‘Te Mana Whakahaere - Te Whaiora Māori’-

Change Management
and Māori Health Development.

William Wiremu Lance Manaia

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Change Management and Māori Health Development.

A study on the management of Māori health strategies in a changing health sector from the 1991 health reforms to the year 2001.

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He Mihi

E ngā waka

E ngā hau e whā

E ngā iwi

Kia mihia te mano tini kua mene ki ngā Hawaiki katoa

Rātou te tutūtanga o te puehu

Te whiunga o te kupu i ngā wā takatū ai rātou

Heoi, waiho ake rātou ki a rātou,

Tātou te urupā o rātou mā

Ngā waihotanga mai e hāpai nei i ō rātou wawata

Tūmanako hoki

Kia mau ki te kura whero

Kia mau ki te kura tāwhiwhi

Kei waiho tātou hei whakamōmona i te whenua tangata

Hokia ki ngā maunga kia purea tātou e ngā hau a Tāwhirimatea

Nō reira

Whakarongo, whakarongo, whakarongo

Ki te tangi a te manu e karanga nei

Tui, tui, tui, tuia

Tuia i runga, tuia i raro

Tuia i roto, tuia i waho

Tuia i te here tangata

Ka rongo te pō, ka rongo te ao

Tuia i te kāwai tangata

I heke mai i Hawaiki nui

I Hawaiki roa

I Hawaiki pāmamao

I hono ki te wairua

Ki te whai-ao ki te Ao-mārama

Tihei Mauri Ora.

Ko Tainui me Mataatua nga waka,

Ko Kakepuku me Putauaki nga maunga,

Ko Waipa me Rangtaiki nga awa,

Ko Ngati Maniapoto me Ngati Awa nga iwi,

Ko Ngati Apa kura me Nga Maihi nga hapu,

Ko Kahotea me Tuteao nga marae,

Ko Te Awamutu me Te Teko aku kainga tipu,

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Ko William Wiremu Lance Manaia toku ingoa.

Ko te mea tuatahi ko te wehe ano ki a Io matuakore heoi ano te timatanga me the whakotinga i nga mea katoa.

Tuarua nga mihi atu ki a ratou nga mea kua wehe atu ke ki te po,

Nga manu whetua kua uhia ki roto i a Ihu,

Nga poutokomanawa i nga wharemairo a o tatou matua tipuna,

I puawai te ata huakitanga,

I unuhia ai a tatou maha o tikitiki o Rangi,

I unuhia te hunga mate ki te hunga, te hunga o te tuawhakarere.

No reira, he mihi aroha tenei kia ratou nga kaitautoko i nga rangahau kupu korero nei.

Ratou nga mea i whakatuwheratia o ratou ngakau, o ratou whakaaro, o ratou kupu korero hei rauemi rangahau mo te iwi.

Koutou nga mea e okioki ana i waenganui i nga uauatanga o te Ao Hurihuri nei.

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Tena koutou, tena koutou, kia ora ano tatou katoa.

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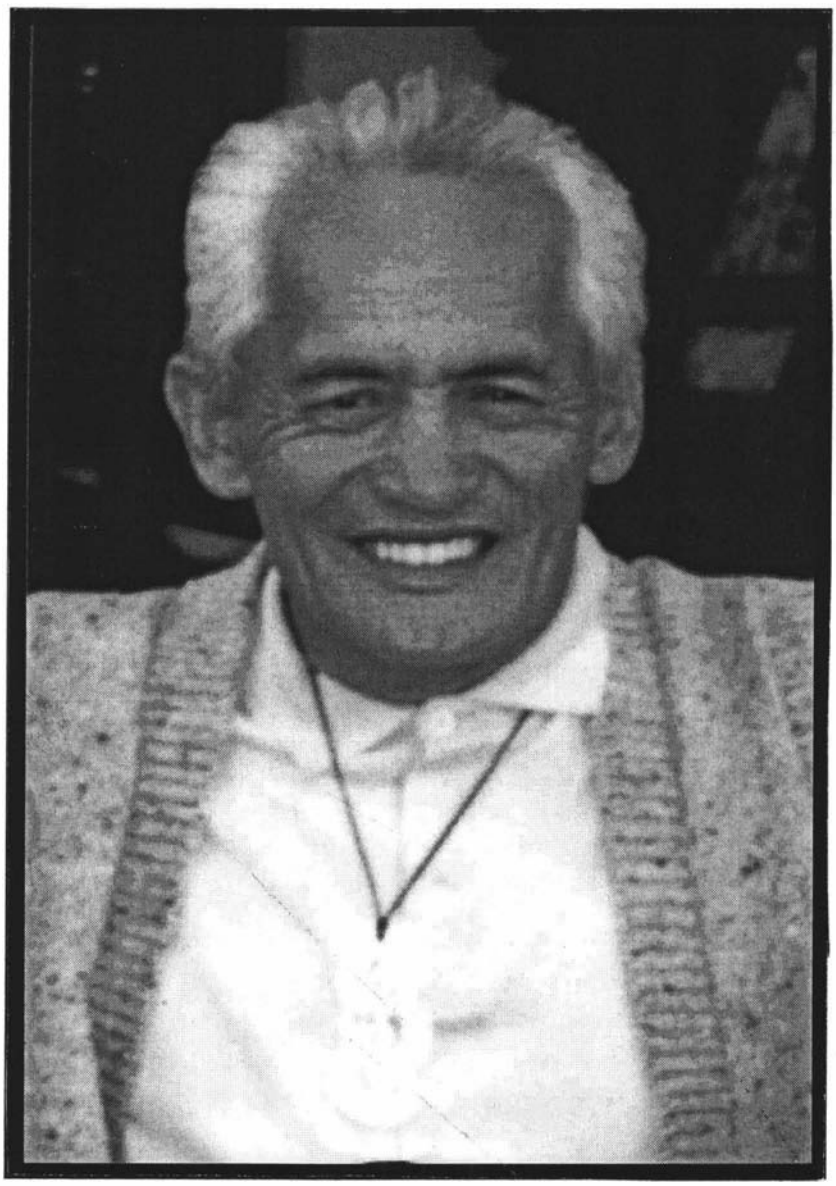

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FIGURES AND GRAPHS

GLOSSARY OF MĀORI TERMS

Aotearoa	New Zealand
Aroha	Love
Atua	God
Awhi	to support / to comfort / hug
Hauora	Healthy
Hapu	Sub-tribe
Hoha	Nuisance
Hui	Meeting / gathering / conference
Iwi	Tribe
Kai	Food
Kapahaka	Maori performing arts
Kaumatua	A Māori elder.
Kaupapa	Topic / plan / idea / concept / philosophy
Koha	Gift, donation.
Kohanga Reo	Māori language nest / Total immersion Māori language early childhood care centre
Koro	Māori male elder.
Kura kaupapa Māori	Total immersion Māori language school
Kuia	Māori women elder.
Manaaki / Manakitanga	To care for / to take care of.
Marae	Traditional Māori meeting house
Matauranga	Education / knowledge / training
Moana	Sea
Pakeha	Non-Māori / European
Reo	Language
Tane	Man / Male
Tapa	Side
Tapu	Sacred
Te	The

Tikanga	Māori protocol
Tino Rangatiratanga	Self determination
Wahine	Woman / Female
Wananga	Learning session / Place of learning / University
Wha	Four
Whakapono	Faith.
Whanau	Family
Whare	House
Whenua	Land

Sources:

Ryan, P.M., (1995) *The Reed Dictionary of Modern Māori.* Auckland, Reed.

Williams, H.W., (1985) *A Dictionary of Māori Language.* Wellington: Government Printer.

APPENDICES

CHAPTER ONE

THE FOUNDATIONS

OVERVIEW

Two themes form the basis of this thesis. One is Maori health development, and the other is Māori health management or, in particular, the management of health sector change by Māori health professionals. Both themes are inextricably linked. One is about definitions of Maori progress and is focussed on health gains. The other is about process. Although both are examined in the context of positive development and differing perspectives, this research is essentially about Māori health management strategies, or processes through change for achieving best outcomes for Maori health service delivery. This thesis is primarily focussed within the time span 1991 to 2001, though there are speculations that go beyond that period of time. For convenience sake, the focus period for this thesis is continuously referred to as 'the 1990s'.

In 1991 the National Government introduced a series of significant health reforms which accelerated a privatisation trend, making the health sector more accountable in business and commercial terms. Democratic control of hospital boards was replaced by appointed boards with business objectives, thus forming a market place within the health sector. This transformation was justified by the needs for efficiency, cost containment and accountability to consumers but in the process it increased the growing importance of management through social policy reform.

Whether better health care for Māori would eventuate, and what management practices would ensure better outcomes for Māori health from the reforms, are both addressed in this thesis and two fundamental questions are asked:

1. What was the impact of the 1991 health reforms on the organisation of Maori health services?

2. What were the experiences of Māori health workers at all levels of the health sector from 1991 - 2001?

THE HYPOTHESIS

At the inception of this research the following hypothesis was formulated:

"The aspirations and objectives of Maori health planners and providers have been frustrated and compromised by politically imposed policies in the New Zealand health sector."

From the outset, the thesis sought to either prove or disprove this hypothesis by identifying Māori health issues and outcomes from health sector reforms implemented through political changes between 1991 and 2001. All research findings were analysed for relevance to the hypothesis.

THE HEALTH SECTOR

New Zealand attracted much international attention in the mid 1980s for its radical economic and social reforms. This reforming tendency continued throughout the next decade and showed no signs of decreasing. In late 1999 the National Government was replaced by a Labour led coalition, which rapidly and significantly changed the way publicly financed health services were organised.

Before the general election in 1999, Labour had criticised the National government's market-led system because of its narrow focus on the production of services rather than the improvement of health, for having fragmented a public service, for fostering inappropriate commercial behaviour, for increasing transaction costs, and for lacking local democratic input.[1] These problems were attributed to the corporate model of public hospital provision with four regional health purchasing agencies. After the 1999 general election both were replaced by a system promoted as allowing greater community input in health sector decision making and increasing public input into the public health system.

This thesis is focussed in the era prior to 1999 developments and examines Māori experiences with the quasimarket model in the 1990s and the rationale for structural change. It identifies challenges Māori health professionals have faced in addressing Māori health needs within this environment and considers general lessons provided from these experiences.

CHANGE MANAGEMENT

In the public sector, change is inevitable and typically occurs when governments themselves are replaced. It is a political reality that when governments change, social policy changes and reforms follow. Consequently, governments that manage to retain political power for more than one term are more likely to derive benefits from public sector reforms, at least in theory.

In the private sector change is often stimulated by environmental pressures as well as strategic policy.[2] In the public sector strategic policy is the primary mechanism for affecting change in the environment.[3] Public sector agencies must also deliver results in an environment involving much greater community scrutiny than the private sector.[4] Public sector managers must relate to a wide range of stakeholders who often have contradictory expectations. For instance, a tax payer who favours less taxes may also favour increased spending on health. Taxpayers in general all seek a degree of control over public servants. Within such an environment, the degree of autonomy granted to the public agencies and their managers is a critical management issue. Central to this issue is the element of control.

