorienting its role, separating tikanga matters from business matters, and reorienting the policy making role of He Kamaka Oranga within the corporate body of the CHE, while also looking for a more direct relationship between Māori service managers and corporate strategy.

Operating within an existing mainstream provider presented added difficulties for this Māori provider. The obvious need to fit within an existing organisational structure and to comply with organisational requirements, is one small part of this difficulty. This was further complicated by the level of complexity of this CHE environment, with its regional, national and South Pacific specialties. Such specialization inevitably led to high levels of professionalisation within specialties and sub-specialties, making requirements for Māori input more difficult to identify and negotiate. Furthermore, these specialisations occurred within an organisational structure that negotiated these interactions for each patient. Co-ordinating these services across the spectrum of support services, acute services and specialties was difficult enough, let alone convincing them that it would make a difference to the quality of their service and clinical outcomes if they responded to Māori input.

The Māori Health Management Service was established at this CHE as a direct response to the Crown's objectives on Māori health. The inclusion of Māori health at the

²⁴ Dial-a-Kaumātua is the slightly derogatory term used by Māori to refer to token use of Māori expertise by organisations, where they call on Kaumātua and kuia to assist for events such as blessings and welcomes, but little else.

corporate level was considered an achievement for Māori health services. As the CHE explains:

This movement not only symbolically signaled the importance of Māori health and the Treaty of Waitangi within Auckland Healthcare, it also allowed Māori Health Managers to gain a comprehensive overview of the whole organisation for the first time and its performance relating to Māori health (Auckland Healthcare, 1998).

He Kamaka Oranga was to effect change through input into policy and planning, and by monitoring the performance of the CHE with respect to Māori. While some efforts have focused on gaining the support of general managers and service managers for Māori health gains, little attention has been paid to gaining the loyalty and trust of senior clinical staff. Of major concern was the scarcity of appropriately trained Māori staff in the health sector. Workforce development therefore became necessary. Auckland Healthcare estimated its Māori workforce at less than 2% of their total workforce of 6,800 in 1997.

One difficulty identified in the Review of He Kamaka Oranga in 1997 and the Service Level Cultural Quality Review in 1997, was the need to translate these philosophical principles into operational activities. This required both expertise to translate these cultural and philosophical principles, and interest and commitment by service level clinical and management staff.

Clear themes emerged, such as the need to link corporate philosophy, that is, Board Governance and Senior Management commitment on Māori health, to human resource practices, professional values and clinical practice. This was absent in all providers (Māori Health Development Division, 1997c, p 2).

The reference to all providers is for all Auckland CHEs who were the subjects of this review (in addition to one Northland disability provider).

How Do These Initiatives Compare With Other Māori Health Initiatives?

These two strategies of mainstream enhancement and Māori provider development differed from the 'by Māori for Māori' health providers' initiatives in crucial ways. They represented an attempt by North Health to address two important realities of the health system; the dominance of mainstream providers in servicing Māori and the embryonic state of Māori provider development within New Zealand during the period of the 1990s reforms.

These initiatives can be considered as having three dimensions of difference; the sector that the provider operates within, service orientation and ownership structure. Differences between these strategies and other Māori provider initiatives considered in the case studies are summarised in the Table below. These case studies are reflective of the range of Māori providers within the Auckland region during the period 1993 to 1997.

With respect to the sectors within which the provider operates, these range from primary and community care for 'by Māori for Māori' providers, to secondary and tertiary care for mainstream enhancement. The Māori Provider Development provider works across all these sectors in health, providing consultancy advice to all types of Māori providers, to both for Māori provider development. These providers include those who are mainly concerned with primary care provision in a General Practice environment, to those operating more strategically as change managers within a hospital and community services environment. The last type of Māori provider, the Māori provider development contract works with Māori providers across a broad spectrum of services ranging from the health purchaser, to by Māori for Māori providers to those working in mainstream enhancement. Differences in legal structure and ownership illustrate the divergence between these providers. The 'by Māori for Māori' providers are owned exclusively by Māori trusts who are affiliated to 'parent' Māori organisations such as iwi Trusts or Māori urban authorities. In comparison, the Crown Health Enterprise owns the mainstream enhancement provider and a private company owns the Māori provider development provider.

Table 23 Differences Between North Health Māori Providers

By Māori For Māori	Mainstream Enhancement	Māori Provider Dev.
Primary and community care orientation	Secondary and Tertiary care oriented	Work across primary, secondary, tertiary and purchasing environments
Owned by Māori charitable organisations	Owned by CHE	Owned privately by Māori
Multiple providers (including disability, mental health and primary care)	3 providers in Auckland in each of the main CHEs (excluding other Māori units within specialist areas such as mental health)	1 provider – although independent private sector consultants widely available and used
Operational orientation	Strategic orientation	Developmental orientation
Direct client service provision with health promotion orientation	Indirect client service provision with change management orientation	Indirect client service provision with provider development orientation
Funded mainly by health purchaser with some ‘top-up’ and establishment costs met by owner	Joint funded by health funder and CHE	Funded mainly through private work with a small contract base contract with the Purchaser

Mainstream enhancement was one arm of the strategy developed by North Health to achieve Māori Health Gains, as per government policy and North Health and the Minister of Health’s annual funding agreement. This CHE contract differed from other Māori provider contracts in a number of ways. Firstly, it was located within a CHE service. Secondly, it was bi-cultural (not by Māori for Māori). Thirdly, it focused on corporate change rather than direct service provision.

For these reasons, this case study is unique and provides insight into how Māori health gains were taken up in a CHE corporate environment, in conjunction with an evolving Māori managers service at service and hospital levels. Furthermore, it appears that this CHE has been more proactive than others in implementing a corporate change strategy and establishing a separate Māori health service arm across its range of services (Māori Health Development Division, 1997c).

Māori providers shared a common view that many Māori patients had been under-serviced with regard to primary and secondary care services. This has been borne out in subsequent studies showing that Māori under-utilise health services relative to their high health needs (Gribben, 1999; Jackson, 1999; Jackson, Kelsall, Parr, & Papa, 1998; Malcolm, 1996; Scott, 2000; Vaithianathan & Mutch, 2000). This view was widely accepted amongst the case studies and was shared by the purchaser. They believed that Māori health status reflected a lack of investment in Māori health and furthermore, that there was inappropriate care in the health sector that failed to account for the 'cultural' aspects crucial to health improvement for Māori. These cultural determinants were identified in the National Health Committee report (National Health Committee, 1998) and were also suggested in a re-analysis of the data for the 1996/97 New Zealand Health Survey which showed that despite evidence that Māori visited GPs more frequently than non-Māori (and contrary to common perception), they did not visit often enough when their health needs were considered (Scott, 1999; Scott, 2000).

Crown Health Enterprise Māori Cultural Units

All Crown Health Enterprises within Auckland found different ways to accommodate Māori needs within their structures. All of the CHEs established a Māori Cultural Unit to act in an advisory capacity. The degree of influence of each of these units varied, but what is clear is that only one of these Māori 'units' was designed to explicitly influence the corporate culture of the organisation and retained the right to sit on the Executive Management group for that CHE. Units in other CHEs appeared to have a more generic and advisory role rather than responsibility for organisation wide policy development and a capacity for input into service level planning. He Kamaka Oranga therefore had a

responsibility for affecting the corporate policies and culture of the CHE in ways that were intended to be beneficial to Māori. This included reviewing, advising and writing policies on Māori health within the CHE, as well as service-based responses for specific areas such as how the CHE should deal with tupāpaku and interact with whanau during illness or death within a hospital setting. Some of this advice can be described as trying to make health professionals' behaviour more appropriate and is therefore an extension of the cultural safety discourse that has occurred within the nursing profession in New Zealand.²⁵ However, some of this advice also concerned a more systematic response by the CHE and became reflected in formal policies. For example, the attempt to secure early release of the tupāpaku so the whanau could hold tangihanga, and active encouragement of whanau in caring for their member wherever possible within the hospital setting (assuming it did not interfere with necessary medical procedures).

Cultural advisory units in other CHEs tended to concentrate solely on the advice at the level of individual service or health professional, rather than the more systematic approach adopted by this CHE (Māori Health Development Division, 1997c).

Despite this, there remained significant problems with the service, including the lack of sufficient integration between corporate and service level Māori analysts and managers. There were also major shortcomings in the quality of relations between the service and senior managers in terms of securing 'buy-in' for recommended changes and similarly, absence of understanding of their role among senior clinicians.

This process of translation of Māori health principles into mainstream services is not straightforward. There is an active discourse among Māori on how fundamental cultural

²⁵ This discourse arose from a challenge by Māori nurses to non-Māori nurses (and other health professionals/ managers) about the safety of their practice for Māori patients, given that they often did not understand even basic cultural values (such as the tapu nature of the human head). It was further argued that nurses had a responsibility to learn how to respond more appropriately to cultural needs to guarantee this safety to Māori patients. This influenced nursing education curricula and consequently resulted in a few high profile media cases regarding challenges to these ideas by Pakeha students.

principles such as mana, can be interpreted within a health setting. Being able to measure such a principle during the process of health intervention is even more complicated. This kind of cultural translation is one of the many challenges facing He Kamaka Oranga and clinical staff. The Strategic Plan 1998-2007 for He Kamaka Oranga identifies these key Māori principles as,

1. Maintenance of a vital spoken language
2. Tribal control and usage of traditional lands, forests, lakes, rivers and seas as providers of spiritual and material sustenance for the people
3. Recognition of the social, dietary and economic importance of traditional food sources free of restriction, pollution and plunder
4. Primacy of the Māori health ethic and its spiritual components, including access to traditional Māori medicine and its practitioners
5. Reasonable access to Western medical services

The plan goes on to identify the following as underpinning any act, process or mechanism of these principles with respect to Māori health

1. The importance of tikanga and te reo Māori
2. A need to recognise the mana of the iwi, hapū and whanau and respective responsibilities for the health and welfare of their people
3. Incorporating whanau concepts into the delivery of health services
4. Recognising indigenous yet complementary Māori approaches to health and healing
5. A need for Māori to have access to the benefits of Western medicine

The healing practices used by Māori encompass five main practices. This includes the use of rongoa (medicinal flora), mirimiri (massage) and ritenga / karakia (incantations and rituals), wai (water) and surgical interventions (Durie, 1998c, p 18). Differences between traditional Māori and western scientific approaches to health may be less obvious than they were a few years ago. There appears to be convergence in some health practices with the growing acceptance of the importance of environmental and social factors on health and well-being. As Durie explains;

Only recently has the influence of mind on health been given widespread medical prominence. Actual physical changes associated with placebo response have been measured. Causative agents in any illness have been shown to encompass a multitude of factors: physical, psychological, social and environmental. In one sense the holistic Māori tradition had been ahead of the Western preoccupation with individual pathology as if simple cause and effect relationships existed between host and disease. But, in another sense, Māori traditional practices have much in common with pre-industrial western emphases on religion and moral behaviour as explanations for illness (Durie, 1998c, p 21).

The Service Level Cultural Quality Review report showed that there was some knowledge of and goodwill amongst medical and nursing staff towards Māori health approaches within the CHE. For example, “staff made varying attempts to provide culturally relevant care”, (Māori Health Development Division, 1997c p 20) and “Staff feedback suggests goodwill towards organisational responses to improve Māori health” (ibid, p 23). However, there were also problems identified which required a more systematic and organisational-level response, rather than individual clinical response. For example, “[there is a] risk of stalling or regressing in their development and understanding of Māori health issues due to changes in training and unmet staff expectation” (ibid, p 23). While staff at Starship were willing and able to use Te Whanau Atawhai and Te Kahurangi services by asking Kaitiaki for help there was a need to further integrate these resources with services and to establish organisational protocols that help staff understand “the purpose and relevance of Māori services and support mechanisms” (ibid, p 20).

In contrast, other Auckland CHEs tended to use their Māori Advisory Units (or Cultural Resource Units) for generic purposes with even less clearly defined protocols for their involvement. Those matters seen as Māori ‘issues’ that occurred during health interventions were referred by clinical staff to the Cultural Unit. These Māori ‘issues’ were therefore seen as extraneous to their clinical practice and not as an aspect of cultural quality care (Māori Health Development Division, 1997c, p 3). These approaches are

questionable for Māori patients because they enable the add-on approach to continue with no systematised development or organisational and professional response to aspects of cultural quality practice.

Māori Health And Continuity of Care

It can be argued that the better meeting of Māori cultural need (as well as clinical need), will increasingly be a business imperative for mainstream providers as Māori providers develop and provide alternative choices for Māori patients. The belief amongst the primary care Case Studies in this research was that Māori patients will choose to go to Māori providers increasingly because they are offering appropriate clinical care, but also because they offer culturally appropriate care. However in respect of He Kamaka Oranga this was a somewhat academic exercise when considering CHE based services since there are no Māori secondary or tertiary Māori providers. This is due in part to the complexities involved in providing such services with the requisite skills and mix of services required (including x-ray, laboratory, physiotherapy and psychological assessment). These are also resource intensive services with high price tags.

While Māori have been willing to take on additional risk by acting as brokers in purchasing secondary and tertiary services and sub-contracting to suitable providers, transferring this level of risk to Māori providers has been assessed as too high given the relative inexperience of Māori providers in the secondary and tertiary care market (Hon. Wyatt Creech speech to IPA Network Conference, Awataha Marae, 26 March 1999). Instead, the Super Clinic at Middlemore Hospital with Raukura Hauora remains the only example in Auckland, of Māori realisation of this type of service.

The transfer of activities previously deemed secondary or tertiary may change however, with a trend in primary care towards minor surgical procedures performed by trained specialists working as GPs within the community. These changes within the hospital sector also coincide with an increase in day surgery procedures and community based care where patients are discharged to the community following surgical procedures or other hospital interventions, or where they are treated within the community rather than

within the hospital setting. In this respect, Māori providers are part of a much larger trend of hospitals reaching out to primary care and primary care reaching out to hospital services. This primary / secondary integration has been gathering strength as it offers the potential for a seamless transition within the health sector. The focus would be on the continuum of care for patients irrespective of their health 'episode'. The choices for patients about where they could be treated for a wider range of illnesses would increase, and it would be possible to better utilise their own support structures within their communities, thereby minimising disruption to their families and lives. Such ideas have gathered further momentum with the election of the new government and release of discussion documents from the Minister of Health (Health, 2000b) and Royal College of General Practitioners (Taskforce, 1999).

This blurring of sector lines may suit some Māori patients particularly well. There will be some medical conditions that require hospital intervention and Māori are more likely to have co-morbidities and may also have fewer support systems able to care full time for them during a period of convalescence. All of these may mean that hospital care will remain an important component of treatment for illness for Māori. This suggests that considerable effort is needed to improve mainstream services responses to Māori patients.