The management approach to public sector reforms is captured within the dual objectives of *'let the managers manage'* but *'hold them accountable for the results.'*[5] All organisations use levels of control for achieving goals and objectives by channeling the focus of their members. Organisations choose to create this focus through mechanisms of control that can range from harsh manipulation to mild supervision[6]. Delegation is a modified form of control in which autonomy is

constrained within clear rules. Relaxation of central control is a process of progressive willingness to first delegate power and resources and then devolve responsibility for key decisions. Devolved control is a more permanent form of delegated power, often underpinned by legislative backing.

In contrast, autonomy is a bottom-up form of control in which the focus of power is decentralised.[7] Autonomy is a state of independence which is very important to professionals and entrepreneurs. Autonomy is a need to be independent in making decisions, to feel free and not be obliged to conform.[8]

> *"Those who need autonomy wish to decide their own agenda, to work around hierarchies, and resist coercion and restriction. They are self-sustained."*[9]

Autonomy is a critical element in organisational innovation.[10] Innovation in a large organisation occurs, almost invariably, as the result of small independent groups of imaginative action-takers working to circumvent or even sabotage the formal systems.[11] The 1991 reforms were about encouraging entrepreneurial innovative action which isn't necessarily a bottom up process as implied here though the ability for such influence does exist.

Unfortunately, public sector reformers face a paradox in the adoption of business control methods in order to achieve change. By virtue of democratic decision, bureaucratic control from the top down is built into publicly owned organisations. Methods of control, whether based on inputs or outputs, appear to offer predictability for the maintenance of democratic control. Yet, if overdone, control mechanisms can stifle the innovation which is sought as a primary purpose of reform. Without the willing involvement of powerful individuals such control may be more illusory than real. Historically, four dominant modes of public sector management have been evident;

- control;
- delegation;
- devolution; and
- autonomy.[12]

For almost a century, the hierarchical or classic bureaucracy was the dominant method for managing public sector organisations. However, over recent years, the language and structures of bureaucracy have been gradually replaced by an infusion of business management methods. This is examined further in Chapter Four, Crown Policies for Change. A shift from bureaucratic to business control is not a simple process. A more diversified approach to change strategies is required. In 1998, Norman and Stace proposed a change management model which acknowledges the peculiar difficulties of specifying outputs and outcomes for some public sector functions. It specifically allows for a stabilising role, which is a distinctive public sector contribution to communities. Far from one single best way to manage public sector change, there are a rich variety of options influenced by the results sought and the mode of management used. The model from Norman and Stace (1998) suggests four modes of change management:

- autonomous change;
- stabilising bureaucracy;
- entrepreneurial change; and
- business revolution.[13]

Autonomous change is used in human services or professional organisations where heavy emphasis is on processes reliant on the input of high-level individual skills. Outcomes have as much to do with process and client interaction as they do with formal tangible outputs. Use of this change management strategy assumes tolerant and accepting stakeholders and a predominance of skilled professionals who buy into the change goals.

Stabilising bureaucracy is used when autonomous or devolved leadership styles have not yielded sufficiently reliable results. Over-emphasis on tangible outputs and outcomes has left the organisation vulnerable to market failure through inadequate controls on inputs or processes. In some cases this process of change can be disastrous. In using business methods to revolutionise New Zealand's public sector, one of the first professional groups to lose its power base was the engineers, or in particular the former Ministry of Works. The lack of engineering expertise in the replacement structure, however, may well have contributed to two striking failures – the loss of electricity for two weeks in central Auckland in 1998, and the loss of fourteen lives in April 1995 with the collapse of a Department of Conservation viewing platform at Cave Creek on the West Coast of the South Island.[14]

Entrepreneurial change is seen in periods of major turbulence when the organisation needs to radically change its operating culture, while still retaining the commitment of the major internal players. This type of change is highly leader dependent and is often susceptible to political intervention if stakeholder needs are being ignored.[15] The entrepreneur and public sector bureaucrat are often portrayed as opposites. Business control methods emphasise the role of rationally developed plans.[16] However, entrepreneurial change is more aptly described as strategic intent with emergent strategy and goals.[17]

The business revolution method of organisational change involves the retention of hierarchical control through monitoring of funds, and statistics of outputs and outcomes. It is a change process implemented with great speed and is comparative to a business revolution in its overthrow of bureaucratic forms and procedures. The business revolution style is a centrally driven approach using methods of economics and accountancy as its central discipline and language.

This latter method of change management was the dominant style of change within the New Zealand public sector in the 1990s. Private sector accounting

methods were standard practice for all government organisations, enabling New Zealand, in 1992, to become the first country in the world to report its finances on the same basis as a large corporation.[18] The new budgeting system, combined with accountability based employment contracts, created a disincentive to overspend. The initial state owned enterprises were joined by Crown companies which in the health sector consisted of Crown Health Enterprises, each with Boards of Directors drawn primarily from private sector backgrounds. While these organisations had a greater degree of autonomy than core public services, they operated within a strategic framework which required approval of corporate plans as well as financial results.

This business revolution brought considerable improvement to elements of the health sector – the structures, strategies and systems but, in contrast, the human issues were seen to experience neglect.[19] The issues around public sector change management and outcomes for Māori health are examined further in Chapter Four – *Crown Policies for Change*, and Chapter Nine, *Change management and Māori Health Development*.

KAUPAPA MĀORI RESEARCH

Over the past two decades, the Maori renaissance, or cultural revival, has engendered an environment in which Māori intellectuals have begun to challenge western models of knowledge construction. Māori definitions of kaupapa Māori research include research which is:

> *'...culturally safe which involves mentorship of kaumatua which is culturally relevant and appropriate while satisfying the rigour of research and which is undertaken by a Māori researcher and not a researcher who just happens to be Māori.'*[20]

Glover (1997) describes it as a:

> *'...desire to recover and reinstate mātauranga Māori the indigenous system that was in place before colonisation.'*[21]

Other Māori have made clear distinctions between Pakeha and Māori approaches to the acquisition and construction of knowledge. Cram (1993) argues that:

> *'...the purpose of Māori knowledge is to uphold the integrity of the community. Non-Māori, on the other hand, view knowledge as cumulative, whose component parts can be drawn together to discover universal laws.'*[22]

Therefore, Māori research embraces traditional beliefs and ethics, while incorporating contemporary resistance strategies that embody the drive for self-determination and empowerment for Māori people. Maori themselves are concerned about the accountability of researchers, and who or what controls the creation and distribution of knowledge about Māori. Bishop (1996) advocates that kaupapa Maori research must be founded on self-determination, legitimacy, authority and empowerment for Māori:

> *'We know that there is a way of knowing that is different from that which was taught to those colonised into the western way of thought. We know about a way that was born of time, connectedness, kinship, commitment, and participation.'*[23]

Thus Bishop develops understanding of the historical and cultural factors that underpin kaupapa Māori, both as a resistance and reconstruction strategy and a Māori centred approach.

Durie (1996) outlines three developments that have accelerated the adoption of a Māori centred approach to Māori health research:

1. the world wide move by indigenous people towards self-determination and greater autonomy,
2. New Zealand's reaffirmed commitment to the Treaty of Waitangi in the 1980s and the subsequent inclusion of the Treaty in obligations, though not necessarily legislation, and
3. recognition by 1980, that Māori world views and Māori understandings of knowledge were themselves distinctive.[24]

Kaupapa Māori research requires that cultural factors be recognised and incorporated into both the design and implementation of projects. Māori researchers are being confronted with challenges not the least of which is rediscovering and centering Māori specific research theories and methodologies. Smith (1999) outlines three further challenges for Māori research:

1. to convince Māori people of the value of research to Māori
2. to convince the various, fragmented but powerful research communities of the need for greater Māori involvement in research; and
3. to develop approaches and ways of carrying out research which take into account, without being limited by, the legacies of previous research, and the parameters of both and current approaches.[25]

Kilgour and Keefe (1992) identify another consideration for kaupapa Māori research motivated by repeated calls from Māori for:

"Māori to do their own research and to generate their own statistics."[26]

The momentum of increasing Māori health research is exemplified in the growing number of Māori research centres throughout the country and the increasing number of Maori health research development awards. These initiatives have contributed to the development of a Māori health research infrastructure alongside tribal reconstruction and redevelopment. Research has been recognised by iwi as having potential to support development. According to Moewaka Barnes and Stanley:

"Maori health research is in its relative infancy and we are merely contributors to this field..... we are all in a time of dynamic change with regard to Māori health research and being a part of that frontline allows some unique contributions and opportunities."[27]

Māori literature on this topic identifies a loss of Māori structure and processes which necessitated the passing on of Māori knowledge. There are however, information gaps which created a need to do 'survival research'[28] by establishing baseline data, documenting and describing current states, answering questions of high practical value, rather than pursuing academic or scientific theories with less definable practical use. For this reason kaupapa Māori health researchers must incorporate ethical and accountability requirements:

"We need to give ourselves the space and the resources to set our own rules and guidelines for the work that we do. The reality of the majority colonising paradigm forces us to take our tikanga, take our views and twist and shape them into a set of

protocols which are not our own and the end result is research which is damaging to our people."[29]

Given the historical involvement of Pakeha in research relating to Māori, the acceptability of non-Māori researchers in matters Māori has been questioned.[30] Furthermore, Māori genetic constitution does not automatically qualify a person to research kaupapa Māori.[31] In other words, kaupapa Māori is underpinned as much by values and tikanga as by the ethnicity of the researcher.

Much has also been written about the process of colonisation and the consequential imposition of Pakeha culture, values and practices, institutions, language, education, economics and law on Māori. A further criticism has been that research on Māori is merely descriptive, only telling Māori what they already know or reinforcing negative stereotypes and not producing any substantive and beneficial outcome.

Increasingly, research projects conducted in New Zealand have had to address Māori involvement. Cunningham (1998) classified research into four areas:

1. research not involving Māori
2. research involving Māori
3. Māori centred research, and
4. kaupapa Māori research [32]

Based on these categories, Māori participation can range from no involvement to complete management and control. For Cunningham, research can only be described as kaupapa Māori when the project is under complete Māori control which is in contrast to Māori centred research, where control may rest outside Māori hands.

Non-Māori involvement in the conduct of Māori research is a contentious issue. Some Māori are opposed to Pakeha conducting research on Māori believing non-Māori involvement is unnecessary and counter productive.[33] Apart from their different historical, social and cultural views, which inhibit accurate understandings of Māori, there are also simple practical deterrents which can hinder researcher performance and project outcomes such as being effective in Māori consultation and participation with Māori protocols. The development of rapport with research participants and the ability to collect detailed and accurate data are enhanced when Māori researchers work with Māori participants. This is not to say that all research conducted by Māori is under a kaupapa Māori framework, nor do all Māori researchers regard themselves, or their research, as fitting within a kaupapa Māori framework.[34] Whilst some Māori researchers accept non-Māori involvement in research, for kaupapa Māori health research, being Māori, identifying as Māori and as a Māori researcher, are critical elements.

Kaupapa Māori research is a manifestation of Māori cosmology. In its contemporary context, kaupapa Māori research seeks to meet a challenge outlined by Mira Szazy (1993) when she called upon young Māori to build a vision founded on a new humanism:

> *"...a humanism based on ancient values but versed in contemporary idiom."*[35]

Kaupapa Māori research challenges western research paradigms and, in the process, critically examines the role of a learning institution as an implicit western institutional form.[36] Kaupapa Māori recognises the political, cultural and intellectual capital that universities own and distribute. Thus, for Māori, the western university is as problematic as the knowledge it constructs and perpetuates.

MĀORI RESEARCH PARADIGMS

Māori research can be defined in many different paradigms. Pomare (1992), defines Māori health research as:

> *"...research which has direct relevance to Māori health and includes both the acquisition of information and its analysis."*[37]

Smith (1995) distinguishes kaupapa Māori research as Māori controlled conducted by Māori, for Māori and with Māori.[38] For Graham Smith (cited in Smith 1999), kaupapa Māori research takes for granted the validity and legitimacy of Māori, the importance of Māori language and culture.[39]

Nepe (also cited in Smith 1999), argues that kaupapa Māori is derived from very different epistemological and metaphysical foundations and it is these which gives kaupapa Māori its distinctiveness from Western philosophies. According to Nepe, kaupapa Māori is:

> *"...a conceptualisation of Māori knowledge, reflecting on it, engaging with it, taking it for granted sometimes, making assumptions based on it, and at times critically engaging in the way it has been and is being constructed."*[40]

Smith (1999) argues that kaupapa Māori research has a wider ambit which includes all those researchers who are attempting to work with Māori on topics of importance to Māori. Although Māori control is a consistent theme, Smith (1999) goes further and outlines the need for Māori to set their own priorities and have control over the agenda for research.[41]

Māori have repeatedly questioned the purpose of research and, aware of that concern, Te Awekotuku (1991) considers that research should benefit Māori and the

Māori community expects researchers to explain what those benefits are.[42] On this issue Pomare (1992) suggests that:

> *"...to maximise the value of the research it should, as often as possible, be associated with a Māori health development programme."*[43]

Appropriateness of research can therefore be partially measured by its purpose. Too often, the aims, objectives and method of research are predetermined by the research purchaser, which is often the state. An implication for this according to Smith (1996) is that:

> *"The research is not research if it is a purchased product which becomes owned by the state...there are accountabilities and pre-research discussions which have already framed, and to an extent, transformed the approach to research."*[44]

In the past, priorities have often been defined by Pakeha health professionals rather than the communities being studied. As a result the key issues, as seen by the community, have often not been addressed and the research has been of limited value.[45] Furthermore, most research on Māori tended to focus on various stages of cultural decay (Smith, 1999), and the common practice has been to measure Māori health by comparing Māori against non-Māori morbidity and mortality rates.[46]

Research on Māori does not necessarily always need to compare Māori with non-Māori but might instead focus on celebrating progress. Palmer (1991) criticises past research that has not been enlightening for Māori:

"We already know that differences exist between cultures, what is the point of trying to document each variation."[47]

Maori researchers have concluded that it is unnecessary to collect information that is not useful or appropriate therefore it is not ethical to carry out projects which do no more than describe what is already known. Much Māori health research is reactive and often driven by the need to influence policy. This is in line with the underlying theory for this thesis which is that strategies for addressing Māori health are invariably reactive to changing social policy and corresponding change management practices are also reactive.

Kaupapa Māori health research literature identifies several issues, the majority of which are centred around Māori control, priorities, appropriateness and ownership. The first step, however is to formulate an aim that is consistent with Māori goals and aspirations and then is to employ the most appropriate methodology including the engagement of researchers who can ensure cultural safety for any respondents.

THE METHODOLOGY

To maximise beneficial outcomes a kaupapa Māori research method was used in this study. A qualitative approach was used around the two themes outlined earlier, change management and Māori health development. The research processes included a combination of the following methods:

- literature review;
- key participant interviews;
- case studies;
- evaluation and analysis;
- peer review.

The literature research was extensive and primarily focussed on material relevant to the themes. Unfortunately there is very limited published literature on Māori health and most is comprised of government reports and unpublished papers. Furthermore, what is available was not particularly relevant to the specifics of this topic. Comparative studies conducted in other countries proved to be of limited value and low relevance to Māori health issues and circumstances.

In Canada, the focus for the development of First Nations people was on accountability among partners or equals.[48] There was conflict because accountability in government is generally viewed as a hierarchical relationship involving a delegator who assigns responsibility to another – a delegate. It was evident there were significant differences between this concept and the one that First Nations people felt would address their needs. The emphasis for them was the establishment of a two-way perspective as an essential ingredient for accountability and progress could be gained if agencies were more accountable to them. In general, most literature highlighted the unequal relationship between government agencies and First Nations groups who are totally accountable to the agency, while the agency has no accountability back to them or their communities.

In Australia, proponents of Aboriginal development are combating programmes designed by government that do not reflect the needs of their communities.[49] This was often because the only thing that had changed about the programme was the delivery agent. In order for services to work appropriately in the community, Aboriginal health proponents argue that community projects should support and be based on self-determination and empowerment within that community Implementation of any health programme should utilise and expand the resources available to the community. The problem is that there is very little consultation with the community on the design and delivery of Aboriginal health programmes.[50]

Like Māori, development needs for indigenous peoples in Canada and Australia are specific to their social, cultural and political realities. Although there

are some commonalties, such as the need to work with Government structures, systems and processes, their circumstances are drawn from very different historical experiences and their realities are generally specific to them. What is consistent with other indigenous peoples is the importance of greater autonomy and self determination. Although this can be interpreted in different ways the examples here indicate that at the very least self determination is about the right of indigenous peoples to exercise authority in the development and control of resources that impact on them, or to interact with their governments according to their own needs and inclinations. Self determination is about taking control of resources and activities that impact on their lives in a way that strengthens personal and collective identity.[51]

For Māori, the most significant difference is the Treaty of Waitangi and the recognition and acknowledgement by Government of the special status of Māori in New Zealand society. Consequently, Māori development is motivated by political imperatives mindful of a need to be accountable to Māori and the Treaty of Waitangi. This is a situation specific to New Zealand and consequently Māori tend to be at better, or at least different, stages of development when compared with first-nation groups overseas. Māori population data analysis, especially for Māori demographics and socio-economic status, continues to provide indicators for Māori development but is significantly limited because the collection of Māori specific data is a relatively new development.

Research of published literature on Māori development was examined and analysed in relation to this thesis. Similar research with other first nation groups was also examined for comparative analysis. Crown policy documents from several Government Departments including the Ministry of Health and the Ministry of Māori Development – Te Puni Kokiri were also examined and analysed for relevance to this thesis. Change management research was compiled and analysed in collaboration with the Centre for Corporate Change, University of New South Wales, Sydney, Australia. Extensive internet searches were conducted on the two identified themes

with updated relevant material obtained from several web-sites including www.hauora.com and www.hauoramaori.com.

Sixty four key participant interviews were conducted over a four year period with a selection of health professionals working in Māori health at all levels of the health sector throughout the country. Appendix A contains a list of respondents and interviewees. It should be noted that many respondents wished to remain anonymous so it was decided that all interviewee descriptions would be limited. This list is therefore not itemised by name.

The thematic research methodology used meant the two themes of change management and Māori health development were the common issues targeted in the analysis of all research findings. The themes were supported by the literature review and all information gathered from the interviews and case studies were analysed against them. Interviews, case studies and literature were the source materials. A thematic analysis was conducted on all the collated findings and generally focussed on Māori health policies, practices and perspectives. Peer review processes included consultation with academic specialists, professional experts, whanau, hapu & iwi Māori, as well as specific formal and informal supervision. Some of the research findings were derived from Maori health hui, Māori health research documents, interviews, case studies, literature reviews, Ministry of Health policy projects, strategic planning meetings, Parliamentary enquiries, and health sector monitoring projects that the researcher had been associated with while working at Auckland Healthcare and the Ministry of Health. All research sources are referenced accordingly. Referencing was formatted, managed and stored using the Microsoft Endnote software programme.

THE SELECTION OF INTERVIEWS AND CASE STUDIES

In 1996 this researcher was part of a Ministry of Health team that conducted a review on Regional Health Authority (RHA) strategies for improving Māori health

status[52]. The review was conducted in three stages over four months. Stage one involved interviews with Māori health purchasing staff in the four RHA's.

All interviews were to examine issues associated with Māori health purchasing such as contracting, monitoring, working relationships, communication systems, provider and workforce development. From these interviews a diverse range of mainstream and Māori providers at various stages of operation and development in a wide range of health sector activities were identified. Stage two of the review involved nation wide interviews with those providers. Stage three was analysis, evaluation, follow up interviews where deemed necessary, and consultation on the outcomes with all parties involved in the review.

This review was intended to provide the Ministry of Health with an overview of how Māori health strategies were progressing after three years of health sector reforms. Consequently, through this project an effective nation wide network with Māori providers and Māori health workers in mainstream was established.

Recognising the advantage this network provided, the General Manager of Māori Health, Ria Earp, decided to establish the Māori Provider Reference Committee (MPRC). On the 5th of March 1997, a consultation hui was held at Tapu te Ranga Marae in Wellington. Appendix F is a list of attendants at the hui.

The hui was intended to establish a Māori Providers Reference Committee representative of Māori health service providers nationwide. The committee would work with Te Kete Hauora (within the Ministry of Health) on issues of general policy direction for Māori health, including:

- the exchange of information and concerns currently facing Māori providers;
    1. the development of Māori health providers including;
    2. the accelerated development of a professional Māori workforce;

- the development of administrative and organisational expertise
- resource allocation priorities which take account of Māori health needs and perspectives, and;
- other Māori health issues that may arise.[53]

Given the nature of the health sector structure and the purchaser/provider relationships, Māori health managers in the RHA's were asked to invite Maori health provider representatives from their regions to attend the hui. In order to assist the selection of participants for the MPRC, Te Kete Hauora suggested the following selection criteria:

- a balance between persons with strategic policy skills, and persons with operational and service policy skills
- a balance between iwi based provider organisations and urban or community based organisations
- a balance between people with health management backgrounds and those with a health professional background;
- representation from providers who contract to the regional health authorities, and those who contract to hospitals;
- a balance between backgrounds in community, secondary, public health continuing care, and disability services.[54]

Te Kete Hauora was satisfied that those at the hui represented a cross-section of Māori providers. Te Raukura Hauora o Tainui were unable to attend due to a Board meeting, and there were no representatives from the region covered by the Piki te Ora Joint Venture Board in the Waikato which had been disestablished. These two Māori Provider organisations were the only notable omissions. Appendix F contains a list of attendees. At the conclusion of the hui it was agreed that:

- an interim Māori Provider's Reference Committee (MPRC) would be established to provide advice to the Ministry of Health.

- the interim MPRC would have a life span from March 1997 to June 1998

- the interim MPRC would have the following member representation: six representatives from Southern; four representatives from the Midland region; four representatives from the Central region and six representatives from the North Health region.[55]

Members from each of the regions identified were to be responsible for ensuring that appropriate criteria was used in the final nomination of members including skills, experience, qualifications, representational issues and accreditation skills.

All nominations were forwarded to the Ministry of Health and the inaugural meeting of the MPRC was held on the 18th of April 1997. Appendix G contains a list of the MPRC members. For the following seven months this researcher maintained regular contact with the committee members and managed communication, deliberations and all meetings. Some of the findings in this research were identified in MPRC meetings and are referenced in this thesis. The MPRC proved to be a valuable resource for both the Ministry of Health, the RHA's and Māori providers with positive relationships formed and consolidated between all parties involved.