Despite the importance of specialist clinical staff in Crown Health Enterprises and the obvious difficulties of recruiting suitably trained medical and nursing staff, none of the Crown Health Enterprises, including Auckland Healthcare, was able to show a clear Māori workforce development strategy (Māori Health Development Division, 1997c). There are a number of reasons for this lapse, not least being the long-term nature of the task. Specialist medical training requires enormous resources and New Zealand health providers have had almost no responsibility for direct workforce development except through making training opportunities available to doctors and nurses. Universities and Polytechnics are trying to cope with recruitment of Māori into medicine, nursing and

allied professions through innovative programmes such as Vision 2000.²⁶ Workforce development has been identified as an essential part of the next tier of strategies in Māori health, but all of these will take time to come to fruition, and once trained, keeping doctors, nurses and other allied professionals in New Zealand will be a further challenge.

Organisational Structure of Crown Health Enterprise / Hospital and Health Services

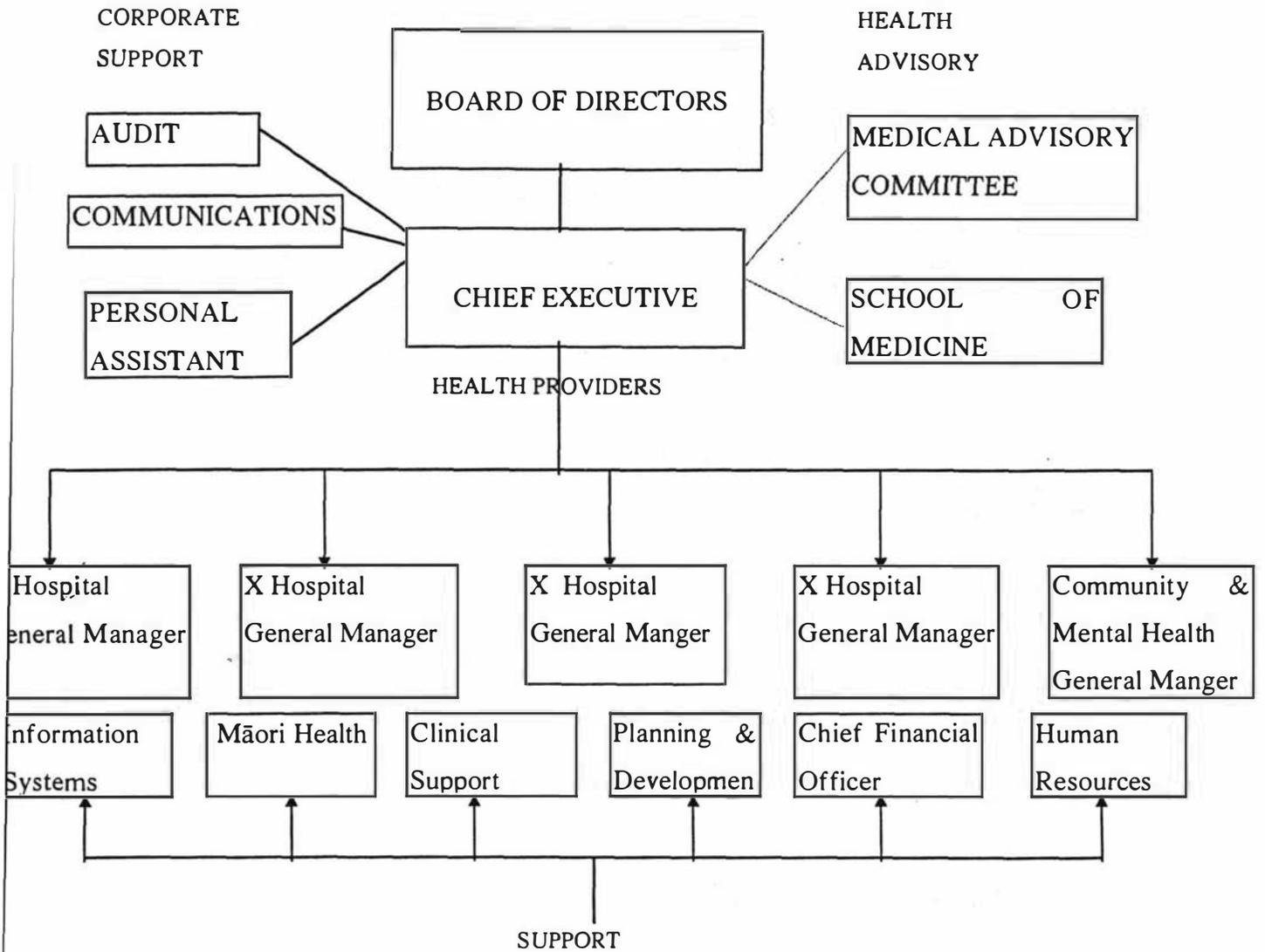
The shareholders of the CHE are the Ministers of Finance and Health of behalf of New Zealand citizens. With 7500 staff and four hospitals, the CHE provides services of national and regional significance (Auckland Healthcare, 1998, p3).

An initiative by He Kamaka Oranga to establish Māori Service Managers will result in a matrix structure in Māori Health Management within this CHE, where He Kamaka Oranga will provide corporate oversight, policy and planning roles for the overall organisation, and Service Managers will provide Māori oversight for particular hospital sites and / or services. This is intended to address the problem of integrating services with corporate objectives.

CHEs are incredibly complex health bodies, with highly trained health professionals working within highly segmented and specialist areas. This is exacerbated by the 'silo' mentality, which dominates health services within New Zealand. This mentality views hospital sites as the defining feature of health services. As such, it cuts across continuity of care and utilisation of the full range of services available to patients. Reconciling this reality has created major challenges to protecting the mana of Māori patients and their whanau. Unfortunately, very little literature exists that explicitly addresses this silo mentality, despite the fact that managers regularly talk about this preventing more effective multi-disciplinary team and multi-site work for patients.

²⁶ Vision 2000 is a Certificate Health Sciences course offered at the University of Auckland Medical School with the hope of identifying people suitable for entry into Medical School.

Figure 16 Organisational Structure of Crown Health Enterprise (He Kamaka Oranga, As at July 1997)



Source: Auckland Healthcare internal report, July 1997.

This tendency to work within disciplines such as Oncology, Hematology, intensive care or Pediatrics has implications for Māori patients since they are more likely to experience co-morbidities requiring more cross-discipline coordination.

Within CHE environments senior clinicians have a crucial role in decision-making, since they provide the services that constitute the core business of CHes, namely specialist

health advice and treatment. This is countered to some extent by the power of managers. During the period of neo-liberal reforms, some authority held by clinicians under the old structures, was transferred to managers (Pollitt, 1994). This change is due in part to the culture of general management promoted during the late 1980s when general management was introduced in a series of legislation during this period such as the State Sector Act 1988, Public Finance Act 1989 and Area Health Board Act amendments. The effect of this was to increase the need for Māori providers to influence both senior managers and senior clinicians to implement changes beneficial to Māori patients and whanau within CHE, whilst appeasing the Purchaser, Māori and public at large.

Other He Kamaka Oranga Issues

He Kamaka Oranga had a three-fold responsibility in the CHE: advising and reporting to the CEO, advising the General Managers about services and hospitals, and advising other staff on an ad hoc basis. The totality of this advice constituted an organisational response to Māori patients and whanau, and sometimes led to formalized policy. Existing policy was also reviewed and rewritten in some instances.

He Kamaka Oranga's manager had the same status as a General Manager, reporting directly to the Chief Executive and participating in the Executive Team for the CHE.

The role of He Kamaka Oranga was to prepare Māori policies for the CHE and to garner support within the organisation for greater responsiveness to Māori patient need. This included re-writing the bi-cultural policy of the Auckland Area Health Board and other policies such as 'Arahi Whanaungatanga' that promotes the interests of Māori whanau within the CHE. This policy relies on an

Integrated single CHE focus so that the service Māori received in Starship²⁷ was the same service they were going to receive in Auckland as in Green Lane as in National Women's as in Community [services].

²⁷ Starship Childrens Hospital is the largest child specialist hospital in the South Pacific, and is based in Auckland.

Māori had an integrated single CHE focus for Māori [To] set the benchmarks (Glavish, 1997, p1).

Ensuring acceptance and implementation of these policies at CHE Board level was considered essential to their success. Failure to do this, they believed, would make them a tekoteko (an add-on figurehead).

He Kamaka Oranga had no peers whom they could ask for assistance or guidance as no one else in the country was doing what they were doing.

We set the benchmarks ... we had no-one in the country we could look to for support or help...there was nothing there ... to my knowledge, there is no Māori corporate service that is a direct report to a CEO that has the same powers of influence and decision making as He Kamaka Oranga (Glavish, 1997, p 2).

While an enormous amount has been achieved, they recognise the need for further improvements. Early establishment efforts focused on getting staff on board, making themselves known to managers and Board members and clinical staff, and identifying the principles and symbols that enabled a unifying force to be developed around their work. For example, the logo of He Kamaka Oranga consists of three koru, which together represent a philosophy. The policies are developed around this philosophy. The koru design of the CHEs Māori Change Management Service reflects the Māori ideas around the three cycles of life. The first cycle represents the period in the mother's womb; the second cycle the period of whanau, hapū and iwi (the living world as Māori know it), the third cycle represents the journey from this life, to the afterlife.

CHE policies did not reflect these ideas at the time. Thus policies have been derived from these principles by HKO: for example, the way in which tupāpaku (corpses) were treated. All rights that people held in life were transferred automatically to the whanau, hapū, iwi on their death (Glavish, 1997).

As another example, the Arahi Whanaungatanga philosophy included intangibles such as tapu, ihi, wehi, wairua and mātauku. These are complicated concepts requiring an in-

depth understanding of Māori society and are therefore understandably difficult for those outside the culture to grasp. Adapting these for incorporation into large and complex health organisations makes the challenge of policy formulation even more difficult. He Kamaka Oranga has used Māori concepts and ideas as the yardstick by which to make moral and clinical judgments about Māori patients. Thus a tupāpaku is “not a piece of meat” (Glavish, 1997), but continues to maintain its mana until returned to papatuanuku (mother earth). If this assumption is made then the tupāpaku must be treated with the same kind of respect reserved for living people - this includes talking to them, ensuring they are with their whanau, hapū, iwi such as returning the body promptly to the whanau following death and minimising surgical intervention (including autopsies).

Reconciling traditional cultural values with modern medical practice in large public hospitals is difficult. Health professionals and health managers want someone to tell them exactly what the implications of particular principles and concepts are, and this is not always possible or clear-cut. One of the first difficulties is in explaining the principle or concept itself. Then there is the challenge of applying these principles in this environment, and then there is the problem of identifying a way of operating which addresses Māori cultural need alongside medical clinical need.

Historically, only medical need was considered - so the introduction of another matrix of considerations has added to the complexity of clinicians' work. Their reward is to participate in a type of care that is regarded as more appropriate and successful by Māori clients. This may, or may not mean, that the medical interventions are ultimately successful in preventing illness or extending life.

Significantly, consumers of hospital services may well be more concerned with how they were treated by staff, than with the health outcome per se. The relationship of trust established with their key caregivers was identified as a crucial component in the healing process by patients (Quality of Service data, Auckland Healthcare Services 1992-1998).

Future of He Kamaka Oranga

The restructuring of He Kamaka Oranga following the review of 1997 sought to clarify the respective roles inherent in managing He Kamaka Oranga including policy development and line management expertise and Māori tikanga expertise. Between 1994 and 1998 the needs of Māori health services had changed partly as a response to the evolving Māori Service Managers who reported through their Service Managers and through He Kamaka Oranga for Māori outcomes. It also recognised that change management required a new skill mix with a greater emphasis on specific policy development, monitoring expertise and line management responsibility. The matrix of Māori Service Managers and Corporate Policy Analysts would require greater co-ordination and a clearer strategic direction.

The proposed corporate role for He Kamaka Oranga requires,

- Ensuring that the Māori health strategy aligns with He Kamaka Oranga CHE strategy
- Coordinating business planning in Māori health
- Monitoring and evaluating He Kamaka Oranga CHE systems
- Developing / co-ordinating monitoring and evaluation follow-ups
- Providing leadership advice

Performing this role requires that the silo mentalities mentioned earlier, are addressed to ensure adequate coordination across services with the patient as the basis for such transactions between specialties and support services. There is also the added difficulty of validating Māori knowledge and skills and incorporating aspects of Treaty partnerships within the running of these large organisations. Convincing managers and clinicians that there should be changes requires evidence of benefits and persistence at all levels within the CHE. Constant restructuring and changing rules within the health sector has done little to stabilise the organisation so it can concentrate efforts on addressing these fundamental and long-standing problems.

As with many other health services, another review of He Kamaka Oranga took place in 1999. The results of this review were unavailable at the time of this thesis completion

but were likely to include a further restructuring to facilitate the matrix structure including a focus on working with the general managers and a service level focus of dealing with senior clinicians and service managers who are responsible for operational activities. It may also clarify the respective responsibilities within the CHE of the Manager of Māori Health Services and General Manager Tikanga.

Bi-Culturalism And Māori Health Development

The debate around bi-culturalism has largely died in the 1990s, despite the vociferous support and soul searching which occurred within government departments in the 1980s following publication of the Department of Social Welfare report on Institutional Racism in the mid-1980s and *Puao-te-ata-tu*²⁸ in 1988. This may have resulted from three things: the frustration experienced by Māori in trying to turn around large government bureaucracies to become more sensitised to Māori needs, the rise and dominance of neo-liberalism, and the shift of these together to a more localised, iwi based response contracted out from central government.

The mainstream enhancement strategy was similar to those initiatives undertaken during the late 1980s under the banner of biculturalism being more towards the middle of the continuum proposed by Durie (1998) in *Whaiora*. This strategy included aspects of bicultural reformism, with the adaptation of Pakeha institutions to meet the needs of Māori, and bicultural distributivism, under which different and specific Māori institutions would share authority as defined by the Treaty (Durie, 1998c, p 102). This health initiative goes further than the acquisition of cultural skills and knowledge and a better awareness of the Māori position. It includes a clearer focus on Māori issues and networks in the search for better outcomes for Māori in all activities and even, the possibility of joint venturing within agreed frameworks with independent Māori authorities (primarily iwi) (Durie, 1998c, pp 101-107).

²⁸ *Puao-te-ata-tu* was a 1987 report by a Ministerial taskforce on the Department of Social Welfare. The findings of this widely consultative report chaired by respected Kaumātua John Rangihau, were widely believed to have contributed to substantial practice and policy changes within the Department, and to the ground-breaking 1989 Children, Young Persons and Their Families legislation.