Through this researchers involvement in the RHA review and the MPRC, and considering the detailed selection processes used to conduct both projects, it was decided that this network would be used to recruit subjects for interviews and case studies in this thesis. Therefore, Māori health workers and providers involved in both projects were invited to participate in *Te Mana Whakahaere, Te Whaiora Maori.*

CONFIDENTIALITY

For a range of different reasons, many interviewees were willing to participate but asked that their specific details remain confidential. At the time interviews and case studies were conducted the health sector environment was competitive and highly contestable. Many interviewees did not want to expose or risk sensitive contract issues or working relationships and therefore felt it would be wise to remain anonymous. For consistency reasons it was decided that all respondents, interviewees and case study references would remain anonymous and provide only general cursory descriptive information such as the type of provider interviewed and its general location.

THE IMPACT OF PREVIOUS ROLES

From 1994 and 95 the researcher was a policy analyst for the Māori Health Management Service, He Kamaka Oranga (HKO) at Auckland Healthcare Service Limited (A+) in Auckland. Consequently one of the case studies for this thesis is the Maori Health Management Service, He Kamaka Oranga.

In 1996 and 97, the researcher was a senior policy analyst with the Māori Health Group, Te Kete Hauora at the Ministry of Health in Wellington. Preliminary research relevant to this thesis was compiled while working in that role, in particular Māori health policy, purchasing, provision and mainstream enhancement. It had also been an important step towards linking up with the national Māori health network.

In 1998, the researcher was awarded a Training Fellowship from the Health Research Council of New Zealand to undertake research for this thesis. Preliminary ideas gained in previous roles were incorporated into this study and from 1998-2001 they were revised, analysed and developed further. Fresh interviews and case studies were conducted again in this recent period.

KAUMATUA AND TIKANGA SUPPORT

Māori consultation on the goals of this research was conducted at the beginning of the study. Two Hui were held at Tuteao marae, Te Teko, in October

1997 and at Kahotea marae in November of the same year. Kaumatua and tikanga support was requested at both Hui and was granted by tribal elders. On-going contact has been maintained with Kaumatua and Kuia from both marae as this has research progressed and when needed there has been ready access. All suggestions and comments from Kaumatua support have been discussed and where applicable, incorporated into the text.

The Māori title *'Te Mana Whakahaere, Te Whaiora Māori – The Changing Management of Māori Health Development.'* is not a simple translation to English. The Māori title was derived from consultation with selected Maori elders and was finally agreed upon at a hui held at Tuteao Marae, Te Teko, in the Eastern Bay of Plenty, June 1998. The words *'Te Mana Whakahaere'* emphasis the power of controlling destiny and is synonymous with Māori endeavours for self determination. *'Te Whaiora Māori '* suggests a comprehensive emphasis on Māori well being which in Maori understanding is wider than simply physical health. The *'Te Mana Whakahaere - Te Whaiora Māori '* combined Māori title carries an implication that if there is a sense of control over their own endeavours, Māori will make greater advances in health.

THE FORMAT

'Te Mana Whakahaere, Te Whaiora Māori has relied heavily on the research paradigms of Māori development research. This chapter, *The Foundations,* provides a brief outline of Māori health research theory, methodological issues and an explanation of topics that were relevant and influential in the compilation of this thesis. It outlines the format and objectives of the thesis and provides an informative basis of the circumstances around which it was written.

Chapter Two, *Maori Development and the Inevitability of Change*, provides a brief history of New Zealands political development and the impact on Māori health status through to the 1990s period. The significance of the Treaty of Waitangi is

examined along with its implications for the health sector. Future issues for Māori development are also raised.

Chapter Three, *Māori Socio-economic Status*, explores Māori social status in the 1990s and provides some speculation on potential for the next fifty years. Some of the focus areas include Māori demographics, education, unemployment, income and life expectancy.

Chapter Four, *Māori Health Development,* reviews Māori perspectives of public health and Māori models of health. The Māori health policy guidelines and Māori health disparities are examined in the context of socio-economic determinants of Māori health. This leads to the development and implementation of Māori health strategies such as Māori provider development, Māori workforce development and Māori integrated care all of which were significant in the focus period of this study, 1991-2001.

Chapter Five, *Crown Policies for Change*, analyses the health reforms and the strengthening of privatisation in the health sector. The economic reforms from 1984 through to 1993 provide a lead-in for this section and set the scene for understanding the rationale and impetus for privatisation. Chapter four also assesses the impact of the health reforms on Māori and the influence of market-lead policies on Māori development.

Chapter Six, *From Policy to Purchasing*, investigates the transition of Māori health policy and development into Maori health purchasing strategies. The first outcomes from interviews with Māori health policy and purchasing managers are presented and examined in the context of this study. This chapter highlights the confusion and misunderstanding created by roles that are not clearly defined by the Crown with goals and objectives that are either too similar to differentiate, or are so different that both parties end up working either against, or around, each other.

A similar approach is taken in Chapter Seven, *Māori Health Service Providers.* The chapter is centred on Māori health service providers and the experiences of managers trying to work with health sector changes at the service provision level. The issues are diverse and include funding, contracting, compliance and service development. Comparisons are made with the experiences of other indigenous peoples struggling with the same health issues including Australian Aborigines, Native Americans and First Nations of Canada.

Chapter Eight, *Mainstream Enhancement*, focuses on similar issues but from the perspective of a mainstream health service provider. This chapter considers the experiences of Māori working in mainstream health services and includes a case study with Auckland Healthcare Services Limited. The move from cultural safety to cultural competence is outlined in the context of effective health service delivery to Māori from a mainstream health service environment. Mainstream Enhancement frameworks are presented and Māori experiences with them are examined.

In Chapter Nine, *Change Management and Maori Health Development*, the focus is shifted to an analysis. The 1993 health reform structure is discussed in relation to the previous three chapters and interaction with Māori is highlighted. Identified Māori health issues are analysed including service delivery and barriers to access such as culturally appropriate and effective health services. Māori participation in the health sector and the capacity of central government, especially the Ministry of Health, to meet Māori health needs are evaluated against the aspirations of Māori health workers at the policy, purchase, and provision levels of the health sector. Drawing on this research some key Maori health outcomes are identified and five approaches to future Māori health needs are proposed.

This concluding chapter looks broadly at Māori health development within an unstable, uneven and highly competitive environment. Changing Māori health needs, a changing health sector, a changing Māori world and uncertainty about the Māori position within it are seen as challenges for Māori adaptability in the future.

CONCLUSION

'Te Mana Wahakahaere, Te Whaiora Māori - The changing management of Māori Health Development', is essentially about Māori experiences with managing Māori health strategies in the midst of health sector privatisation. This thesis covers a broad spectrum of Māori health strategies including the effective delivery of conventional mainstream health services to Māori people. Māori are not always comfortable with moves away from clear state provision and often prefer that treatment needs be met within conventional professional settings. In the climate of a privatised competitive health sector, Māori have not been entirely convinced that a reformed health system will be able to accommodate Māori interests and needs.

Māori activities in health have also become increasingly concerned with re-evaluating the roles and values of health professionals and many of the basic assumptions that are often made. Being a proponent of Māori health development does not mean a lack of confidence in technological advances in health, nor does it dismiss outright effective health institutions, though it does consider the need for balance. It rejects any claim that the health of Māori people is a prerogative of health professionals, or that health delivery systems are beyond Māori control and management. Māori health development is strongly influenced by associations between poor health and disadvantage and is primarily focussed on Māori aspirations for their people to enjoy high standards of health while at the same time being able to live as Māori.

This thesis is about how Māori health professionals have coped within a health care system which some would say was established for ideological reasons. *'Te Mana Whakahaere, Te Whaiora Māori'*, examines Māori health from several perspectives. Its purpose is to provide an initial forum of understanding and to bridge a gap between health sector expectations and Māori experiences. Though written in the context of health sector changes, it is not just about the reforms. If there is an over riding theme, then it is that Māori health development is

disadvantaged by politically imposed health sector changes which do little to consider long term Māori health strategies and gains.

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[1] Labour Party, (1999), *Focus on patients: Labour on health.* Wellington.

[2] Norman, R. Stace, D., (1998), *The Rich Agenda of Public Sector Change.*, CCC Paper No. 094, Corporate Centre for Change, University of New South Wales, Sydney, Australia, p 7.

[3] Norman, R. Stace, D., (1998),p 7.

[4] Wilson, James. Q. (1989), *Bureaucracy: what government agencies do and why they do it.* New York, Basic Books, United States, p 37.

[5] Norman, R. Stace, D., (1998), *The Rich Agenda of Public Sector Change.* CCC Paper No. 094, Corporate Centre for Change, University of New South Wales, Sydney, Australia, p 6.

[6] Norman, R. Stace, D., (1998), p 14.

[7] Benfari, R., (1991), *Understanding your management style beyond the Myer-Brigss type indicator.* New York, Lexington Books, p10.

[8] Benfari, R., (1991), p10.

[9] Benfari, R., (1991), p29.

[10] Pinchot, G., (1985), *Intrapreneuring: why you don't have to leave the organisation.* New York, Harper & Row, p19.

[11] Pinchot, G., (1985), p21.

[12] Norman, R.; Stace, D., (1998), *The Rich Agenda of Public Sector Change.* CCC Paper No. 094, Corporate Centre for Change, University of New South Wales, Sydney, Australia, p 8.

[13] Norman, R.; Stace, D., (1998), pp10-11.

[14] Evening Post, (1996), 3rd April, Wellington, p6.

[15] Norman, R.; Stace, D., (1998), *The Rich Agenda of Public Sector Change.* CCC Paper No. 094, Corporate Centre for Change, University of New South Wales, Sydney, Australia, p 19.

[16] Andrews, K. R., (1971), *The concept of corporate strategy.* 3rd edition, Homewood Illinois, Irwin, p 16.

[17] Hamel, G., and Prahalad, C. K., (1994), *Competing for the future.* Boston, Massachusetts, Harvard Business School Press, p 14.

[18] Norman, R.; Stace, D., (1998), *The Rich Agenda of Public Sector Change.* CCC Paper No. 094, Corporate Centre for Change, University of New South Wales, Sydney, Australia, p 17.

[19] Stace, D., and Norman, R., (1997), *Re-invented Government: The New Zealand Experience.* Asia Pacific Journal of Human Resources, Vol. 35, No 1, p17.

[20] Irwin, K., (1994), *'Māori Research Methods and Processes: An Exploration'*, Sites Journal 28, pp 25-43.

[21] Glover, M., (1997), *Kaupapa Māori Health Research, A Developing Discipline*, Paper presented at Hui Whakapiripiri, Wahiora Marae, Otara, Auckland.

[22] Cram, F., (1993) *Ethics in Māori Research*, in Nikora, L. (ed.) *Cultural Justice and Ethics*, Proceedings of a Symposium at the Annual Conference of the New Zealand Psychological, University of Victoria, Wellington, August, pp.31-33

[23] Bishop. R., (1996), *Addressing Issues of Self-determination and Legitimation in Kaupapa Maori Research'* in Beverley Webber (comp.) *He Paepae Korero*, Wellington: New Zealand Council for Education Research., p 9.

[24] Durie, M.H., (1996), *Characteristics of Māori Health Research.* Paper presented at Te Hui Whakapiripiri, Hongoeka Marae.

[25] Smith, L.T., (1999), *Decolonising Methodologies; Research and Indigenous Peoples.* London: Zed Books and Dunedin: University of Otago Press.

[26] Kilgour, R., & Keefe, V. (1992), *Kia piki te ora: The collection of Māori Health Statistics.* Wellington: Department of Health, p 68.

[27] Moewaka-Barnes, H., & Stanley, P., (1996), *Kia mau te mana.* Alcohol and Public Health Research Unit, University of Auckland, Auckland, p 8.

[28] Moewaka-Barnes, H., & Stanley, P., (1996), p 9.

[29] Jackson, M., (1996), *Māori Health Research and the Treaty of Waitangi.* Te Roopu Rangahau Hauora a Eru Pomare, (Ed), *Hui Whakapiripiri: A hui to discuss strategic directions for Māori health research.* Wellington School of Medicine, Wellington, pp 8-10.

[30] Bevan-Brown, J. (1999), *By Māori, For Māori, About Māori – Is that enough?*, Proceedings of Te Oru Rangahau Māori Research and Development Conference, School of Māori Studies, Massey University, 7-9 July 1998, Palmerston North.

[31] Stokes, E. (1998), *Bicultural Methodology and consultative process in research - a discussion paper* , Dept of Geography, University of Waikato, Hamilton.

[32] Cunningham, C., (1998), *A Framework for Māori Knowledge in Research Science and Technology.* Te Oru Rangahau – Māori Research and Development Conference, 7-9 July 1998, Te Putahi a Toi School of Māori Studies and Te Pumanawa Hauora – Māori Health Research Unit, Massey University, Palmerston North, pp 394 405.

[33] Cram, F., (1995), *Ethics and Cross Cultural Research.* (Unpublished Paper) University of Auckland, Auckland.

[34] Smith, L.T., (1996), *Kaupapa Māori Health Research, in Te Roopu Rangahau Hauora a Eru Pomare.* Hui Whakapiripiri – A hui to discuss strategic directions for Māori Health Research, Wellington School of Medicine, Wellington, pp 14-30.

[35] Szazy, Dame Mira. (1993), *Unpublished Keynote Speech at the Māori Graduation Ceremony*, Victoria University, Wellington.

[36] Henry, E. and Pene, H. (2001) *Kaupapa Māori: Locating Indigenous Ontology, Epistemology and Methodology in the Academy*, Organisation Journal, Vol. 8 (2), pp 234-242.

[37] Pomare, E., (1992), *Te Manawa Hauora.* Wellington School of Medicine, Wellington, p 7.

[38] Smith, L.T., (1995), *Toward Kaupapa Māori Research.* A paper presented at the Matawhanui Māori University Teachers Conference, Massey University, Palmerston North.

[39] Smith, L.T., (1999), *Decolonising Methodologies; Research and Indigenous Peoples.* London: Zed Books and Dunedin: University of Otago Press. p185.

[40] Smith, L.T., (1999), p188.

[41] Smith, L.T., (1996), *Kaupapa Māori Health Research, in Te Roopu Rangahau Hauora a Eru Pomare.* Hui Whakapiripiri – A hui to discuss strategic directions for Māori Health Research, Wellington School of Medicine, Wellington, p 25.

[42] Te Awekotuku, N., (1991), *He Tikanga Whakaaro: Research Ethics in the Māori Community.* Manatu Māori, Wellington, p 118.

[43] Pomare, E., (1992) *Te Manawa Hauora.* Wellington School of Medicine, Wellington, p 8.

[44] Smith, L.T., (1996), *Kaupapa Māori Health Research, in Te Roopu Rangahau Hauora a Eru Pomare.* Hui Whakapiripiri – A hui to discuss strategic directions for Māori Health Research, Wellington School of Medicine, Wellington, p19.

[45] Pomare, E., (1992), *Te Manawa Hauora.* Wellington School of Medicine, Wellington, p 8.

[46] Smith, L.T., (1999), *Decolonising Methodologies; Research and Indigenous Peoples.* London: Zed Books and Dunedin: University of Otago Press. p 87.

[47] Palmer, S., (1991), *Wero: A panui of Māori students in psychology.* Department of Psychology, Waikato University, Hamilton, p 13.

[48] Ministry of Māori Development (2000) *Māori Provider Views of Government Funding - Key issues from literature and interviews*, Wellington.

[49] Peirce, J.P., Mackaskill, P., Hill, D. (1996) *Long Term Effectiveness of anti-smoking campaigns in Australia, American Journal of Public Health*, (80) pp 565-567.

[50] Peirce, J.P., Mackaskill, P., Hill, D. (1996) (80) p 569.

[51] Durie, M.H. (1995), *Tino Rangatiratanga - Māori Self-determination, He Pukenga Korero, A Journal of Māori Studies*, vol. 1, no. 1, pp44-53.

[52] Ministry of Health, (1997), *Review of Regional Health Authority Strategies for Improving Māori Health Status.* The Performance Management Unit & The Māori Health Group - Te Kete Hauora, Wellington.

[53] Ministry of Health, (1997), *Māori Provider Reference Committee Hui Report.* Tapu te Ranga Marae, Wellington.

[54] Ministry of Health, (1997)

[55] Ministry of Health, (1997)

CHAPTER TWO

MĀORI DEVELOPMENT AND THE INEVITABILITY OF CHANGE.

Māori development is not a new concept. It is as old as the Māori struggle for survival and was first identified in the 19th century by many reknowned Māori including Sir Apirana Ngata and Sir Maui Pomare. Māori development is largely about progress. In a more general sense it is often referred to as providing Maori solutions to Maori problems. Publicly, it is an issue synonymous with Maori advancement or improvement, or when a significant Maori gain has been identified. However, the concept of Maori development is as much about process as it is about outcome. Without a process that is distinctively Maori, Maori gains may not be possible.

Change management is a specialist area in the field of management and process is fundamental to any change management strategy. If Māori development is about progress, managing the change is part of that progress. This is a task made more difficult by the fact that change, and its management, can often challenge the values and signposts that have served the past. This thesis examines the significance of change for the delivery of Māori health services. It is about the management of change within the context of Māori health and positive Māori development. Fundamentally however, it is about Māori people at the beginning of the third millenium, after a thousand years of habitation in Aotearoa - New Zealand.

Māori health can be measured against a variety of indicators including standards of health care, equity, and gains in health but its significance can only be understood within the wider context of Māori development. In the 1990's, Māori development was extensively discussed in a series of Maori development conferences which brought some meaning to the many facets of contemporary Māori life and the wider social, economic and political agendas within which Māori live.

To understand how Māori development evolved it is useful to look briefly at New Zealand's political history.

NEW ZEALAND POLITICAL DEVELOPMENT - IMPLICATIONS FOR MĀORI

In the final decade of the 19th century, New Zealand experienced an influx of fortune that saw it go from a largely egalitarian society to a country of considerable wealth.[1] Despite that, some of the most appalling living conditions experienced by this country occurred in the 1920s when the only assistance was from philanthropic institutions like the church. Māori communities were able to exist modestly with effective communal efforts of self-sufficiency in small-integrated town pockets that were often marae based. Large vegetable gardens, orchards, and farm animals were common, providing a subsistence economy for many and a respectable income for some.

Twenty years earlier the Maori population had reached its lowest level ever when in 1896 only 42,000 Maori were recorded in the census.[2] Outbreaks of new diseases such as measles, tuberculosis and influenza had caused Maori mortality rates to soar and heralded a Maori population decline that was swift and relentless. There was every reason to believe that Maori survival had come to an end and that the next century would see the passing of the Maori. In defiance of popular expectations however, that fate did not eventuate and instead there was an unprecedented population growth. By 1936 the Maori population had increased to 82,000. [3]

Politically, the 1930s saw new welfare reforms introduced and hailed the beginning of the social contract between the state and its citizens. The welfare state resulted in improved quality housing, public hospitals, public education, unity among families and neighborhoods, and pensions for retirement security. At that time it was sustainable because by international standards New Zealand was a relatively wealthy country. In the 1940s and 50s wool was a highly valuable commodity, partly because of the W.W.II and the Korean War, and during that time New Zealand rated highly among the OECD nations.[4] Māori urban migration accelerated after W.W.II

and large numbers of rural based Māori families relocated to urban areas for employment purposes. Industry was thriving with an abundance of high paying low skill employment that appealed to a now highly mobile and young Māori population. Māori communal living became a rural phenomenon and although efforts to re-establish Māori life manifested themselves in the form of urban marae, urban Māori became more whanau centred.

In the 1960s Britain began movements towards joining the European Union (EU), then known as the European Economic Community (EEC).[5] Such a move was an obvious threat to the New Zealand market for meat, wool and butter. For almost a century nearly all trade had been with Britain, including imports. When Britain finally joined Europe in the early 1970s, the economic shock was compounded by the oil shock of 1974 and New Zealand was in serious economic trouble. The Prime Minister at the time, Robert Muldoon, simply increased the pace of borrowing and spending on projects and then attempted incredible rent, wage and price freezes. When he lost power in the 1984 general election, New Zealand was virtually insolvent.

Prime Minister, David Lange, was immediately faced with a financial crisis. There was virtually no foreign currency, a huge overseas debt and the potential reality of a totally insolvent nation. The road to recovery required major economic reform associated with downsizing of the state and its operations. New markets like the Soviet Union and Asia helped but there was a serious off set. Such a move required the dismantling of trade restrictions and this would affect the protection of New Zealand's industries most of which were major employers of low skilled Māori labour. Consequently unemployment soared to new heights. The pace of change had been dramatic.

In the wake of the economic reforms, large numbers of lower income earners were made redundant and a large percentage of them were Māori. Forestry workers, freezing workers, factory workers, Ministry of Works staff, public sector employees and private sector employees were also losing their jobs in large numbers. An

avalanche of new technology and its appetite to do away with semi-skilled labour accentuated the trend. The reduction of tariffs caused the closure of motor vehicle assembly plants, clothing factories as well as textiles and shoe manufacturing industries. All of these employed large numbers of Māori who were already amongst the highest unemployed group in the country. The Employment Contracts Act was then used to drive down wages to the stage where an average 40-hour a week job was no longer sufficient to support a family in even the most modest circumstances.[6] The only recourse for the mass of unemployed Māori was a dependency on the state and a reliance on social services at the very time when Government was caucused about high welfare expenditure, a cost that the country could not afford.

The welfare state had provided a level of security. It was the conduit to better health, self-esteem, happier relationships, adequate housing and free access to education. Income inequalities tend to occur in countries where free market economic policies are vehemently pursued such as America and Britain. Countries that are relatively more egalitarian such as Germany, Japan and Sweden, experience faster productivity growth rates as well as less ill health, social stress and crime.[7]

In 1991 the Government introduced drastic measures to cut state spending, social welfare benefit cuts and state subsidised rentals for state housing tenants. Given the highest number of beneficiary recipients were Māori and Pacific Island people, the benefit cuts had a devastating effect on Māori households. The early 1990s saw such an increase in domestic violence and a public outcry forced the development of a Domestic Violence policy and imposed a direct strategy for addressing it. Crime skyrocketed so that police resources were unable to cope and prisons services were quickly overcrowded. The market rents policy effectively doubled all Housing New Zealand tenancy rents and many of them were Māori.[8] Māori participants in the urban migration of the 1950s and 60s were now faced with an economic dilemma they would never have foreseen and more worrying, the younger generations were faced with a society that had benefited their parents but had very little to offer them.