The purpose of the He Kamaka Oranga initiative is to respond to a series of layers of accountability to Māori including the Treaty of Waitangi, Crown Objectives with respect to Māori Health Gain, Purchaser Contracting Schedules (Hauora Schedule), internal staff pressure, and iwi and Māori community pressure. Thus there is a constellation of legislative, policy and personal pressures to provide some systematic response to Māori health need within the CHE along with a series of stakeholders interested in seeing something done.

The initiatives that allow for greater Māori independence, particularly those with iwi control, are considered to fulfill tino rangatiratanga requirements. Clearly iwi control of services such as those directed and funded by the CHE are limited, although they may have input into decisions around service planning, policy and sub-contracting. Services within CHEs are primarily designed to meet internal needs. They must also satisfy the Purchaser that they have a legitimate place in the greater scheme of Māori health gains. Such an argument is relatively straightforward since the overwhelming majority of Māori patients continue to use mainstream services. Therefore, irrespective of our ideological commitment to rangatiratanga, some greater responsiveness by these services is required to meet Māori health need. The absence of a Māori secondary or tertiary service, means it is not possible to evaluate the extent to which Māori patients would use such a service, or the extent to which such a service would improve health status for Māori. What is evident, is that existing services probably under-treat Māori given their health need (Jackson, 1999; Vaithianathan & Mutch, 2000).

There are a number of reasons why Māori patients may choose not to use mainstream primary, secondary and tertiary services. These reasons include patient loyalty to existing providers; specialist services that can't be provided by Māori providers currently, such as intensive care, accident and emergency and many specialist services; limited choice of Māori providers within their locale, since most primary health initiatives are located within sizable communities and are not uniformly available around the country; and, a perception by some Māori patients of inferior quality or lack of credibility of

Māori providers (probably linked to the relative newness of the initiatives rather than their personal use of the service).

Because of the number of Māori using these mainstream services and the scope (geographically and clinically) of these services, it is surprising that so little attention has been paid to improving their cultural responsiveness. Rather, energy has been concentrated on consolidating independent Māori providers in the primary sector. The reasons for this have been rehearsed in earlier chapters but bear repeating here. This rationale particularly resonated with the thinking of successive National governments during the 1990s.

Māori utilise primary health services less than non-Māori (Gribben, 1999; Malcolm, 1996), and therefore suffer from levels of illness that are preventable, or present at hospitals with more acute episodes. Successfully reorienting primary health services offers the greatest opportunity to promote wellness, prevent illness and save money. As the population with the greatest burden of illness in New Zealand, Māori could potentially benefit most. Making the transition from utilisation in the secondary and tertiary sector to primary sector requires education and access to effective services.

However, the focus on Māori providers in the primary health sector while improving choice for Māori patients in primary care, was also congruent with the macro policy orientation of government, thereby increasing the shift from state funded activities to privately funded activities (in the primary sector). While Māori are high users of Community Services cards (Gribben, 1999), they are not well informed about entitlements and may well be under-utilising available resources. They may therefore bear a greater personal financial burden for illness. There is also preliminary evidence that the growth in Māori health providers has given considerable political capital to governments keen to cement Treaty settlements in an environment of co-operation with major iwi groups. This may, or may not be according to the extent of their health need (that is that they are likely to have higher health needs by virtue of being Māori, but they

may not necessarily be the highest health priority on a Māori population health status basis).

Awhi Health Māori Health Provider Development

In October 1995 Awhi Health secured a contract with North Health to provide consultancy and training to Māori health providers. The rationale behind the contract for North Health was to build up the infrastructure and workforce capacity of Māori providers by advising them, providing educational opportunities and working alongside them. While a national fund of \$30 million over three years would later be made available (between 1998 and 2000), this strategy represented an early acknowledgement by North Health of shortcomings in existing competencies amongst Māori providers.

Māori Health Development staff in North Health had identified Māori workforce development as an essential component for making the health reforms opportunities work for Māori (Cooper interview, 23 April 1997). In particular, an absence of sufficient skilled staff were identified in business expertise (including management expertise) and clinical expertise. Awhi Health's contribution was to be in the area of business and management expertise, although there was a limited capacity for assistance with nursing expertise because of the nursing experience of the main consultant during this period.

Awhi Health was also distinctive because it was a limited liability company whereas almost all other providers at the time were constituted as Trusts or Incorporated Societies. It was also one of the few companies owned entirely by Māori women. Its unique contract gave the company an opportunity to develop an overview of the needs of Māori health providers, informed by both the Purchaser's assessment and hands-on work with providers within their own environments. This helicopter view of the work created considerable confusion and sometimes suspicion about the Awhi Health contract since consultants were often instructed by North Health about which providers should be worked with and in what areas, thereby indicating perceived shortcomings by the Purchaser, of provider activities. This was not intended by the Purchaser but was a

reasonable conclusion for providers to draw since consultancy was provided in areas in which there were agreed problems or issues.

While Māori providers could themselves initiate the use of the Awhi Health consultancy services, few providers who held Māori Health Development Division (MHDD) contracts took this opportunity within the first 18 months. Māori health providers who had contracts with other North Health services made more use of this contract. That is, those Māori providers in mental health or public health were more responsive to this service than those providers funded entirely from within MHDD. This slowly changed, partly in response to better information amongst MHDD providers, and partly due to representations made by MHDD on behalf of Awhi Health. Another contributing factor was a reconfigured contract which required Awhi Health to target those Māori providers with an MHDD contract (Awhi Health quarterly reports to North Health, 1996-1997).

Māori Provider Development Expertise Gaps

Awhi Health's early work focused around business planning, writing funding proposals and general training on human resource matters such as employment contracts, job specifications, ensuring staff compliance with job descriptions and appropriate governance. High management turnover amongst many Māori providers showed how difficult this establishment and consolidation period was. In particular, the relative inexperience of staff and those responsible for governance, coupled with endless negotiations over contracts with the purchaser, would prove too much for many managers.

While Māori providers brought many new skills into the health arena, there were also obvious shortfalls in expertise. A shortage of clinical expertise meant many Māori providers were reliant on recruiting those few medically qualified Māori doctors and Māori nurses to their services in order to be seen as a Māori service. There were occasional bidding wars between providers for this expertise that was difficult given the very tight budgets for staff that providers operated under. The difficulties in recruiting and retaining Māori doctors finally led to a more realistic approach by providers,

accepting that while having Māori staff (particularly in the core clinical roles) is an important part of being a Māori service, it was not the major part of being a Māori service. Rather, considerations such as ownership of the service, involvement of kuia and Kaumātua in governance and the ongoing activity of the service, use of te reo, and many other features, would identify them as a Māori health service provider.

Adding to this dearth of clinical expertise was the inexperience of most Māori health managers and Māori doctors and nurses. While Māori nurses had nursing experience, most had very limited general practice experience to translate into the new health environment. Making the transition from a hospital service to a primary health and community health setting required new skills, particularly where nurses became responsible for managing large primary care practices. This transition for nurses was not always easy, despite the best intentions of all parties, although nurses remain the most important staff for Māori health providers (O'Connor, 1998).

This relative shortage of managerial and clinical experience led to staff being promoted before they were sufficiently well trained or qualified to take on these more senior roles. Furthermore, they would have to deal with a level of complexity outside that experienced in most general practices. Negotiations with marae committee, local iwi or urban Māori organisations, other health professionals and health agencies - particularly Crown Health Enterprises - were an essential part of the everyday management of these services, thereby adding to the level of complexity to be managed.

The lack of governance and management experience amongst staff and Boards has also meant an ongoing reliance on external expertise. For example some of the large Māori Provider Development Scheme (MPDS) contracts let in the 1998 and 1999 period depended on external consultants to deliver the outputs, including business plans, management reviews and directors training. During the establishment phase many Māori providers experienced difficulties in accurately estimating the true costs of providing their services because of a lack of financial expertise and limited resources for accessing this expertise from consultants. As a result, some early contracts with Māori providers,

in mental health for example, did not reflect the full cost of providing the service (although North Health staff claimed that they were paid favourably when compared with non-Māori providers). This was less of a difficulty in contracts funded through the Māori Health Development Division, since they tended to be more generously supported financially and were on a capitated basis according to the number of projected registrations these primary care providers could attain within a contract period. These providers also had access to Awhi Health's services for business planning at no additional cost since North Health paid for the contract.

Initial work by Awhi Health under this contract with Māori health providers focused around building management expertise in human resources, financial management and interaction between management and governance. Many of these same areas would also be identified as priorities for other new health providers such as Independent Practitioner Associations (IPAs) during this period, and problems in these areas were therefore probably more a reflection of the newness of the providers rather than endemic to Māori providers per se.

Unlike other Māori health providers, Awhi Health was not reliant solely on a contract with North Health. The company survived by generating work outside of the contract because it was viewed as unsustainable. As a private consultancy company they were also able to provide services to other health organisations including IPAs, CHEs and indeed, the purchaser themselves and to MAPO.

The trial nature of the Awhi Health contract also meant that North Health retained a strong hand in negotiating what would happen. At times Awhi Health complained that some of this intervention by North Health was almost operational in nature since it amounted to approving every project done by them irrespective of whether it involved working only a few hours with providers on matters that they might not wish the purchaser to know about. This was addressed in a new contract negotiated in 1997 where Awhi Health was able to work up to six hours with any Māori provider without needing to seek approval from the purchaser. Additional time required an approval from

the purchaser based on a proposal prepared by Awhi Health and the Māori provider. Most contracts went beyond six hours so most still required a formal proposal for approval. The approval process also meant bottlenecks at North Health because of limited staff resource there for such approval processes. Even when the purchaser specified a maximum time in the contract for response, this was regularly exceeded.

There was also a degree of mistrust between many Māori providers and the company contracted as a provider developer because they were considered to be 'spies' acting on behalf of North Health. This was despite the attempts by North Health and Awhi Health to separate work done with providers from the monitoring requirements of the purchaser. The mechanisms and marketing by North Health and Awhi Health proved insufficient to overcome this mistrust. One of the reasons for this arose from the fact that Awhi Health had a contracted requirement through their quarterly reports to North Health and also in the approval of contract monies, to explain what work had been done with providers. There were also another possible reason for this mistrust; Māori providers may have had more confidence in a large well known company than some small Māori provider who was as new to the health reforms as themselves.

Comparison Of These Two Strategies

The two strategies around mainstream enhancement and Māori provider development did not lead to other similar contracts. The reasons for this are varied. They include the cost of the mainstream enhancement contract; its perceived success within the provider for the money invested; and the availability of appropriate skills for similar services. With regard to the Māori provider development contract, possible reasons have been canvassed above. This lack of confidence was addressed in a different way by Māori providers, through the employment of other private sector consultants, particularly from large consultancy firms. The Māori Provider Development Scheme introduced in 1998 also addressed many of the things available under the Awhi Health contract such as business planning, training and quality of service consultancy. Availability of MPDS funding however increased the total amount of work for all consultants, including Awhi

Health. This could be because it gave a focus to the next tier of work required for consolidation and qualitative improvement amongst providers.

Conclusion

The two strategies of mainstream enhancement and Māori provider development have been an important part of North Health's strategies for Māori health gains. These initiatives received considerably less attention than the development of by Māori for Māori providers. They were less attractive than the other strategy, in part because they were seen as more 'distant' from the direct service provision that could be shown as evidence of the increase in choice available to Māori patients.

However there have been important lessons learned as a result of these strategies. Most importantly, the significance of hospital services and the identification of ways of working within these large and complex environments should be passed on in further work on Māori health strategies.

The mainstream enhancement provider operates in a difficult medium, requiring liaison with clinical staff who are often highly specialised and also with managers who have tight budgets and tight objectives to achieve within their services. Convincing them of the need for Māori health strategies should not be their responsibility alone, but it is often left to Māori staff themselves to justify the need for responsiveness to Māori patients in ways that turn around the health statistics. It is notable, that in comparing the approach taken by He Kamaka Oranga with other Māori Advisory Units, that there is a significant difference in orientation within the organisation. Some of this difference has closed in the years between 1998 and 2000, with a more strategic focus and engagement of General Managers of Māori Health in both of the other two Auckland CHes.

The Service Level Cultural Quality Review did identify shortcomings that are much more difficult to change however, since they require complete organisational and professional shifts. In particular, doctors and nurses need to see their responsiveness and understanding of Māori patient needs as more central to a quality of service framework

before gains are likely. To some extent, this will be the most challenging and difficult part of the work on Māori health along with the promotion of lifestyle changes amongst Māori whanau and communities.

The three strategies for Māori health gain adopted by North Health concentrated on a mixture of political and clinical gains, although strategies were framed in ways that often promoted political objectives over clinical objectives. In particular, the absence of a more macro level analysis for Māori health gain, at the level of the Māori population, is not so evident in the strategies adopted. Even the later inclusion of public health contracts, were framed within the narrow health system perspective that limits interventions to a behaviourist lifestyle change through health promotion programmes. The assumption that some of the political objectives around the promotion of Treaty relationships should be emphasized over a focus on health evidence, and that the promotion of these relationships automatically correlates with Māori health gains, has yet to be proven.

This effectiveness of this prioritizing of political objectives is not the responsibility of MHDD who were themselves constrained by the health sector experience and by legislative and policy imperatives within a fragile political environment for Māori development. Rather, it is a criticism of an overall lack of vision among Māori leadership and New Zealand political leadership.

The three pronged approach developed by North Health led to the purchasing of three types of Māori health providers; by Māori for Māori, mainstream bi-cultural services and Māori consultants to work with providers on their development. The research question sought to understand how the 1990s health reforms impacted on Māori health. The previous four chapters identified the particular ways in which North Health as the purchaser, then the various Māori providers, each took up the opportunities presented. Key informants frankly assessed the benefits and limitations of such approaches. This discussion was preceded by an extended explanation of the policy environment, because of the significance of this environment on shaping the possible responses of Māori communities to such opportunities. However, the chapters on North Health and MAPO,

and on Māori providers, highlight the extent to which Māori try and make the best possible of any given situation.

The rapid deployment of resources, the desperate need for skilled staff that was quickly addressed, the innovative community-development oriented approaches, all suggest an adaptability by Māori communities to government inspired policy, particularly in areas of high need such as health and education. Such an appreciation would have been almost impossible without the support of so many policy makers, purchasers and health providers. The invaluable nature of 'insider' knowledge has been borne out in the quality of results from the Case Studies.

CHAPTER 12

The Future For Māori Health Providers: Managed Care And Other Issues

Introduction

Important areas for further development amongst Māori providers and those that fund and develop policy for them can be summarised in three areas: quality of service; mainstream provider accountability and responsiveness; and new service configurations including the discussions around managed care.

While managed care dominated discussion amongst Māori providers from the mid to late-1990s, the 1999 election of a centre-left government has significantly altered the policy environment and will therefore necessitate some re-orientation by these providers.

The debate around managed care was driven by National government policy interest in private sector engagement in the health sector. Such an idea was in keeping with its philosophy of individual responsibility and involvement of the private sector in providing services previously provided only by the public sector and still funded by the government.²⁹ A public safety net would be provided for those who could not take care of themselves. Health Minister Upton's views can be viewed as a dogmatic

²⁹ Easton quotes Simon Upton's Mont Perlin Society prize-winning essay as an example of this thinking. Simon Upton was the Minister of Health who implemented the initial sweeping reforms from 1992. He wrote, "...there are the vicissitudes of ill-health and old age which no one can hope to avoid. These should, whenever possible, be the responsibility of individuals. It may well be desirable to require some form of compulsory insurance to cope with those who would otherwise make no provision and then become a burden at a later stage...because a service is funded out of taxation, it does not mean that the government should actually provide the service itself. In many cases it will be possible to have the work put up for competitive tender by the private sector." (Easton, 1997, *The Commercialisation of New Zealand*, p 151 quoting Simon Upton Mont Perlin Society essay, 1987, pp 24-26).

representation of new right thinking yet they were only ever partially realized in the early flush of the health reforms in policies such as user charges. However, the ideas about personal responsibility are in keeping with the devolution of government that permeated all policies during the period 1984 to 1999 in New Zealand.

The problems associated with managed care for Māori were complex and varied and ranged from ideological problems to practical problems. These problems will be discussed in this chapter.

With the bedding down of Māori providers into the health 'market' attention turned to improving the quality and range of services to meet Māori patient need. This required consideration of the quality of services and how this could be verified with particular health providers. Early interest in accreditation regarding quality of service by Māori providers placed them in the lead in primary health care, since few primary care providers have subjected themselves to accreditation procedures for quality of service. In particular, Māori providers were keen to develop culturally appropriate models of quality of service that reflected culture as a key quality component in health.

Clear trends emerged in this research, such as Māori provider interest in integrated care and Kaupapa Māori services. Defining the latter is a challenge, but the process has already begun amongst Māori providers. The challenge is to get beyond the level of rhetoric, separating out those practices that are generally good quality health care, from those practices that are distinctively Māori. A dual path is discernable, one where mainstream Pakeha services will need to respond more appropriately to Māori consumers who use their services, and one where Māori providers will be able to provide greater clinical depth and breadth to their clients.

All require the future development of good outcomes measures. Māori providers also need to take responsibility for clarifying what a 'Kaupapa Māori' provider is. Work on this has only just started. There is a tendency at present to define anything done by a Māori provider as Kaupapa Māori. This may or may not be an accurate description. The

literature and research identified some features which appear distinctively Māori, such as the employment of Māori staff throughout the service, use of te reo, and the involvement of kuia and Kaumātua in both the governance and operational running of these services. The challenge now for health purchasers and providers is to meet the next phase of development in Māori health service provision. This requires honest evaluation about what has and has not worked well in Māori health strategies in the past. While Māori providers have benefited from investment such as TAGs and MPDS to overcome limitations on capital investment and experience in the health sector, there has been little improvement to baseline operational monies which must hinder Māori providers' ability to develop further (Hudson, interview, 7 August 1999).

Being a quality provider may mean trading off different activities. For example, most Māori primary providers have Clinics with more than one GP employed part-time on a salary. This means that patients may visit a different GP when they come to the service. While some patients do not mind which doctor they visit, many New Zealand patients are familiar with one doctor whom they visit over a period of many years. New Zealand patients exhibit high levels of patient loyalty to GPs, continuing with the same doctor for many years. This loyalty has been difficult to shift even with strong incentives to change such as lower consultation charges, additional services. Most importantly, patients have to believe they are visiting a quality clinical service and New Zealand patients (including Māori patients) seem to value a continuing personal relationship with a General Practitioner.

The shift to larger practices that may include sub-specialties, is a reflection of broader changes occurring within primary care itself and Māori providers are at the forefront of such changes. For example GPs may increasingly provide simple surgical procedures such as removal of lumps currently provided by large hospitals in day surgery. They may also choose to specialise in sports medicine, family medicine, diabetes, and heart disease. Such a move is in keeping with changes within General Practice in New Zealand and overseas. Nurses roles are also likely to change with a move to extending existing

prescribing rights for certain common primary health conditions with certain provisos such as extended training or supervision.

Capitation in primary care is also a possibility in the future as GP tolerance for salaried positions increases after a decade of losing income (Johnson, 1999). Capitation or salary payments for GPS would bring GPs more in-line with Māori providers who pay their doctors an hourly rate. These GPs also avoid the administrative work that dominate other GP practices, including extensive claiming and information demands, quite apart from patient requirements for referrals and case records and prescriptions. However, it does remove the GP as the locus of the small business which may not suit some GPs.

Primary Healthcare Services: Funding Streams And Similarities

Māori primary healthcare providers share much in common with other primary health providers, particularly General Practitioners. Most General Practitioners are sole businesses, employing a GP (or two), a practice nurse (who often doubles as the office clerk) and sometimes a practice manager. They rely on government subsidies in the form of the GMS (General Medical Subsidy) paid for each patient seen by the doctor, and co-payment, which is the fee charged to patients by the doctor. Māori health providers in primary health within the Auckland region are contracted through a mixture of capitation and GMS. They are paid a lump sum for a registered (or at least projected registered) population. In addition ACC claims for accident related consultations are made in the same way as for GP practices. The result of the high degree of capitation is a greater freedom to offset high risk patients (in terms of health need and inability to pay) against their contract, freeing Māori providers to charge lower or no co-payments to patients who cannot afford to pay for their care.

The major funder during the period 1993 to 1996 was the Regional Health Authority, which later became the Health Funding Authority. Its GMS claims process was complicated, adding significantly to GP administration. In Māori providers this claims work was performed by administrative staff, freeing GPs to concentrate on consultations. The emphasis on capitated funding of Māori providers thus placed enormous pressure on

them to ensure that the contracts accurately reflected expectations about patient numbers, types of treatment and service configurations. Many of these contracts were 'rolled-over' during the years 1994 to 1997 under Section 51 of the Health and Disability Services Act 1993.

The average size of a general practice in Auckland is around 1700 patients which is larger than average when compared to the rest of the country. There is however, considerable variation across Auckland with Central Auckland and North Auckland over-serviced when looking at population and number of GPs, relative to South and West Auckland which are under-serviced (Stone, Chair, GP Association of New Zealand, 20 September 1998). While there is regional variation, these sizes of around 1700 patients per GP remain fairly standard in Auckland. Māori health clinics appear to have around the same size as these average practices when accounting for the number of Full Time Equivalent GPs.

The major difference between Māori providers and non-Māori or mainstream providers, has been previously identified as the balance between cultural and clinical competence. Māori providers were established to increase the cultural expertise available within primary and secondary health services. Māori policy makers attributed this as due to an inability or unwillingness by mainstream providers to address specific Māori needs within services. This inability or unwillingness by mainstream providers was based on a view that medicine and clinical skills were value-free – that is, that the diagnosis of illness and prescription of treatment was the same for all, irrespective of cultural differences. Māori providers made the assumption that culture was an inherent part of quality of service. They set about exceeding minimum quality standards for primary care, consultancy and secondary / tertiary care services by responding to those aspects of service delivery most valued (according to the provider) by Māori patients.

North Health assumed similar things in their evaluation of mainstream providers by seeking compliance of these providers with the Hauora Schedule which was included in every contract with health providers during the late 1990s. The Hauora Schedule

specified minimum cultural safety expectations of providers from the purchaser / funder. Cultural appropriateness in service delivery was an integral part of quality of service considerations. This was identified in the CHI model developed by Mason Durie, which suggested that,

Contract clauses that will require providers to meet a degree of responsiveness to Māori”, and “Cultural safety, including the appropriate use of Māori language and the recognition of Māori health perspectives, is another key factor to be used in monitoring the quality of care for Māori. It assumes that providers will be able to show that they have taken cultural factors into account during the delivery of health services to Māori (Durie, 1994, pp 9-10).

North Health identified the creation of Māori health providers, particularly in primary health, as increasing the choices, thereby leading to improvements in the overall quality of care for Māori patients by integrating elements of Māori culture in ways which make all primary health services more likely to be responsive to Māori patient need.

Mainstream Providers And Cultural Compliance

In an evaluation of mainstream services in Auckland, North Health found that,

Most providers are having difficulty in fulfilling their obligations to provide culturally appropriate health and disability support services (Māori Health Development Division, 1997c, p 2).

This is despite the experience of Māori patients who have poorer health than non-Māori. The North Health report went on to explain,

A component of the North Health and MAPO strategic plan is the enhancement of mainstream services, particularly, the cultural quality of services in order to contribute to achieving better health outcomes for Māori (Māori Health Development Division, 1997c, p2).

Significantly the report involved the three MAPO in evaluating providers in their respective areas, the results of which were variable. Some MAPO had well-established relationships with their providers and experience of such evaluations, whereas other

MAPO were inexperienced in undertaking such evaluations and were unable to access expertise from North Health (Te Tai Tokerau MAPO, interview, October 1997). Awhi Health prepared the final report under the auspices of North Health. The key finding of the report was,

The absence of active strategic planning to encourage Māori participation in service delivery and lack of organisation-wide Treaty of Waitangi policies. Lack of Treaty-based policies and implementation plans have implications for every service area (Māori Health Development Division, 1997c, p2).

Specific shortcomings were identified in the report such as the failure of providers (CHEs and disability providers) to actively encourage employment policies which recruit and develop Māori staff, lack of te reo signage, lack of Māori 'space' for whanau, limited training opportunities for all staff to learn about the Treaty of Waitangi, lack of evaluation systems on their effectiveness with regard to Māori health gains, lack of protocols for accessing Māori resources within services when they were available and the perpetuation of the myth of "we are all one people" amongst clinical staff (Māori Health Development Division, 1997c, p 3).

Recommendations to address these shortcomings were made in the report. The Executive Summary explains,

If improvements in the overall health status of Māori are to be made, a number of active strategies will need to be employed by service providers and supported by funders. Attitudes of staff are fundamental if culturally appropriate care is to be provided and attitudes can only be influenced through increased exposure to Māori people, ideologies and practices, education to raise awareness and understanding of issues significant to Māori, and practical assistance to enable staff to implement principles learnt so that ultimately Māori receive high quality culturally appropriate care that will make short- and long-term differences to their health and well-being (Māori Health Development Division, 1997c, p3).

The report confirms a view widely shared between Māori providers and North Health staff, that mainstream providers were unable or unwilling to make necessary changes to accommodate or represent the interests of Māori. This lent ammunition to the argument that mainstream providers lacked the cultural competence to sufficiently meet Māori patient needs, and therefore, other choices were needed to both inspire change with mainstream providers (scare them into changing), or provide models which could be transferred (inspire them into changing).

Neo-Liberal Reforms And Managed Care

The solution to a multitude of problems with the New Zealand health system during the 1990s was believed to be in the innovation of new ways of organising and delivering health care. In particular, managed or integrated care models adapted from the USA, UK and Europe found their way into our vocabulary in New Zealand during this period. Despite apparent enthusiasm, skepticism remains around managed care for two main reasons; firstly, its dubious pedigree in the USA Health Maintenance Organisations of the 1970s, where it was seen as the means of controlling costs created by clinical decisions, sometimes against the individual interests of patients. Secondly, because managed care is associated with a series of neo-liberal reforms in healthcare implemented by the National government in New Zealand from 1991. The major fear of a number of health professionals and the public was that managed care was a Trojan horse for further changes which have more to do with saving money, than saving lives or improving quality of life. As such, managed care was a politically risky debate to have in New Zealand. Despite this, Māori providers were always more receptive to managed care³⁰ because iwi and Māori Urban Authorities saw the opportunity for them to 'broker' services on behalf of their enrolled Māori population. This would allow them greater direct control over the type and quality of health services used by Māori in their district.

³⁰ Managed care, integrated care and co-ordinated care have been understood in similar ways in New Zealand. This refers to the alignment of clinical and financial objectives. See Kiro (1998) for a fuller discussion of integrated care and policy.

Case For Primary Care And Māori Providers

Integrated care was also seen as promising by Independent Practitioner Associations (IPAs) with opportunities for direct involvement of General Practitioners or Māori health professionals in planning, contracting and evaluating care on behalf of their patients. A Coopers and Lybrand report prepared for Te Kete Hauora³¹ in 1995 was enthusiastic about 'co-ordinated care' for Māori. While pointing out that this could include a range of models including fund holding, health care plans, performance incentives, capitation and collaborative purchasing, it argues that Māori aspirations can be better met through this configuration. One of the unexpressed assumptions of this report is that this is because these providers are closer to the populations they serve. However difficulties in co-ordinating public health strategies across vulnerable populations remained unaddressed in the report.

The Coopers and Lybrand report was unashamedly supportive of co-ordinated care, arguing that it potentially offered better integration of services, increased responsiveness, improved equity, stronger incentives for prevention, capped expenditure and better risk management (Lybrand, 1995, Figure 2.1). However little evidence was provided in their report to support these comments. Indeed, managed care was being seriously questioned in the USA, at the very point that New Zealand looked like adopting it in some form.³²

Common features of integrated care are improved communication between providers, easier access to treatment for consumers, clearer flows of information, clearer accountability for service quality and health outcomes, a key person organising care, more convenience for consumers, and more co-ordinated clinical and financial management. (Andrews, 1998). Again, while these are glowing recommendations for a system, they are based on limited evidence. As Shortell (1998) explains, there are no true examples, even in the USA, of managed care organisations (Shortell, 1998). Therefore these proposed benefits are largely theoretical.

³¹ Te Kete Hauora is the Māori Health Policy Unit within the Ministry of Health.

³² Sandra Coney argued this point on Morning Report, National Radio, Wednesday 6 May 1998.

International evidence of the benefits of competition in health services - such as between competing ICOs, was also not encouraging. As Bowie and Shirley point out, "Internationally, the evidence for the benefits of competition is incomplete and far from compelling" (Shirley, 1994, p 318). They argue that the American system is singularly unsuccessful as it is expensive with little evidence of superior health outcomes.

For Americans in lower income groups, the health care provided is commonly acknowledged as unsatisfactory. Moreover, competition has tended to be based on crude indicators of consumer-perceived quality, rather than price (Shirley, 1994, p 318).

Bowie and Shirley go on to say,

Typically, the use of the market mechanism in health care - where consumer knowledge is low and where payment may be by a third party - involves sizeable transaction costs with unproven benefits in terms of resource allocation. Further, even if a competitive market was to succeed in allocating resources efficiently, there could be no assurance that it would meet socially determined equity targets (Shirley, 1994, p 318).