It was therefore no surprise that in 1984 the Māori Economic Summit, Hui Taumata, recommended another approach to Māori policy. Māori development was clearly identified as an imperative goal if Māori were to move out of dependency mode. How society reacted to positive Māori development initiatives would prove to be an awakening process for many in New Zealand, including Māori.

The Hui Taumata had recommended Iwi development as the most logical vehicle for the advancement of Māori people. Iwi programmes in skills training, education, economic development and health flourished as an Iwi centred approach to Māori development was applied as Labour Government policy. When the Department of Māori Affairs was restructured some of its functions were devolved to Iwi and the new Ministry of Māori Affairs, Manatu Māori, or the Iwi Transition Agency, Te Tira Ahu Iwi. Tribal development appealed to Māori by offering hope and acknowledging the fundamental strengths of Maori society – whanau, hapu and Iwi. Here was a chance to gain a measure of control over resources and to use Māori strategies to meet Māori needs. For Māori, Iwi development was the central issue.

For the Government, devolution was the policy however difficulties arose when Iwi could not be readily identified or when more than one authority claimed to speak on behalf of Iwi. To overcome these problems the Labour Government passed the 1990 Runanga Iwi Act. The Act established a mechanism which would facilitate the transfer of public funds to Iwi and was presented as an historic opportunity for tribes to undertake a range of activities for and on behalf of their people and to gain full recognition in legislation. Though the issue of legislation nearly caused the Bill to be withdrawn, the Act was passed in modified form. Its life was brief for even while Iwi were drawing up charters to meet requirements for Iwi recognition that would take advantage of the Act's provisions, the Honourable Winston Peters, Minister of Māori Affairs in the newly elected National Government introduced a Bill to repeal the Act. By 1991 it had become history. Objections to the Runanga Iwi Act were not only confined to concerns Iwi would be compromised. Māori in urban areas doubted that tribal development would be useful to them. Presumptions that all Māori would prefer Iwi delivery systems were dismissed by Māori who had

become alienated from their own people. A report commissioned by Winston Peters in 1991, *Ka Awatea*, supported the four key development areas identified at Hui Taumata - education, labour market, health and economic development, but significantly there was no direct reference to Iwi development. A total reliance on Iwi development mechanisms had not been accepted and parallel recognition of other agencies, equally able to respond to social and economic development, appeared to have gained favour. In urban areas, Iwi development strategies may not be appropriate. Shane Jones, currently chairman of Fisheries Commission, echoed these thoughts:

> *"Tribal sovereignty would do little for most Māori who face daily disadvantage and struggle to educate their children adequately and care suitably for their health and shelter. The marginalisation of Māori in education, health, and housing is a greater threat to a secure and just society than the ideology of a tribal sovereignty."*[9]

In fact a multiple approach had always been regarded by Māori as necessary. Māori development is about the advancement of Māori people as Māori. Durie (1997) identified advancement as encompassing three dimensions:

1. strengthening economic standing, social well-being and cultural identity;
2. developing power and control;
3. planning for the future.[10]

Māori development in relation to this thesis is particularly concerned with the third dimension because planning in the future is about change, or the expedient ability of Māori to adapt to imminent changes in New Zealand society, if not the world. Traditional values and knowledge have important lessons for today and offer some promise for the future but Māori development is not about living in the past.

The challenge is to cope with the impact of global change whilst retaining those values, processes and institutions that characterise Māori. On the one hand traditionalists resist change and seek to isolate themselves from it. On the other hand, adventurers abandon the past and opt for the new world and its new values. Somewhere in the middle lies the sense of Māori development.

The world of the 21st century is fluctuating between the promotion of universal cultures and the fragmentation of existing states and countries. This is witnessed by superpowers deciding how nations should be formed only to be met by smaller powers, such as Taiwan, determined to retain their own nationhood. Indigenous peoples are seeking greater autonomy from States that represent too many negative memories of colonisation. Similar rebellions to reinforce ethnic identity are also happening in the South Pacific. In May 2000, Fiji experienced a second historical coup when prominent Fijian businessman George Speight, used force to take control of Fiji, at least for a few weeks, in a move rationalised as returning power to indigenous Fijians. Two weeks later civil unrest broke out in Honiara, the capital city in the Solomon Islands, as rival militiamen fought to assert their rights upon their land. This is a global trend and within this, New Zealand Māori are wanting to remain Māori but at the same time embracing the newness of the 21st century.

THE TREATY OF WAITANGI

The debate surrounding the application of the Treaty of Waitangi to modern times has been long and arduous. Māori aspirations for recognition of promises made under the Treaty of Waitangi, including compensation and settlement, continue to be voiced. For its part, the Crown appears to have rehabilitated the Treaty so that it now has a clearer place in statute and policy. The Treaty of Waitangi had three objectives:

- the protection of Māori interests;
- the promotion of settler interests; and
- the securement of strategic advantage for the Crown.[11]

Ironically, in 1839 the British Crown felt that the only effective strategy for protecting Māori interests involved seizing Māori sovereignty, because this would allow British law to be instituted and unruly settlers controlled. However, no matter how noble the original intentions, within a decade the Treaty was used to separate Māori from the very land it was intended to protect and to accelerate emigration from Britain.

The conflicting English and Māori text of the Treaty have complicated the debate. In the English version, the Treaty provided for a transfer of sovereignty to the Crown (Article 1) in exchange for guarantees that tribal properties would be protected and sold only to the Crown (Article 2), with an additional promise that individual Māori people would acquire the same citizenship rights as British subjects (Article 3).[12] The Māori translation had different aims, governorship rather than sovereignty was transferred to the Crown and tribes were given full authority (tino rangatiratanga) over their properties.

Regardless of differences in meaning between the English and Māori versions of the Treaty, and whether sovereignty was actually ceded or not, the Crown did acquire the right to govern. Allowing for guarantees to protect Māori interests, the Treaty provided Britain with the authority to control and plan the development of the state.

It is highly unlikely that Māori fully understood the constitutional significance of the Treaty, in particular the wide-ranging powers granted to the Crown. Conversely, the Crown does not appear to have understood its obligations to develop a state that would enhance the Māori interests it had agreed to protect. Uncertain Māori understandings of outcomes from the Treaty were soon made very clear after the Māori sovereignty wars in 1965 when Māori realised they had no active roles in the governance of the country or, as a consequence, their own tribal territories.[13]

Māori have placed greater value on the Treaty than the Crown, and relationships between Māori and the state have generally reflected differing attitudes, and varying levels of commitment to the Treaty of Waitangi. In 1975 the Treaty of Waitangi Act was passed and a Waitangi Tribunal established. Many would say this was largely due to the advocacy and sponsorship of the then Minister of Māori Affairs, the late Matiu Rata. Surprisingly, the Tribunal's potential as a mechanism for reform was relatively unnoticed until the Motunui case in 1983.[14] Only then was it realised that the objectives of previous Governments or the conservative wishes of mainstream New Zealand would not remain unchallenged by Māori.

Māori progressively realised that the Act was a possible conduit for asserting a more open challenge into areas that were previously considered beyond the Māori domain and the Waitangi Tribunal was to provide the necessary leadership and influence. The Tribunals process of providing reports with recommendations on settling long standing Treaty of Waitangi claims also created a new library of evidence. Each report produced explicit historical case-by-case backgrounds of injustices and atrocities imposed upon Māori, which had not hitherto been resolved, or even admitted. Frequently the Tribunal found that the Crown had failed to meet its obligations under the Treaty. This was a shock to many mainstream New Zealanders who were not even aware the Crown had any obligations under the Treaty and were extremely concerned at the prospect that past commitments could realistically be considered in modern times.

The New Zealand Government has since shown progressive inclination to act on Waitangi Tribunal recommendations and has come to recognise the Treaty as integral to New Zealand's constitution. While the degree of recognition might be less than Maori would like, the climate has changed and the Treaty has been reinstated as a constitutional reality.

THE TREATY OF WAITANGI AND HEALTH

In 1985, the Standing Committee on Māori Health recommended that the Treaty of Waitangi be regarded as a foundation for good health.[15] The New Zealand

Board of Health then released a recommendation that *'All legislation relating to health should include recognition of the Treaty of Waitangi.'*[16] At that time, the Government was struggling to come to terms with the Waitangi Tribunal's much publicised evaluation of New Zealand history that had substantiated criticism of unfair legislation for the last 140 years. Now the Board of Health was relating the Treaty to health. It was a major step towards forcing the Government to examine social policy areas from a Treaty perspective.

Although the Treaty of Waitangi was often quoted as the foundation for Māori health development, progress of Māori health policy from a Treaty of Waitangi perspective was largely unexplored and any assertion to examine this area further was consistently resisted by the Crown. The gap was evident in recognition of the importance of the Treaty of Waitangi to Māori health policy and the actual implementation of Treaty based policies and programmes.

The connection between Māori health and the Treaty of Waitangi is primarily evident in the Treaty's economic and social objectives promoting policies of positive protection as an onus on the Crown to ensure Māori would not be unfairly marginalised by British settlement, and that their future well-being would be assured. The three articles provided for transfer of sovereignty (Article One), a continuation of existing property rights (Article Two) and citizenship rights (Article Three).[17]

For Māori health, Article two could imply that iwi and hapu have some continuing authority over their involvement in health but Article 3 has more obvious and direct implications to health. By promising the same rights and privileges as British subjects Māori individuals were guaranteed new citizenship rights. In 1840 that included entitlements such as the right to a fair trial, and the right to carry a British passport. However, today those rights are much more extensive. The Treaty implied fairness and equity with no serious disparities between Māori and other New Zealanders. This point was so emphatic that the Crown stated it would exercise what was termed 'royal protection'[18] in order to meet the new obligations. Thus Article three was as much about equity and parity as it was about citizenship. This is

particularly significant for Māori health because disparities in health status between Māori and non-Māori remain prominent in New Zealand society. The ongoing disparities in standards of health between Māori and non-Māori continue to produce strong arguments for significant health resources to be directed at health services that address Māori health needs. High quality research in this area is a key component in Māori development for it is essential that initiatives to resolve Māori issues be based on a foundation of high quality information.

MĀORI DEVELOPMENT RESEARCH

In June 1998, Te Putahi a Toi, School of Māori Studies at Massey University in Palmerston North, held a Māori Research and Development Conference entitled Te Oru Rangahau. The conference provided an opportunity to consider issues relevant to Māori development from the perspective of researchers involved in education, health, sciences, law, linguistics and Treaty of Waitangi claims. Te Oru Rangahau covered almost every aspect of Māori development and the wide scope of research activities was more than sufficient to confirm that Māori involvement across sectors, disciplines and institutions was gaining strength. Articulate and philosophical debate about the nature of research was also accompanied by day-to-day realities that confront Māori in schools, communities and even on radio broadcasting frequencies.

Two key themes emerged from the conference. Firstly, Māori advancement, whether it is in science, education, culture, the economy or health, will require careful and deliberate planning and such planning must be premised on sound principles so that progress in one area does not create inequities in another. Secondly, Māori researchers will play a strategic role in adding value to positive Māori development.[19] The point here was that research about Māori makes very little sense without Māori involvement. In the past, it was not so apparent but if the 1998 conference were a guide, the situation had significantly changed.

The conference concluded that research relating to Māori development will do more harm than good if it fails to recognise the determination of Māori people to

advance into the next century with improved standards of health, higher educational achievement, greater mobility to navigate the world and generally, improved socio economic status.[20] The key is to do all those things while retaining a secure Māori identity, a distinctive worldview, and a sense of control over Māori destiny.

A FUTURE FOR MĀORI DEVELOPMENT

In New Zealand, Māori development has historically been subjected to uncertain funding and inconsistent policies. If there is one recurring issue that has been born out of experiences with all Crown initiatives, it is that public sector divisions, which are a general characteristic of Government policies, seriously limit Māori development. Fragmented approaches to Maori development lead to sectoral rather than population gains and fail to capture any sense of coherence.

Māori development had initially emphasised social and economic development but in the 1990s, extra emphasis was given to the importance of cultural development and the realisation that material well being does not necessarily by itself result in good health. The result has been greater Māori effort to define this dimension and to account for spiritual values, which are more readily acknowledged as an essential part of being Māori.

Maori have a propensity for survival. It takes many shapes and forms but includes values, philosophies, language and genealogical connections that bring Maori people together. Maori revitalisation strategies, like the Kohanga Reo movement, have allowed Maori to once again regroup and build fresh resolve to determine their own futures.

For future generations of Maori the difficulty will be to embrace the new world without ceasing to be Maori. Given the avalanche of global influences that bombard young people on a daily basis, such as Sony Playstation, text messaging, access to the internet and e-mail, this will become more and more difficult. But Maori development is not about abandoning Maori identity or giving way to the globalisation of western economic colonialism. It is about embracing aspects of the

western world while retaining a Māori ethos. If the legacy of Maori ancestry is not active, it will be of little value.

> *"A people are not a people without a language; a language is not a language if it is not spoken; a waiata (Maori song) is not a waiata unless it is sung; aroha (love) is not aroha unless it is practised; tino rangatiratanga (self-determination) amounts to little unless it is exercised, and kotahitanga (unity) is diminished if fragmentation and divergence prevent the ability to come together."* [21]

The goal is to ensure that children and grandchildren can exercise the legacies inherited from ancestors so that in their world they can be guided by Maori symbols of identity and permanence. There must also be a realisation that Maori development extends beyond people and embraces the wider physical and technical environments. In the 21st century, land will continue to be a contentious issue for Maori. Although much of the focus, especially in the 1990s, had been on the value of water in a world that will eventually run short of clean usable water, natural minerals and ingredients used for Maori traditional healing, and ownership rights for petroleum, natural gas, or geothermal energy are just a few examples.

For future Maori development in this area, Maori will need to reach a clear consensus on the nature of the Maori estate. The radio frequency spectrum may be more economically rewarding than land or fish but in the end the people will remain the most valuable resource.

CONCLUSION

The restructuring of New Zealand since 1984, and especially the collapse of the labour market after 1987, had disastrous effects on Māori. Having been recruited for semi- and unskilled labour in the post war industrial period sector, reductions in

the number of those jobs had an impact on mid-employment workers and those trying to move from the education sector into the workforce. Combined with educational disadvantages, poor health and housing, and dependence on low income or benefit, a significant sector of the Māori population faced intergenerational poverty and disadvantage.

The 1990s saw a wealth of evidence of low Maori participation in the wider society with lower standards of living. Maori were shown as poor, homeless and powerless. Consequently, Maori development policies in the 20th century have been referred to as policies for addressing disparities. However, Aotearoa – New Zealand at the end of the 1990s is in the midst of a new environment. With the restructuring of the state, many attributes of the public sector that prevailed for most of the twentieth century have largely gone. The restructuring of economic, political and welfare policies has created an opportunity for Maori around the issue of indigenous rights. It is not a new scenario but it has implications for the very nature of a modern state:

> *'Fundamental changes to the global political order during the 1990s have thrown open complex issues. Questions of what constitutes nation states, relations between nation states, their constituent peoples and territories, are not so clear cut as they once seemed. Few of the most commonly cited challenges to the world order of post colonial nation states have been concerned directly with indigenous peoples. Yet it is often indigenous peoples whose sovereignty is most profoundly challenged by the processes of state formation.'*[22]

The challenge is to rethink New Zealands core institutions and values in a way that encompasses Māori and addresses the nature of contemporary New Zealand. Much will also depend on Māori leadership. If Maori are to adapt and evolve in order to survive in a rapidly changing world, then future Maori development will require leaders who can exercise wise governance not only domestically, but internationally. Inevitably this will involve consideration of the relationship between Maori and the Crown, but there will also need to be an emphasis on relationships within Maori communities.

The journey for Maori people is not unique and more importantly, it is not made alone. Māori journeys have much in common with indigenous people all over the world and future generations of Maori will need to recognise and work with those relationships. Although the attributes are specific to Māori, interactions and collaborations with other indigenous peoples in trade, cultural exchange, research; scholarships, education and politics will be common elements of Maori development in the future.

Relationships for the past 25 years have generally been preoccupied with the Crown, or the Treaty and its domestic implications. Maori development that is tied to the Crown has its origins in colonial assumptions and runs the risk of depicting Maori as a disadvantaged minority or a people burdened by grievance and disease. Maori development in the future might be less shackled to the Crown and more in tune with other indigenous peoples such as the Hawaiian nation, the Australian Aborigines, the Native American Indians and the Saami Parliaments in Norway and Sweden. The world is shrinking. Populations are growing. Natural resources are strained. Technology is advancing and accelerating. The ability to access the rest of humanity is radically improving. What was in the past-considered geographic isolation in the South Pacific is no longer the case. The future for Maori development may well herald a new era of Maori entering a global society confident and skilled, yet Māori nonetheless.

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[1] Boston, J., Dalziel, P., and St John, S., (1999), *Redesigning the State in New Zealand*. Oxford University Press, Auckland, p 2.

[2] Boston, J., Dalziel, P., and St John, S., (1999), p 3.

[3] Boston, J., Dalziel, P., and St John, S., (1999), p 5.

[4] Boston, J., Martin, J., Pallot, J., and Walsh, P., (1996), *Public Management – the New Zealand Model*, Oxford University Press, Auckland, p 8.

[5] Boston, J., Dalziel, P., and St John, S., (1999), *Redesigning the State in New Zealand*. Oxford University Press, Auckland, p 12.

[6] Boston, J., Dalziel, P., and St John, S., (1999), p 16.

[7] Bourasa, S.C., and Strong, A.L., (1998), *Restitution of Property to Indigenous People: The New Zealand Experience*, Real Estate Research Unit, Working Paper Series, no. 7, Auckland University, Auckland.

[8] Boston, J., Dalziel, P., and St John, S., (1999), *Redesigning the State in New Zealand*. Oxford University Press, Auckland, p 22.

[9] Jones, S., (1993), *Beyond the Boundary of Tribalism*, The Dominion, 19 November 1993, Wellington.

[10] Durie, M.H., (1997), '*Te Mana ,Te Kawanatanga – The Politics of Māori Self-determination'*. Oxford University Press, Auckland, p 4.

[11] Adams, P., (1977), '*Fatal Necessity – British Intervention in New Zealand 1830-1847'*. Auckland University Press/Oxford University Press, Auckland, pp 87-88.

[12] Orange, C., (1987), *The Treaty of Waitangi*. Bridget Williams Books Limited, Wellington, p 93.

[13] Orange, C., (1987), p 98.

[14] Durie, M.H., (1998), *'Whaiora: Māori Health Development'. (Second Edition)* Oxford, University Press, Auckland, p 81.

[15] Durie, M.H., (1998), p 81.

[16] New Zealand Health Board, (1988), *Priorities for the New Zealand Health Services*. New Zealand Board of Health, Wellington, p 16.

[17] Durie, M.H., (1998), *'Whaiora: Māori Health Development' (Second Edition)* Oxford, University Press, Auckland, p 82.

[18] Durie, M.H., (1998), p 84.

[19] Durie, M.H., (1998) '*Te Oru Rangahau – Māori Research and Development Conference.'* Closing Speech comments, Massey University, Palmerston North.

[20] Durie, M.H., (1998).

[21] Durie, M.H., (2000), '*Toi te kupu, Toi te mana, Toi te Whenua – Maori Development in a Global Society Conference'*, Closing Speech, Concluding Comments, Massey University, Palmerston North.

[22] Howitt, R., (1996) *Resources Nations and Indigenous Peoples. Case Studies from Australasia, Melanesia and Southeast Asia*, Oxford University Press, Melbourne, Australia.

CHAPTER THREE

MĀORI SOCIO-ECONOMIC STATUS

This chapter provides a demographic summary of the Māori population. It outlines the situation of Māori in Aotearoa New Zealand during the focus period of this thesis, 1991-2001. It also provides an extensive overview of Māori socio-economic status and some speculations on Māori health status for the next 50 years. This is synonymous with the theme of Māori development outlined in Chapter Two and outlines issues of integration that will be examined in Chapter Four - *Māori Health Development.*

MĀORI HEALTH INFORMATION

Māori health information and data collected in the last two decades shows that there has been a significant improvement of Māori health status in Aotearoa New Zealand. Unfortunately, however it is difficult to draw accurate conclusions on Māori health status from Māori health data because the information on Māori ethnicity is often inconsistent and unreliable. Coupled with this is the reality that no single form of measurement can give an overall indication of Māori health status simply because health encompasses spiritual, mental, physical and family well being. Health measurement indices tend to reflect only one dimension that usually focuses on illness and has little consideration for a wider Māori health view.[1]

Health statistics have largely been about hospital activities and should not be confused with indicators of health outside the hospital arena. Given most health statistics are hospital orientated focussing on injury and illness, more is known about morbidity, mortality and hospitalisation rates than about the health status of people in their everyday lives. Hospitalisation is a relatively rare event for most people.

Māori health information is generally derived from collections of Māori sickness profiles. What also needs to be considered is that health indicators are always designed for a specific purpose such as determining in-patient costs,

estimating discharge rates or assessing hospital performance. The point here is that none of these alone can provide an accurate profile of Māori health.

Another health research methodology is disease prevalence and wellness surveys that emphasise self-assessment of health status and utilisation of health services. Although such prevalence studies are less reliable on smaller populations, are less specifically targeted and favour healthy populations, they sometimes provide a useful complement to other Māori health reports by identifying actual rates or disparities.

In the 1990s, Māori health researchers endeavoured to define a more accurate overview of Māori health status. It is a difficult task for two reasons. Firstly, as mentioned earlier, Māori health encapsulates many different dimensions and the measurement indicators used are often only able reflect one dimension, which is usually clinical. Secondly, the manner with which the Māori health data and statistics are collected and used is inconsistent and often incompatible with other data sets.