Support also exists for "physician accountability and leadership in influencing clinical decision making for both cost and quality" through IPAs (Malcolm & Shalowitz, September 1997). Malcolm believes that, "Progress towards managed / integrated care has been as rapid and appears to be potentially more extensive than any other country including the USA (Malcolm & Shalowitz, September 1997, p 2)".

They argue furthermore that,

Government had high expectations that managed competition, at least between providers, would reduce costs and improve access. These assumptions have been proved to be fundamentally flawed (Malcolm & Shalowitz, September 1997, p 3).

These flaws include financial problems: for example, "since 1993 actual government health expenditure has increased by 25-30%. Access was diminished as the waiting list for elective surgery has grown by 50%" (Ministry of Health, 1996).

Māori And Integrated Care

Māori remain keenly interested in co-ordinated care as a means of allowing more direct control over health services to Māori patients. Iwi led Tribal Authorities were preferred by the purchaser because it was argued that these were consistent with the implementation of Treaty of Waitangi principles by Crown agencies.¹ Already there were a number of examples of these initiatives by 1997. These are identified as,

- Te Roopu Huihuinga Hauora (Hawke's Bay and Wairarapa) - a collective of Māori health providers
- Bestcare Whakapai Hauora (Manawatu) - an iwi based Integrated Care Organisation (ICO)
- Taumata Hauora (Wanganui) - an iwi based ICO
- Tui Ora - an iwi based ICO at Taranaki
- Te Punga o nga Waka (greater Wellington) - an iwi and Taura Here ICO
- Te Poumanawa Oranga (Nelson Marlborough) - a mix of iwi, Marae, provider and other Māori organisations (Andrews, 1998).

Despite these initiatives, little thought was given to possible ethical conflicts as tribal authorities became responsible for telling Māori patients what core services would, and would not be provided, trading off financial against clinical benefits and ensuring co-ordination across tribal boundaries of public health and health protection initiatives. It is difficult for iwi to take on political fights in the interests of public health if they themselves are responsible for these decisions. This is not to suggest that iwi Māori should not make these decisions, but to point out that it fundamentally shifts the risk of political management and creates a very different relationship of trust, responsibility and accountability between iwi beneficiaries, patients and authorities. However this should be balanced against the almost unanimous support for greater Māori control over health policy, service delivery and evaluation.

Grant Gillett (1998) identifies a number of these ethical concerns for all providers.

1. There is a potential conflict if the doctor occupies dual roles as provider of best patient care and as resources manager.
2. Incentives to under treat and incentives to over treat, which must be avoided.
3. The need to make provision for innovation, research and development as part of the improvement of health care services.
4. A requirement to provide a comprehensive range of services, which does not unjustly neglect legitimate patient needs.
5. The ability of the individual doctor to make a choice of treatment tailored to the particular patient's needs (Gillett, 1998).

Problems With Managed Care

Other concerns about integrated care include the possibility of cream skimming by integrated care organisations. This means that these organisations would seek “easy-to-treat, low-cost patients. Doctors might refuse to enroll very sick people, such as Aids or cancer patients, because they were too expensive.” (Laxon, 1998). The Transitional Funding Authority identified two strategies to address this possibility “either paying the health organisations more to take some at-risk groups of people, such as the elderly, or it could force them to take everybody” (Laxon, 1998). Other criticisms of managed care were identified as, “Shifting financial risk away from the Government and on to private organisations, which ultimately would mean more costs to patients”(Laxon, 1998).

In their report on Māori co-ordinated care, Coopers and Lybrand identified the following difficulties with respect to integrated or managed care: enrolment criteria, funding formula, proving membership, cost shifting, restrictions on the use of health and disability, transaction costs, ability to manage risk, management capacity, implementation time frame and accountability (Lybrand, 1995). Coopers and Lybrand's report also pointed out the danger of small populations subject to “fluctuations in demand and hence costs” and suggested a possible minimum membership for co-ordinated care schemes. However a minimum number is not suggested in the report (Lybrand, 1995).

Of particular interest though in discussions around integrated care is cost shifting and ability to manage risk. There is evidence that cost shifting has already occurred within health, with private individuals contributing the greatest increase between 1991 and 1996, followed by the Accident Compensation Corporation (ACC) and private health insurers (Ministry of Health, 1996, p 48).

Despite these limitations, Māori remain interested in a way of organising care that will allow Māori greater control over resources and decisions relating to service delivery. One of the justifications for this interest is the view that integrated care will facilitate Māori aspirations for more holistic care encompassing *nga tapa wha*: *taha wairua* (spiritual wellness), *taha hinengaro* (mental wellness), *taha tinana* (physical wellness), and *taha whanau* (family wellness) (Andrews, 1998).

Crown Policy And Māori Health Services

While there are clear benefits to involving primary and secondary care clinicians more directly in decision-making, along with vulnerable populations such as Māori and Pacific Islands people, these discussions occur in a vacuum of information about what else will exist in a proposed system. There seem to be few opportunities for developing a population-based approach to preventative medicine as promoted by Rose,ⁱⁱ despite the obvious benefits of such an approach. Rather this kind of public health thinking is seen as being woolly and inconsequential³³.

A new health system with a return to Area Health Board-like District Health Boards may mean that managed care is now firmly off the political agenda. Rather the focus will be on retaining gains to date and adding to these through collaborative efforts between

³³ In "Old Wine in New Bottles: The Public Health Commission and the Making of New Zealand Alcohol Policy", by Marten Hutt and Philippa Howden-Chapman quote a National Government Minister, Murray McCully as describing the Public Health Commission (1993-1995), as "pointy-headed wasters" and "playthings for social engineers" in a letter to the Associate Minister of Health, Maurice Williamson in August 1993 (pp 57-58).

Māori providers and with other non-Māori providers where services can be enhanced for patients leading to improved health status for Māori.

These explanations draw on a consensus across the political spectrum. The argument for developing a policy platform for co-ordinated care is drawn from existing policy, for example, from the recognition of the special needs of Māori embedded in the Crown's objectives for Regional Health Authorities which states that RHAs should seek to improve the health status of Māori so that they will enjoy the same level of health as non-Māori. Furthermore, the overall purpose and objectives for RHAs outlined in the Health and Disability Services Act 1993, especially section 8, provides for the special needs of Māori as one of the Crown's social objectives.

The Waitangi Tribunal, Court of Appeal and Royal Commission on Social Policy and the Crown have defined several principles³⁴ arising from the Treaty, including the need for,

- Partnership - an ongoing relationship between the Crown and Iwi; and,
- Participation - a positive Māori involvement in all aspects of New Zealand society, including decision-making and delivering social services; and,
- Active protection - a pro-active approach to ensuring that Māori well-being is enhanced wherever possible (e.g. health promotion and preventative strategies).

There were fundamental problems with some of the models of managed care proposed in terms of delivering benefits to Māori patients. For example more flexible use of resources to address social and economic causes is not borne out in any proposed model of managed care - although there was the potential for greater intersectoral collaboration, the agents might or might not act upon this. Also, access to a wider range of traditional curative and wellness services is unlikely if New Zealand pursues a similar model to the USA where litigation and financial constraints act to create risk averse structures that do not support a range of options for users.

³⁴ There is debate about whether principles of the Treaty is the correct framework, rather than using the provisions or Articles of the Treaty of Waitangi as the basis for enactment.

With managed care, Māori were offered the carrot of greater autonomy over health services. This is explained by a provider as follows.

Oh, I think ideologically it was tremendous, yeah. So from an ideological and conceptual framework it provided huge opportunity in terms of philosophical capacity. Yeah, now that we're a bit down the track there, that the reality, the reality of that is that the shine's gone right off it ... the expectation was that there would be a range of opportunities for Māori participation for the first time in the health industry, other than being a patient of it. And so, there is the opportunity to aggregate our populations who were committed to some form of Māori contribution for their health and that was those health care plan capacities. There was the opportunity, we thought, of actually getting into provision of health care. Now, what you've got to understand from an economic model is that what you see in industry is only arguably 30-35% of it. What I mean by that, well, health is an industry on its own. It's but one industry but there's huge service related industries that are connected into it, everything from baseline cleaning, security, all the way through to the provision of supplies. Well and clips, right down to clips, paperclips ... So, it afforded us for the very first time, a window of opportunity that we'd previously been precluded (Tamihere, 1996, pp 2-3).

These new opportunities could have turned into a poisoned chalice if government abdicated responsibility and transferred all risk for Māori to Māori. It would effectively deny the myriad causes leading to preventable Māori illness and early death. It is unlikely that this would be a deliberate intention of government policy, but it was likely to be an unintended but likely consequence of such a policy shift, particularly in the absence of clear formulae of costs, populations and responsibilities by providers.

However, governments and the private sector viewed these models of managed care as desirable during the 1990s, because they offered opportunities for more effective risk

management of population illness, containment of government expenditure and they created opportunities for private sector involvement.

Māori Providers and Quality of Service

Ensuring quality of service will be the next step for many Māori providers. This may mean one of two choices for providers, either accrediting themselves through an existing quality framework including programmes such as Health Standards New Zealand, or by developing their own quality frameworks and evaluating themselves against this. Some Māori providers have shown greater interest in the development of their own framework because they believe that existing frameworks do not reflect Kaupapa Māori, which is an essential part of their service. There are few Māori quality frameworks available as a guide to providers. The clearest is that based on Donabedian's work which Martin (1997) has adapted for Māori community providers. Martin developed a model called He Mahere Whakamua (Martin, 1997, pp 70-75).

Donabedian's model includes Structure, Process, and Outcome and comprises the following categories: technical management, management of interpersonal relationships, accessibility and continuity. There are a number of principles or themes of continuous quality improvement attached to these areas. For example technical management includes principles and themes of training, planning information, quality information systems, personnel and buildings and equipment (Martin, 1997, p 70). Martin concludes,

The environmental pressures facing Māori to provide quality services require dialogue amongst Māori providers about quality and opportunities to gather evidence of the effectiveness of quality strategies for Māori. Unless Māori providers attempt strategies for quality improvement, which may contribute to a knowledge base of understanding applicable to Māori, the alternative may be to accept Māori health service quality, being benchmarked against Western practices (Martin, 1997, p 93).

Thus considerably more effort and expertise is required before appropriate models measuring quality of service for Māori providers can be confidently adopted by the health sector.

Likely Future Alternatives

Subsequent changes to the health sector following the election of a Labour and Alliance Coalition Government in November 1999 suggest that managed care is unlikely to be a favoured option for Māori health. However, aspects of managed care that emphasise collaboration with other health providers and integration between primary and secondary care are likely to be promoted.

In particular the key relationship between Māori providers and the new District Health Boards will be the focus of future relationships and will need to be cemented. These new relationships centre on the establishment of a Māori health Directorate in the Ministry of Health and possible Māori health committees as standing committees in each of the District Health Boards following the introduction of the Public Health and Health Reforms Act in late 2000.

Cabinet papers released in March 2000 identify likely future responsibilities of District Health Boards for Māori health. District Health Boards will be Crown Entities (Statutory Corporations) with responsibility to the Minister of Health for achievement of health and disability outcomes for their populations (Health, 2000a; Health, 2000c). District Health Boards will have to manage relations between their communities whom they represent and Government objectives in health and disability. Māori 'issues' are to be taken into account in considering representation on District Health Boards (DHBs), regulatory design of the DHB sector and accountability mechanisms to ensure that DHBs have incentives for delivering Māori health gain (Health, 2000d, p 1).

The Minister's advice to Cabinet emphasises the need to;

- Continue to build Māori capacity for participating in the health and disability sector and allow Māori communities to provide for their own health needs
- Encourage effective relationships between DHBs and Māori
- Create incentives to improve Māori health outcomes and reduce health disparities between Māori and other New Zealanders (Health, 2000d, p 3).

All of these are premised on the obligations arising from the Treaty of Waitangi between the Crown and Māori. Principles identified as important include building forward, flexibility, integration with social and economic services, clear accountabilities for achieving Māori health objectives and cost effectiveness (Health, 2000d, p 4).

While the Minister's advice to Cabinet focuses on Māori advisory mechanisms, it also states that Māori should be "well represented on the two DHB committees, the Primary Care Advisory Committee and the Hospitals Committee, to ensure their advice is integral to the work of these committees" (Health, 2000d, p 6). Standing Māori advisory committees are not recommended because the possibility that they would be 'side-lined'. Māori representation should include both iwi and non-iwi Māori (that is, be broader than iwi representation) (Health, 2000d, p 6).

The Minister identifies three models for Māori participation in the health sector. These models are the generic, delegated and sub-purchasing models (Health, 2000d, p 9-12).

The generic model argues for Māori participation at all levels of the health and disability sector but proposes that the "DHB board would establish Treaty-based relationship agreements with local iwi to work together to establish strategic priorities for their Māori populations" (Health, 2000d, p 9). At operational levels Māori input would be through "working with Māori providers, mainstream providers, and other sectors to co-ordinate services and foster the delivery of high quality, effective services for Māori" (Health, 2000d, p 9).

The delegated model would see DHB functions delegated to regional or local Māori bodies. This could be covered by statute or Ministerial powers and could be staged over time with "functions such as strategic planning and workforce development to be 'transferred' in stages" (Health, 2000d, p 11).

With the sub-purchasing model, the DHB would give responsibility for a Māori population to a Māori organisation would could "provide or arrange for a range of

services for that population to improve their health status” (Health, 2000d, p 12). This model is closest to the MAPO arrangements of North Health, although MAPO also included aspects of the delegated model.

At the meeting of the Ad Hoc Ministerial Committee on 9 March 2000 a number of decisions were made concerning this advice. These decisions included an acknowledgement of the Treaty of Waitangi and inclusion of this in the proposed Public Health Services Act to be introduced in late 2000 to replace the Health and Disability Services Act. Their other decisions with respect to Māori health were to continue possibilities for Māori capacity building in the health and disability sector using regulatory powers and leadership of key agencies in the sector. The following decisions were made with regard to Māori representation:

- Noted that DHBs be required to consult with their Māori communities just as they will with other populations for whom they are responsible
- Agreed that DHBs should be able to set up Māori advisory committees or similar
- Noted that the Health Sector Development Officials Group report back to the committee by 13 April 2000 on ensuring equitable representation on DHB Boards and on their committees (Health, 2000d, p 14).

The Ad Hoc Ministerial Committee also decided that the generic partnership model be preferred which would encourage Māori participation throughout the sector and that further work also be done by the Health Sector Development Officials Group which would report back by 13 April 2000. This group was also to investigate the possibility of “transferring some DHB functions to Māori as proposed under the mandated or delegated options” described in the Minister’s Memorandum to Cabinet (Health, 2000d, p 16). Lastly, it was agreed that “the Health Funding Authority’s existing Treaty relationship agreements be continued in the new environment until replaced with more appropriate ones at the DHB level, and that where such agreements do not exist at present, DHBs develop a Treaty relationship agreement with mana whenua” (Health, 2000d, p 16).

Conclusion

The health reforms in Auckland were in many respects at the forefront of Māori health policy development, and the resulting Māori providers at the forefront of Māori health provider practice development. Policy makers and practitioners have actively participated in the political discourse around Māori development and health policy. At a macro levels the reforms were an integral component of the neo-liberal reforms pursued in New Zealand from 1984. The direction of these changes continues, despite public misgivings about this direction.

Debate around managed care has been the focus of reform from the mid-1990s until the election of a Labour-Alliance Government in November 1999 when a move back to Area Health Board-like, District Health Boards was promoted.

Māori health providers and Māori tribal and Urban Authorities were receptive to managed care because of the opportunities it offered, including the possibility of controlling significant budgets for their own populations (or for Māori populations resident in their traditional tribal areas). This meant the possibility of accessing secondary and tertiary care budgets, which was where the bulk of health services monies went, and also of controlling primary care, which acts as a gatekeeper to accessing secondary and tertiary care services. Māori Authorities are closer to the populations served by these services and they believed that they were therefore in a stronger position to respond to their health needs and ensure value for health dollar spent on their care. Such control over funding and provision also meant the exercise of tino rangatiratanga for Māori, consistent with Māori rights under Te Tiriti O Waitangi (Treaty of Waitangi).

However, critics of managed care considered that its primary purpose was cost control and the shifting of risk from Government to the private sector in a way that would allow governments to distance themselves from the implications of health decisions affecting populations. It would also theoretically allow easier cost containment by governments facing rising health costs due to increased demands from the public.

The tension inherent in the relationship between Government and providers depended upon the extent to which these providers reflected their patients' communities' priorities. Achieving community or iwi responsiveness was more difficult because of the duality of roles of funding services and providing services whilst also running a business with profit motives and financial accountabilities to the organisation funding these services.

The move to District Health Boards and an up-scaled Ministry of Health (which would now provide uncontested advice to the Minister on the health and disability sector and fund some services) has moved the debate away from managed care to one of representation. The DHB is an attempt to reinstate a form of local democracy back into health in line with the new Governments thinking about community involvement in such decisions. However, the timeframes for these changes are very limited, input into design of the new sector is limited and opportunity for loss of some of the gains (and losses) is great. Decisions from the Ad Hoc Ministerial Group suggest a desire to ensure that gains around Māori health are not only retained but also improved. It is difficult however to assess the extent to which a more universalistic approach to Māori health will be adopted, or whether the Treaty relations model developed by North Health which emphasised iwi relations with Crown agencies, will dominate future representation. These remain to be tested.

CHAPTER 13

Conclusion: Contextualising Health

Introduction

Despite widespread criticism of the health reforms made during the early 1990s, Māori continued to view these reforms more positively than others in the health sector because they allowed new opportunities for Māori to contract for provision of health services. However this support was not universal and Māori retained a healthy skepticism about government's intentions with respect to risk shifting and cost control. Māori were also concerned about the degree to which promises of greater autonomy would eventuate. As Durie stated;

Māori reaction to the reforms was mixed. On the one hand, the prospect that the State would have a reduced provider role caused some anxiety. Even though the Government had acted unevenly in respect of the Treaty of Waitangi, it had at least shown a recent capacity to listen and, often, to respond fairly. There was no guarantee that local authorities or private institutions would respond in a similar manner. And there was the added concern that targeting policies would be aimed at a narrow section of the Māori community, disadvantaging those on the borderline. On the other hand, there was considerable agreement with a deregulated approach to health care and the promise of a more direct role for Māori in the provision of services. When the enthusiasm for Iwi health care plans had subsided, Māori still saw in the health reforms opportunities for positive roles in planning and service delivery (Durie, 1998c p 174).

Criticisms by liberal commentators such as Ashton, Easton, and Cheyne et al, of the 1990s health reforms based on the Green and White paper of 1991 (Upton, 1991) mirrored public skepticism about them. While the reasons for these criticisms vary, they include the following: that the approach identified in the paper was untried anywhere in the Western world; that no evaluation had been built into their introduction; and that they

required a capacity for management expertise in these new processes such as contracting and profit-orientation that was not developed within New Zealand, and further, that fragmentation would inevitably result whereas increased co-ordination was what was required.

There were also questions about the impact of these reforms on equity outcomes removed as a priority in government policy as part of the reforms from 1990 (Boston et al., 1999). This surrendering of equity in public policy would have the greatest implication for Māori who were arguably better off with a more universal and rights based policy approach (Kiro, 1998b). Despite this, a number of Māori benefited from the new regime and as a result, they were willing accomplices for taking greater responsibility for devolved service delivery, greater risk and greater policy involvement than had previously been the case.

As a result of this willingness to engage, there has been a corresponding increase in the number of Māori health providers nation-wide. While this research has concentrated on Tamaki Makaurau (or Auckland), many of the points raised apply to Māori providers nationally. These service providers have been located in a wide range of services during the 1990s period of the health reforms, expanding their range to incorporate disability services, mental health services, primary care, limited secondary care, and health promotion. This expansion was the result of a planned strategy developed between 1990 and 1994 and implemented from 1993 to 1997. The key element here is that this strategy involved Māori in the planning, delivery, and evaluation of Māori health services.

Such an extensive involvement should invite international interest in these health initiatives by Māori and possibly contribute something to health service and policy developments with other indigenous peoples. There is already a perception that Māori may be at the forefront of positive changes for indigenous peoples, for example visiting Australians working with Aboriginal Australians praised these initiatives and spoke of their application for Australia (New Zealand Herald, 17 September 1997, Healthy Case of Respect).

Social Policy and Health

This research confirms that there is cause for celebration of the achievements of Māori in designing, implementing and delivering these services. However, these achievements have been accompanied by some reservations as the focus on the creation of new providers has consumed Māori energy that could have been more effectively directed against punitive economic and social programmes implemented during this period that have inevitably affected Māori health and well-being. While there is consensus about the effects on health outcomes of factors such as unemployment, inadequate housing and low incomes, little concerted and coordinated effort has resulted within Māoridom during a period of rapid and overwhelming change on these areas. Durie explains,

Because of the complexities of the problem [Māori illness] and its multi-factorial origins, there is no single method which will be sufficient to embrace the range of health problems or the diversity of Māori realities. Nor is it reasonable to suppose that the health services, by themselves, will be able to effect dramatic changes in Māori health status. Indeed skepticism about the health reforms expressed at a hui in 1992 often arose from the observation that health was closely linked to socio-economic conditions and that no amount of manipulation with primary or secondary health care would mitigate against the ill effects of unemployment, substandard housing, low incomes, or inadequate housing (Durie, 1998c, p 176).

The clearest evidence of this failure is expressed in the 1998 Closing the Gaps report by Te Puni Kokiri that identified the continuing, and in a many cases, widening of the social and economic gaps between Māori and non-Māori within New Zealand society during the 1990s (Te Puni Kokiri, 1998). Despite criticisms about the 'gaps' orientation of the report and some methodological shortcomings, the fundamental message, that what was happening to Māori in New Zealand society remained serious and was worsening, was an important one. This was further highlighted with the National Health Committee report on Social, Economic and Cultural Determinants of Health. This report identified some of the evidence of high Māori health need and theorised the way in which health

outcomes are affected by social, economic and cultural events that shape our health experiences (National Health Committee, 1998).

There has also been a fundamental problem with a strategy that focused on personal health care and provided limited opportunities for population based approaches that may have been more successful for Māori. The benefits of most of these Māori provider initiatives are likely to be highly localised and may not even reach those Māori most in need, namely Māori who are disenfranchised from any Māori network. The bulk of Māori still use mainstream GP or CHE based services, and the lack of interest in these areas by policy makers has to be addressed for genuine large-scale improvements to occur. Two reasons can be identified for ignoring this strategy; firstly, the enormous time, effort and resource required to get mainstream providers' on board' and willing to change. There is a tendency to see these mainstream Pakeha providers as a black hole into which money for improving Māori health could be poured, with little return. A genuine interest and willingness to change attitudes and practice are necessary and this will take a long time. Secondly, the attractiveness of 'by Māori for Māori providers' encouraged investment of time, energy and resources. This strategy generated considerable 'brownie points' for policy makers, politicians and providers alike, and was therefore considered more rewarding than addressing mainstream Pakeha providers. With the exception of the Hauora Māori schedule, a few contracts such as He Kamaka Oranga, and limited evaluations, little effort was made to address the appropriateness or effectiveness of Pakeha mainstream providers for Māori health status during this period.

Changes in social income and economic opportunity since the mid-1980s detrimentally affected Māori and the development of by Māori for Māori providers could not compensate for failures in health gain across the population. This is not to say that Māori health providers should not have grown or increased in number, but rather that their effectiveness will be limited by the broader social policy environment. Indeed, Māori organisations were among the first to recognise this dynamic.

The fragmentation of services resulting from the 1990s health reforms led to a lack of clear accountability in some instances, for example failure to achieve health gains across the population. This was not helped by the early competition of the health reforms that foreclosed information sharing between providers for the benefit of patients. Such competition stalled the continuum of care approach needed, particularly for high need populations who may have multiple health difficulties that require earlier intervention or closer monitoring. A more collaborative environment emerged in the late 1990s, but competition for resources between providers, especially primary and secondary / tertiary providers, continues to undermine a continuity of care approach to patient care in the New Zealand health sector.

The 1990s health reforms allowed the Government to shift responsibility for Māori health to iwi Māori, organisations, and communities. This was the very population with the greatest health needs. As a result, the political significance of Māori health statistics could be downplayed and Government subsequently enjoyed an undeserved kudos resulting from the reforms. While Māori view the opportunity to provide services to Māori as a positive step, it was arguably a poisoned chalice since it required swallowing a libertarian public policy agenda that did not serve Māori interests in the long-term.

The health reforms focused on developments in personal healthcare, which limited opportunities for implementing a broader population-based approach. Such a population-based approach is likely to deliver greater benefits to Māori through improvements in the standards of living that would inevitably improve health status. A population health approach is concerned with more than the aggregated individual experiences of people and acknowledges that the whole of peoples health experiences is more than the sum of these experiences.

Contracts with Māori providers remain limited and are usually rolled over with no increases in operational funding. Providers rely on one-off capital grants or special national grants such as the Māori Provider Development Scheme, which are extremely competitive and require effort and inside knowledge to apply for. There is perceived

variability in respect of resources available to Māori health service providers compared to other primary care providers: for example, most Māori providers identified their funding as inadequate, despite the purchaser's view that they were well served when compared to some other contracts. While one of the Case Studies viewed their funding as generous, others considered it inadequate. Despite the much lauded increase in the number of Māori health providers and commitment to their development through the Transitional Assistance Grants and Māori Health Provider Development Scheme which was allocated \$7.5 million (GST inclusive) in 1997/98 (Minister of Māori Affairs Press Release, 14 July 1998), Māori health has continued to suffer relative to non-Māori. While there are improvements in some areas, for example the Māori SIDS³⁵ rate, there is also evidence of declines in areas such as life expectancy.³⁶

Much of this experience can be attributed to the impact of other economic and social reforms. In particular, the effects of massive unemployment, long term unemployment, lack of school qualifications, continued institutional racism against Māori, Māori squabbling over Treaty claims, are all possible contributors to such a decline. What is surprising, is that given the evidence of ongoing disadvantage, Māori continue to function as well as they do, and they continue to initiate both educational and business opportunities with so few resources.

Divergent Māori Population

Māori health policy has tended to be developed as if Māori were a homogeneous population and yet the evidence shows that this has never been the case, and in fact, this perception is becoming increasingly inaccurate. Māori are a heterogeneous population who may require a number of coordinated health strategies to address their complex health needs. An analysis about the divergent nature of the Māori population is best explained by Cunningham's model of Māori population, comprising four main groups.

³⁵ SIDS is Sudden Infant Death Syndrome

³⁶ The debate about the extent to which this decreasing life expectancy is due to technical numerator/denominator problems, or to societal changes has been covered earlier.

His typology suggests that there are essentially four population groupings amongst Māori, each with a unique profile. These are pluralistic, traditional, Pakeha and gap Māori. As mentioned in chapter 3, each of these groups has a particular profile. Each of these profiles have implications for the way that health services and supporting public policy will impact on their well-being. These groups are therefore related to particular features that include educational status, income levels, employment associations, rural and urban living environments and cultural identity. The latter includes two dimensions from access and participation to Māori culture and institutions, and security of identity.

Cunningham points out that the benefits of the last decade have disproportionately been to pluralistic and traditional Māori, with an attempt in health to find the 'kohanga reo'³⁷ solution in health. In contrast, the highest health needs are among those who are in the 'gaps' and 'traditional' Māori categories.

Choice

Māori now have more choices than they had prior to the 1990s health reforms in that they can now choose a Māori health provider and can benefit from a bi-cultural or kaupapa Māori service. However, this may have meant more choice for those Māori who already have choices and therefore may not significantly improve the situation for those Māori who are most vulnerable. While the research found that high numbers of Community Card holders (who are by definition low income) use Māori providers, more research is needed to identify precisely who uses the services and what benefits they derive from them.

Experience in kura kaupapa education services suggest that middle-class Māori may be disproportionately involved with these new Māori initiatives. The middle-class are early innovators, taking up new opportunities quickly, partly because they see that they have a choice. Making such choices may require more resources in the short-term, for example in requiring travel to and from such initiatives rather than relying exclusively on local

³⁷ Kohanga Reo are pre-school language nests that are widely considered the beginning of the latest Māori renaissance by promoting te reo and tikanga from children upwards within the Māori population.

Schools or GP clinics within walking distance of home. Māori middle-class may be better able to participate in new initiatives such as by Māori for Māori health providers, just as they were able to participate in Māori educational initiatives. In contrast 'gap' Māori since they do not feel confident in either Māori or Pakeha worlds, and therefore may be less inclined to make the choice to take up new opportunities.

Choice is also an important component of neo-liberalism since it assumes that individual free will is the ultimate expression of freedom. Such a view may be at odds with traditional Māori values that may consider group identity the most powerful expression of freedom. This kind of 'choice' has allowed Government to shed some risk and responsibility for the parlous state of Māori health by promoting individual freedom of choice.

Like other New Zealanders, Māori may be more inclined to use mainstream providers. The reasons for this are unknown but evidence about the low rates of movement between one GP to another in New Zealand suggest that there are powerful factors that lead patients to stay with their GPs, irrespective of service. Loyalty, apathy, access and familiarity may all be factors in this decision. It is also likely that the lack of history of Māori providers may also play a part. This reflects the fact that Māori providers have only had a few years to establish themselves and prove their worth in a well-established health market.

This sub-group of Māori population termed 'gaps Māori', are the most vulnerable. Their experience of social isolation makes them less likely to take up the option of Māori providers, with the possible exception of 'Pakeha Māori' – those Māori who are indistinguishable from Pakeha in their lifestyles. The premise that all Māori will select a Māori provider when provided the opportunity is based on a simplistic assumption of the homogenous nature of Māori society. If anything, the diversity that has emerged amongst Māori is increasing (Kiro, 1998a; Kiro, 1998b), along with inequality between Māori and non-Māori (Chatterjee & Podder, 1998; Statistics New Zealand, 1998; Statistics New Zealand, 1999; Te Puni Kokiri, 1998).

The framing of discourse in Māori health policy around notions of choice have therefore been misleading for Māori, since the policies have actually reduced the choices of the majority of Māori while increasing the apparent choice for some Māori.

This diversity of Māori population leads to two conclusions. Firstly, there is unlikely to be one solution to Māori health. Māori health purchasing or service strategies need to reflect this reality. There may be a variety of mechanisms for delivery of services to Māori and a need to engage multiple Māori communities, including iwi, national Māori organisations and locally based Māori communities, in policy development and service configurations.

Secondly, there is still a need to understand the position of Māori 'vis a vis' non-Māori. While there is enormous variation within Māori society, there is also great similarity. Some things are shared by Māori whether they choose it or not, by virtue of being Māori within New Zealand society. Māori may not necessarily choose whether or not they are identified and treated as Māori by other New Zealanders, even when such judgements have negative effects for them such as that which occurs with racism. There are also similarities with respect to a shared cultural heritage, some knowledge of whanau (and possibly hapū and iwi), of being identified as Māori in some settings, and other cultural practices including tangihanga, marae, reo, and other tikanga.

This commonality of experience is borne out in the statistical evidence of health status which shows that there appears to be an 'ethnic' factor at all socio-economic levels with respect to certain diseases, such as heart disease. Māori die earlier than non-Māori and have higher levels of illness for major causes of mortality relative to others in their socio-economic group. Māori also earn less income than others, even when they are equally well qualified. This evidence suggests that there is a factor relating to ethnicity, or being Māori in New Zealand, that affects our outcomes, whether we choose it or not. There is therefore an imperative for policy makers to recognise this and build a more sophisticated

analysis around health policy that allows for flexibility and diversity, while emphasising population based approaches that address underlying structural inequalities.

Risk And Ownership

The transfer of risk has been an underlying theme of the 1990s health reforms. Risk has been primarily oriented towards managing the level of fiscal demand on Government for extra monies in health expenditure created by increased demand and expectations of health care from an aging population. Government subsequently sought to increase efficiency within the health sector as a means of controlling this fiscal risk. However such efficiencies were premised on dubious data and faulty assumptions about the level of waste within the public health system in New Zealand when compared with other health systems (Ashton et al., 1991) and about the savings to be made in this system as a result (Easton, 1997a).

These reforms have resulted in ostensibly greater risk because of the high needs of sectors of the population. The untried nature of the 1990s health reforms also created significant risk for Government with considerable monies spent on consultants and professional Directors and Managers to establish new institutions in health. Adjustments to the funding formula were based on pricing models that were not transparent to the sector, only to the Purchaser. While contract prices included a premium for high risk populations such as Māori, the prices were largely based on a 'best guess' as no-one really knew how much it cost to cover such risks, or even how much it cost to provide such services. Most of the prices were costed on the basis of historical prices only. Such 'guesses' would presumably become more accurate over time, but for the period of implementation, it meant that high risk populations in particular may bear the brunt of inaccurate projections around price based on the true cost of providing services to these populations.

There was an added risk for Māori providers because of the small size of many of them. Smaller providers have fewer margins to draw on when making decisions and therefore have less room to maneuver for expansion of services, financial risk management,

clinical peer quality assurance or organisational growth. These providers continued to have additional accountabilities however, to their owners, communities, patients and their whanau, staff, professional colleagues, purchaser, political stakeholders and public.

Public Health Approaches

A major finding of this research is the importance of public health approaches to reinforce benefits for those Māori who cannot, or will not access services through Māori primary health providers. The majority of Māori patients continue to visit non-Māori providers for their primary, secondary and tertiary care. This is not a criticism of Māori providers, but a reflection of certain geographical, logistical or choice decisions made by Māori patients.

This therefore raises questions about the extent to which Māori health strategies have been driven by ideological views of Māori society (iwi, hapū, whanau) and have ignored opportunities for mainstream providers.

Limited efforts have been made to change mainstream providers to make them more accountable for Māori patient health outcomes. Where these have existed, they are piecemeal and badly implemented, such as with the attempt to force compliance with the Hauora Māori schedule. No contracts were withheld or withdrawn by the Purchaser because of failure to conform with the Hauora Schedule. This may be because the Schedule was relatively recent and monitoring and evaluation so infrequent by the Purchaser. Where evaluations were carried out they found inadequate and variable responses to contractual obligations to meet Māori patient needs (see Cultural Quality of Service report, North Health, 1997). A possible reason for this lack of engagement by the Purchaser with mainstream providers with respect to Māori health may be the frustration expressed by MHDD staff when trying to force changes amongst mainstream providers, in particular with CHEs and GPs. They argued that these providers required an enormous investment of time and effort for what was seen as producing little benefit for Māori. In comparison, Māori providers were very accessible for MHDD staff, willing

to adapt to meet requirements for funding, and often enjoying a more amiable relationship with MHDD and other North Health staff.

Public health approaches are essential for Māori because universal, rights-based approaches avoid some of the stigmatisation which occurs with more targeted regimes (Kiro, 1998b). Also, this approach is more likely to address health needs based on a population analysis and to consider the total burden of illness.

There have been marked successes by Māori providers when adopting public health approaches in primary care, so it is important that Māori are intimately involved in the planning and delivering of such approaches. These approaches, however, have encountered some difficulties. For example there have been some ethically difficult issues arising from public health campaigns such as one provider having an opt-out system for immunisation. In this case, children are immunised *unless* their parents opt-out of immunisation. Letters are sent to parents informing them that their child is to be immunised when a mobile clinic visits their Kura or Kohanga and parents must proactively select to not have their child immunised. Thus far, very few have. As a result of this and other strategies by Māori providers, immunisation rates have dramatically improved.

In this instance there are interesting ethical conflicts between individually based consent (exercised by adult parents on behalf of children with respect to immunisation), and the rights of whanau, hapū, iwi and/or Māori communities, taking precedence over these individual rights. Thus, the development of individual consumer rights may be exercised differently from group rights of communities, who may over-ride consent and privacy concerns with a population based health approach. Public health often grapples with these kinds of debates about the relative merits of an approach that benefits the majority over that of the individual. When considering Māori health, this becomes complicated by a 'cultural' layer where an ethnic group may exercise their collective rights to survival and improved health by striking a balance in favour of whanau, hapū, iwi or Māori communities rather than respect of individuals rights to with-hold consent or ensure

privacy. This is greatly assisted by the evidence of public health benefits that flow from this approach. For example, in West Auckland immunization rates amongst the dominant Māori providers' registered populations have been said to have increased to around 90% in 1998, from around 70% two years ago (Well Child programme, Wai Health, presentation by Sue Cregnell, July 1998). The Auckland average immunisation rate is just under 70% in 1998, also reflecting an improvement from over two years ago.

Integrated Social Policy: Case For Co-Ordination And Integration In Services

A common theme amongst Māori providers is the extent to which their health strategies are part of a bigger picture of Māori development. In particular, the Case Studies in this research viewed health as a necessary pre-condition to Māori development and success. Close relations between Māori authorities and these health initiatives (both iwi and multi-tribal), resulted in an integrated policy approach incorporating health, training and employment and education initiatives, along with cultural promotion of marae development, te reo, kapa haka and traditional arts such as taniko weaving, rongoa, whakairo and taiaha.

Evidence of Māori provider commitment to integrated approaches to care can be seen in their community development orientation that extends beyond their own members (such as iwi), to incorporate manāki ki tangata principles for others in their areas. Their community development practices also sit within a broader analysis that highlights the importance of high quality health services for Māori communities. Achieving high quality services for Māori requires relationships between Māori and non-Māori providers because of the necessity for transferring levels of clinical and organisational expertise to Māori communities. Such a transfer is however dependent upon a high degree of trust, and will take time to build. Trust is especially important for Māori given the experience of colonisation. Voyle and Simmons argue that,

Most significant encountered [issues for partnership] related to trust, or more specifically, distrust among Māori engendered by historical and contemporaneous experiences of contact with Europeans (Voyle, 1999, abstract).

Shortfall In Funding - Expectation Of Community And Private Contribution In Funding

Strong relationships existed between parent Trust boards and their Māori health provider offspring but there were still understandably gripes. These gripes covered things such as the extent to which the Trust interfered in the governance of the health provider, or the use of the health contract as a cash cow that then became responsible for funding other initiatives. Health contracts may have cost parent organisations money during the establishment phase, but have become important, regular and significant revenue streams for Māori communities around New Zealand.

The criticism by providers that their contracts did not allow for growth, unless they contracted for new services, raised questions about the long term viability of their core contracts. Much of government policy during the 1990s focused on the establishment of pilot projects funded on a marginal and ad hoc basis. Māori health providers contracted for an increased range of services as a means of accessing new funding streams, sometimes before they were able to provide the service (such as recruiting new specialist staff for example). Access to other social services money has been especially tight during this period (1990s) particularly for ongoing services. An example is the criteria for Community Funding Agency funding that supported the establishment of new services, but would not pay for any co-ordination or infrastructure development by providers, despite many complaining that this was exactly what was needed.

Health purchasers recognised the need for more regular, guaranteed funding and funding for infrastructure development, the only source of which was competitively available ad hoc funds such as TAGs and MPDS grants. However, even here, ongoing co-ordination was not funded. Balancing these interests is of course difficult and by and large RHAs managed to be more flexible with Māori providers in allowing for this type of co-ordination within the operational budgets and special grant budgets.

Government policy, with respect to social services during the 1990s, assumed that the wider community would take up responsibility for these. This transfer of responsibility

and cost meant that individuals and families were faced with making a greater contribution to caring for 'their own'. There was also an increased role for Territorial Local Governments, many of whom picked up increased responsibility for social services funding with the withdrawal of central Government from funding many community services. The assumption of central Government that corporate or private sponsorship would fill the gap created by the withdrawal of central Government support, was consistent with what occurred in overseas liberal democracies, but such a view was woefully optimistic given New Zealand's history. There is considerably less philanthropic support from the corporate or private sector in New Zealand than in comparable liberal democracies like the USA, Canada and UK, partly due to the small size of our corporate sector and partly because of our history that has not included this type of philanthropy.

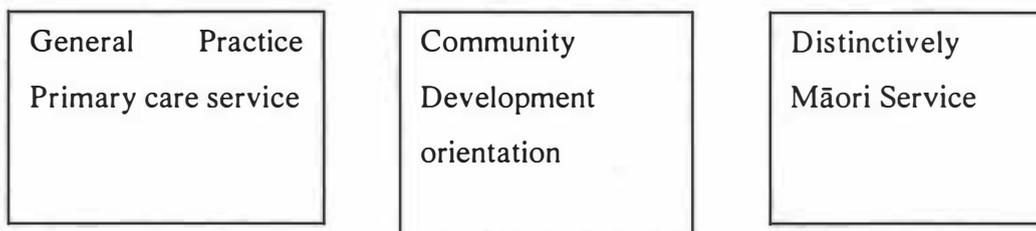
Furthermore, individual philanthropy was constrained by the increased transfer of costs for items such as education, health, low-income housing and increased unemployment. Less disposable income for middle and low-income New Zealanders, meant hard times for social services during the period of neo-liberal reforms. This meant that Māori social service providers (some of whom had been the precursors for Māori health providers), were even more reliant on those revenue streams from Government which they could access, and in some cases, social service delivery became part of this 'hauora' delivery programme.

Hauora And Kaupapa Māori Providers

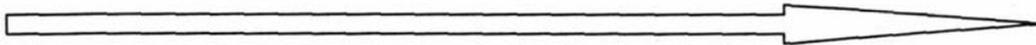
A key finding of this research is that of the operationalisation of a concept of hauora Māori by Māori health providers. All providers considered themselves kaupapa Māori providers. However, there were few who could articulate what it meant to be a kaupapa Māori service or a Māori kaupapa service. When asked what a kaupapa Māori service was, they identified practices such as "committed to helping Māori", "being Māori", "doing whatever it takes to help" and "speaking Māori" as evidence of operating a Māori kaupapa. The question about whether a Māori kaupapa is the same as a kaupapa Māori service, or indeed a Māori health service is worth teasing out a bit more.

Māori providers can be considered as falling into one, two or three of the following categories covering a spectrum of elements moving towards a kaupapa Māori service. The spectrum begins with a core General Practice service, includes elements of community development through providers' health promotion arms and community networks, then moves towards the incorporation of elements of a distinctively Māori service.

Figure 17 Model of Comparison Kaupapa Māori Service Elements



Spectrum of elements of Māori health providers – towards a Māori kaupapa service



The elements of General Practice and Community Development incorporated in Māori providers have been covered in the thesis, but it is worth reiterating those elements that are distinctively Māori.

A Māori health service can be considered a service aimed at improving Māori health. This does not differentiate between a service run by Māori or non-Māori. However a kaupapa Māori service, or Māori kaupapa service, must be owned by Māori, service mainly Māori patients, have a significant proportion of Māori staff, be networked into local Māori communities, and have a shared analysis of 'being Māori' and being responsible to Māori.

All primary care providers in the research Case Studies identified themselves as having a Māori kaupapa because they contained all of these elements. However, the question of a

difference between kaupapa Māori and Māori kaupapa is more difficult. There does appear to be a difference in the extent to which a kaupapa Māori service has a sophisticated analysis of their position in relation to Māori development, rather than expressing operational or more superficial elements of being Māori. The distinction therefore, is between a health provider who has a Kaupapa Theory analysis including a liberationist philosophy of empowerment, and one which is a replacement for a third sector or community health clinic, albeit with significant 'Māori elements' such as use of te reo in signage, presence of Kaumātua and kuia, and their location on a marae,.

The more difficult question to answer from this research, is whether being a kaupapa Māori service delivers inherently superior health benefits to those delivered by a Māori primary care service, or a Māori kaupapa service. It was not possible from this research to tell if such a difference exists. There is a perception amongst Māori providers that the further along the spectrum of being distinctively Māori, then the more inherently superior the benefits. This belief needs to be tested. Certainly, the health evidence suggests that Māori may benefit from all types of approaches, as long as they are done well. This is partly due to the linking of Māori health with development, in that clinical and health outcomes have also become inherently linked with Māori desire to achieve political outcomes. It has been argued by many in Māoridom that the best results have come from the 'purest' models of Māori development, such as, arguably, those based upon the historical entitlement of iwi. Only urban Māori, some hapū, and now Tainui, have questioned this view.

This research does show however, that there is a Māori model of health care delivery and that furthermore, the preliminary evidence suggests beneficial effects from their presence. However, longer term and more extensive research is required to determine what these benefits are. Such research requires an honest appraisal of the whole spectrum of Māori health care, including a consideration of the role of public health, mainstream Pakeha services delivering to Māori, and all Māori health providers.

Future Of Māori Health Care

The successful election of a centre-left Government in November 1999 has led to another substantial change in health policy. The Health Funding Authority established from the merger of the Regional Health Authorities, will be dis-established and its functions merged with the Ministry of Health and new District Health Boards. District Health Boards are very similar to the old Area Health Boards. Thus many commentators believe that health policy has almost come full circle from 1990 to 1991 when Area Health Boards were gaining momentum, to the purchaser provider split and establishment of Regional Health Authorities and Crown Health Enterprises, following a transition period of around two years when the health sector was effectively managed by the Interim Provider Board and Commissioners. The Interim Provider Board and Commissioners were replaced when the new structures came into effect with the Health and Disability Services Act in 1993. These were changed again in 1997 to the Transitional Health Board and Health and Hospital Services, to the Health Funding Authority in January 1998, and now to District Health Boards before the end of 2000 with the introduction of the Public Health Services Act.

Despite the enormous uncertainty in the health sector and fatigue from continual changes to staff, structures, and contracts, it is almost certain that independent Māori providers will stay as a feature of the new health landscape. They may change form to make themselves more attractive to District Health Boards and will need to be more responsive to population based health approaches, as will many other health providers. Attention should still be paid to opportunities to integrate primary and secondary health care services. A revolution in primary care in New Zealand is taking place, and Māori health providers in the primary care sector, are at the forefront of such a revolution. Their experience of capitated funding, budget holding, community outreach, alliance building with other providers and addressing the needs of a high health risk population, all contribute to this possibility.

Managed care is unlikely to be on the political agenda now, with efforts focused on community contribution to high need populations. There will be a re-emergence of a

Health Charter by the Minister of Health detailing health priorities, including Māori health gains (the previous Labour Minister of Health, Hon. Helen Clark developed such a Charter for Area Health Boards in the late 1980s). Māori providers and Māori health are likely to continue as key features of new health strategies to address the high health needs and poor health outcomes of Māori.

One of the difficulties currently presaged is the inherent conflict between MAPO who are co-purchasers (although their role is extremely unclear under the HFA) and other Māori providers whom they appear to regard as competition in the new environment. This assertion of iwi mana is considered to over-ride other considerations. Although iwi have a responsibility for manāki tangata for all those within their rohe, they also have an expectation that services should be provided by themselves, as this guarantees their continued mana. Such assumptions may be under considerable scrutiny with the new government who are more inclined to a pan-Māori approach.

This provides a direct challenge to the Treaty Partnerships strategy developed by North Health and the Health Funding Authority. It is likely therefore, that the question of iwi rights and the place of Māori urban Authorities will continue to be a point of tension with the health sector and more generally within public policy.

The Māori Provider Development Scheme is in its final year, having spent \$30 million over three years on Māori Provider Development. It remains to be seen whether the new government will target monies for Māori health in the same way. This is unlikely. It is more likely that they will return to some sort of Departmental model which will act as a conduit for government monies intended for Māori development. This will be balanced by increasingly clear prescriptions for achievement of Māori health goals by mainstream providers.

It is also possible and desirable, that Māori workforce development strategies continue. Māori health scholarships, Provider Assistance, Workforce and Service Pilots and Best Practice and Procedures Models are all part of achieving qualitative improvements in

Māori health services. These services, coupled with changes to the macro and micro policy environment for Māori, such as improvements in education, employment, income, and housing will inevitably have an impact on health.

Achievements Of Māori Providers

Māori health providers have achieved an enormous amount within a short timeframe. They have had to grapple with complex and changing policy environments and clinical services, while convincing Māori and Crown agencies of their suitability. Compliance costs have been high, and in many situations resources inadequate to the scale of the task. Despite this, they have managed to establish credible services that offer Māori genuine alternatives not available a few years ago.

There remain many areas for development, not least of which is the absence of clinical depth among Māori, and management and governance inexperience that has manifested itself in unnecessary staff difficulties and inadequate planning and information. These shortcomings have been identified by the Purchaser and by providers themselves, and a pool of funds made available to develop such expertise. However, here again there have been controversial approaches such as spending around \$25 million on one Māori Provider Development initiative (most of the funds available in 1998), rather than a more sensible or measured approach to development.

Māori health providers have been successful primary care service providers, and have also operated within a difficult CHE environment. There is room for improvement. The tendency for an authoritarian management style, despite espousing collective responsibility was evident with more than one provider. There were also confused lines of accountability on some sites, particularly where marae committee members became involved in employment matters concerning family members.

These examples are few and overall Māori providers have managed the transition to the health 'market' responsibly and with few hiccups. They have tolerated low salaries (among non-clinical staff), temporary premises and inadequate equipment (until

equipment grants were available), onerous reporting and contracting responsibilities, limited room for growth within operational budgets despite increasing pressure on services and incredibly high expectations for performance and accountability from their multiple communities of interest.

The effects of public debates around race relations are likely to lead to unhealthy consequences for Māori in the current climate. A climate of tolerance does not presently exist in New Zealand society (Kiro, 1998b). Ironically Treaty settlements have fuelled this unease and increased tensions between tribes and consequent tension between tribes and pan-tribal Māori organisations. Without a major change in policy direction the outcome is likely to be continued conflict and possible growing inequality within Māori society. The Labour-Alliance Government of 1999, appears to want to address these problems, particularly through their Prime Minister led 'Gaps' Cabinet Committee. Such political leadership is an essential component to improving the lot of Māori. In order for improvements to occur, this leadership it needs to be coupled with other social and economic policies that address the underlying position of Māori in New Zealand society,. The continuation of policies that contribute to inequality, such as those of the last 16 years, will lead to a deterioration in Māori health status.

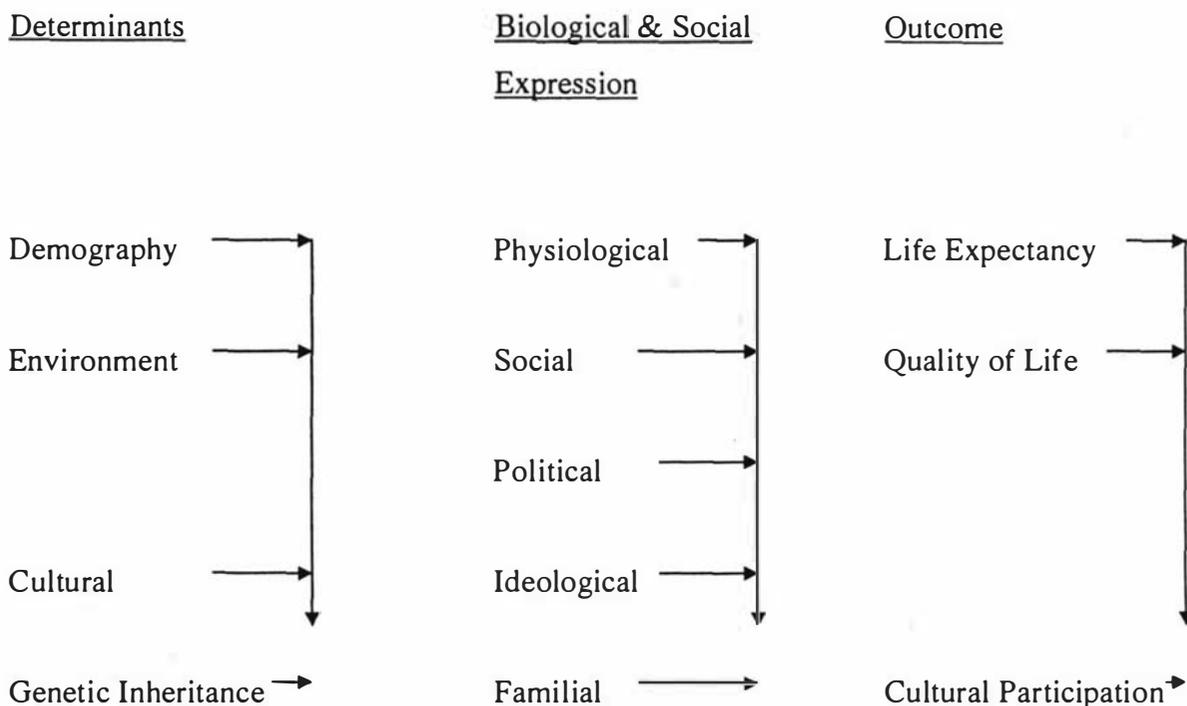
What is clear is that there is a need for long-term investment by Government in Māori development in health, with clear guidelines and commitment to broad public health campaigns and personal healthcare solutions. Clear messages need to be given, along with resources, to concentrate Māori energy on the important lifestyle health issues such as smoking, however, these messages and resources must also address socio-economic and cultural determinants of health.

The Relationship Between Determinants And Outcomes

In determining health strategies, policy makers need to understand the relationship between those factors that contribute to health outcomes. These include processes incorporating biological and social factors. These result, in an interactive process, in

certain outcomes. These relationships have been described throughout this research and are summarised below.

Figure 18 Relationship Between Determinants And Outcomes In Health



All of the factors identified above are important components of a holistic health model. Hauora encompasses many of the same concepts, but recognises whakapapa, tikanga, knowledge of tribal history, participation in Māori networks, strong identity (not just as a Māori or particular iwi, but also as a person), and feelings of belonging and well-being. Hauora includes physical well-being, but is not limited to this. Also important is the sense of spiritual place, connection to physical environment (connection with Papatuanuku – Mother Earth and Ranginui – Father Sky), family functioning and emotional functioning. Intellect and mental balance are also important components of hauora.

Formulating Māori health policy that addresses this diverse and all encompassing range may prove too difficult in the short term. It is therefore sensible to concentrate on those things which policy appears to make a difference to in Māori health. In particular, the

congruence with public health and population-based approaches is something that requires the active partnering of Government and Māori communities to address.

Conclusion

The Minister of Health's press release dated 13 October 1997 stated that, "Māori providers in the health sector have increased from around 30 providers in 1993, to over 200 providers in 1997". It goes on to say that,

Māori providers have made significant gains in a range of issues including: the promotion of public health messages; the uptake of immunisation; improved access of Māori to primary care services; and the health of Māori women. Organising health services around a particular community, which provide local solutions to local problems are key elements in the success of Māori providers. We must continue to be built on these gains so that Māori can enjoy the same level of health as non-Māori (Minister of Health, Parliament, 13 October 1997).

By 1999, the number of Māori providers nationally was 240, with around \$32 million in total budgets between them (Request For Proposal for Māori Provider Evaluation, Health Funding Authority, March 1999).

The use of the terms, "provide local solutions to local problems" is significant as an idea since it allowed the fruition of locally responsive solutions, thereby facilitating Māori communities and iwi to provide services to themselves. Successive National Governments during the 1990s, intended that communities would themselves find the solutions to their problems, without acknowledging that the very environment within which people operate has a great determining effect on them. The location of the 'problem' in local communities, has been a feature of the new right policy agenda around the world. It has not succeeded in New Zealand in terms of economic performance relative to similar economies and in terms of health outcomes for Māori.

While Māori providers have been extremely successful at establishing, consolidating and growing their services, it has occurred within an environment that is not conducive to

Māori health and well-being. It is not enough to pepper-pot marae based GP clinics around Auckland. We must also address the wider socio-cultural questions and economic circumstances of Māori, before improvements in health can occur. This approach requires the combined efforts of government departments working together for a common purpose, and the combined efforts of Māori organisations - including all Iwi Authorities. Ad hoc, piecemeal approaches will not work. This has not been the responsibility of the health authorities alone. They have been amongst the more innovative of government agencies in respect of Māori development. However, the strategies have been largely ideological with inadequate exposure to sufficient critical evidence about the long-term effects. In particular, the concentration on by Māori for Māori providers to the exclusion of mainstream enhancement strategies, must be questioned.

The major conclusion of this research is that for all the good work done by Māori providers, an essential component for ensuring Māori health gain will be through North Health's (now the Health Funding Authority, and soon to be the Ministry of Health and District Health Boards), mainstream enhancement strategy. By Māori for Māori providers remain a small part of the overall health sector as evidenced by the tiny proportion of the budget and service contracts provided by Māori health providers. Most Māori using the health services visit mainstream providers in primary, secondary and tertiary care. More attention is needed here to substantially shift these deeply entrenched silo cultures based on medical disciplines and historical jealousies. However, the good work done by Māori providers in the primary health arena should be acknowledged, celebrated and consolidated. While much greater clinical depth is required amongst by Māori for Māori providers, much greater cultural competence is required within mainstream services, and more Māori are needed in these key clinical, policy and management roles throughout New Zealand's health system.

It is not enough to offer Māori the carrot of health service contracts. Clearly Māori are no longer willing to be passive recipients of health services and are intent on expanding services offered by Māori to Māori. However Māori must recognise the difficulties which have brought Māori to this situation and at the very least be willing to confront the

disproportionate burden of illness which falls on Māori as impoverished members of this society. Health is an issue for populations, not just individuals. Māori health is an issue for all New Zealanders, not just Māori.

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APPENDIX

Interview Questions Semi-Structured Interviews

Policy Makers

1. Can you please tell me about the key aspects of health reforms introduced by the early 1990s?
2. What do you think was the intent of these reforms?
3. What have been the implications for Maori of these reforms?
4. What do you identify as the key policies resulting from these reforms?
5. Is there anything else you wish to add?

Maori Providers

1. Can you please tell me about the key aspects of health reforms introduced by the early 1990s?
2. What do you think was the intent of these reforms?
3. What have been the implications for Maori of these reforms?
4. Can you tell me about your service?
5. What specific features would you identify as being uniquely Maori as a service provider?

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6. What do you identify as the main advantages and disadvantages of these health reforms?
 7. Is there anything else you wish to add?

North Health Staff

1. Can you please tell me about the key aspects of health reforms introduced by the early 1990s?
2. How did North Health implement these reforms?
3. What have been the implications for Maori of these reforms?
4. What do you identify as the key policies and outcomes resulting from these reforms?
5. Is there anything you would do differently?
6. Is there anything else you wish to add?