MĀORI DEMOGRAPHY

In the general New Zealand population, the major causes of premature death and ill health are cardiovascular (heart) disease and cancer, predominantly lung, breast, bowel and prostate. It is likely that these will remain the leading causes of death well into the 21st century.[2] Compared with other developed OECD countries, New Zealand has very high mortality rates for heart disease, respiratory disease, breast and bowel cancer, motor vehicle injuries and suicide. The main reasons for admission to hospital in New Zealand tend to vary with age; in young adult's pregnancy related admissions and injuries, and in middle aged and older people, respiratory diseases, cancer and cardiovascular disease. The infant mortality rate in New Zealand declined steadily until 1992 where it has remained level up until the most recent data were collated in 1996. Hospital admissions are increasing at around 2% annually even after accounting for population growth.[3]

In the 1996 New Zealand census Māori statistics information compiled provided the best information on Māori demographics largely because the marketing, promotion, collection systems and processes. Māori were active participants in the census process.

THE MAORI GROWTH RATE

Even by 1840 it was evident that the Māori population was declining – a trend that continued at least until 1896.[4] The effects of early colonisation, wars and epidemics saw the Māori population fall to a low of about 42,000 in that year. At that time non-Māori outnumbered Māori by more than 16 to 1. However, by 1901, the Māori population's recovery was under way with high birth rates and improved life expectancy leading to rapid growth. Growth slowed after World War II due to lower fertility, but the Māori population continued to grow more quickly than the non-Māori population.[5]

In 1996 New Zealanders identifying with the Māori ethnic group numbered 511,278, some fifteen percent of the total population. The Māori population is expected to reach nearly one million by 2051 and will comprise 22 percent of the total population. The annual growth rate of the Māori population is expected to slow down, though it is likely to continue to grow more rapidly than the non-Māori population. The growth rate is expected to fall from 1.9 percent in 1997 to 0.7 percent in 2051, compared with the non-Māori population's growth rate falling from 1.2 percent to just below zero in the same period. [6]

The higher annual growth rates for Māori can be attributed to higher fertility rates for Māori women than non-Māori and the Māori population having a relatively larger number of women in the reproductive ages. As well there has been progressive increase in life expectancy. The Māori population's younger age structure also means there are relatively fewer deaths than in the non-Māori population.

A YOUNG MAORI POPULATION

New Zealand's Māori population is relatively youthful compared with the non-Māori population. In 1996 the median age for the Māori ethnic group was 21.6 years, compared with 33.0 years for New Zealanders in general.[7] Children (aged 0 to 14 years) made up 37 percent of the total Māori population compared with 22.8 percent of the total New Zealand population.

Although the Māori population will age over the next 50 years, it will remain relatively young. By 2051, the median age for the Māori population is expected to be 31.7 years compared with 45 years for the total New Zealand population. An increasing number of Māori in the present population will reach retirement age in the next 50 years. By 2051, Māori in the 65-and-over age group are expected to make up 13 percent of the total Māori population, compared with only 3 percent in 1996. The number of Māori children is expected to grow 27 percent between 1996 and 2051. This means that 1 in 3 New Zealand children in 2051 will be Māori compared with 1 in 4 in 1996. But a projected drop in the birth rate and gradual ageing of the Māori population over the next 50 years means that the proportion of children in the Māori population will drop from 37 percent in 1996 to 26 percent in 2051. In the working age group (15 to 64 years) numbers of Māori are projected to rise 85 percent over the next 50 years. Although their share of the Maori population should remain unchanged at around 60 to 61 percent, those aged 40 to 64 years should make up a larger proportion of the total number in the 15 to 64-year-old group by 2051.[8]

MAORI LIFE EXPECTANCY

Māori life expectancy is lower than that of non-Māori by about 7 years. However, it has been increasing in recent decades. A Māori boy born in 1996 can expect to live 67 years, 13 years longer than his counterpart born in 1951. A Māori girl born in 1996 can expect to live to age 72, up 16 years on her 1951 counterpart.

Historically Māori life expectancy has been much lower than that of non-Māori New Zealanders, but the gap has narrowed considerably over time. The difference in life expectancy for Māori males and non-Māori males has dropped from

around 13 years in 1950-52 to seven years in 1996. For females, the difference between Māori and non-Māori life expectancy has fallen from around 15 years in 1950-52 to seven years in 1996. Age-standardised mortality rates for Māori fell more rapidly than for non-Māori between 1972 and 1987. But since 1987, Māori mortality rates have dropped more slowly than non-Māori and the gap between Māori and non-Māori mortality rates has widened.[9]

In 1994 Māori mortality rates were greater than for non-Māori at all ages except 15 to 24 years and 75 years and over. The differences were most marked for those aged under 1 year and for female's aged 45 to 64, whose rates were nearly twice those of non-Māori. Māori males aged 15 to 24 had a death rate nearly three times that of their female counterparts in 1994. At the same time, the rate for male Māori children aged 1 to 14 was nearly twice that of their female counterparts. The gender differences in the 1 to 24-year age group is largely due to the high number of male accidental deaths, particularly in motor vehicle accidents.[10]

MAORI EMPLOYMENT

Māori have experienced considerable change in their employment circumstances over the last ten years. Māori populations, and in particular Māori men, were strongly affected by the economic downturn of the late 1980s. The figure shows that the proportion of Māori men in employment dropped 21.9 percentage points between 1986 and 1991, from 72.5 percent to 50.6 percent.[11] The contraction of the manufacturing sector during this period meant that large numbers of Māori men who were concentrated in manufacturing industries lost their jobs as protectionist measures were removed. The proportion of Māori women employed for an hour or more per week also dropped sharply over this period from 45.0 percent to 35.3 percent.[12] In comparison, the proportions for non-Māori men and women dropped by 8.7 and 1.7 percentage points respectively from 1986 to 1991. As New Zealand's economic position began to improve in the early 1990s, the proportion of Māori people in employment also increased. Between 1991 and 1996, Māori women experienced the largest rise; the proportion with jobs climbed from 35.3 percent to 47.0 percent over this 5 year period.[13] This reflects not only an improved economic

climate, but also a general increase in labour force participation among women, and a growing demand for part-time labour. Māori men also experienced a marked increase in employment over this period, moving from 50.6 percent to 61.4 percent. This is outlined in Figure 3.1.

TABLE 3.1

Employment-to-Population Ratios[1] for Māori and Non-Māori, by Sex, 1986-1996

	Māori women	Māori men	Non-Māori women	Non-Māori men
			Percent	
1986	45.0	72.5	48.8	73.7
1991	35.3	50.6	47.1	65.0
1996	47.0	61.4	54.0	69.3

[1] An employment/population ratio refers to the proportion of people employed for one hour or more per week out of the total working-age population (all those aged 15 years and over).

Source: Statistics New Zealand. Censuses of Population and Dwellings, 1986-1996

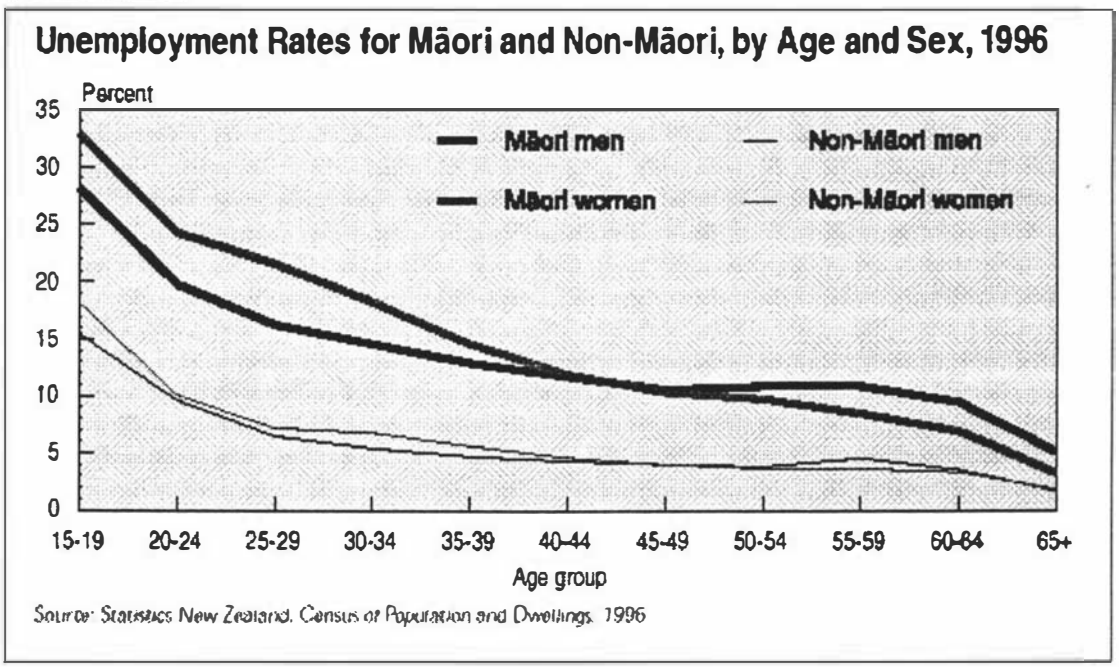
Between 1991 and 1996, the employment levels for Māori men and women increased at a faster rate than those for non-Māori. While the proportion of Māori in employment in 1996 remained lower than the proportion of non-Māori, the disparity was smaller than in 1991. Despite these improvements, Māori have not regained the position reached in 1986, when 58.5 percent of the total working age population were employed. The contraction of the manufacturing sector in the 1980s left many Māori who lost their jobs with work experience and skills which are not directly transferable to jobs now being created in the expanding service sector. Overall, just over half of all working age Māori were employed for an hour or more per week in 1996. This compared with 61.4 percent of non-Māori aged 15 years and over.

MAORI UNEMPLOYMENT

Māori continue to be over-represented amongst New Zealand's unemployed. In 1996 Māori comprised 27.7 percent of all unemployed people but only 12.3 percent of the total working age population. In 1996, 7.5 percent of the Māori labour force was unemployed. This was almost 3 times higher than for non-Māori and

represents a widening gap between the two groups since 1986.[14] The rise in unemployment between 1986 and 1991 strongly affected Māori. Over this period the unemployment rate for Māori rose from 14.9 percent to 24.2 percent while the rate for non-Māori increased from 5.8 percent to 9.0 percent. Much of the increase in unemployment experienced by Māori was due to increased unemployment amongst Māori men. This largely occurred during the late 1980s as a result of substantial job losses in the manufacturing sector. The unemployment rate for Māori men almost doubled between 1986 and 1991, moving from 12.0 percent to 23.8 percent. Over the same period, the rate for Māori women increased from 19.1 percent to 24.7 percent. However, between 1991 and 1996, the unemployment rate for Māori men dropped more than the rate for Māori women, as an improved economic environment allowed entry back into the employed work force.[15] The proportion of the Māori labour force that is unemployed varies considerably by age as shown in the figure below. The pattern is similar for both Māori and non-Māori, with unemployment highest among the younger age groups. Young Māori in the 15-19 and 20-24 age groups experienced the highest rates of unemployment in 1996, with rates of 30.4 percent and 21.8 percent respectively.

FIGURE 3.2

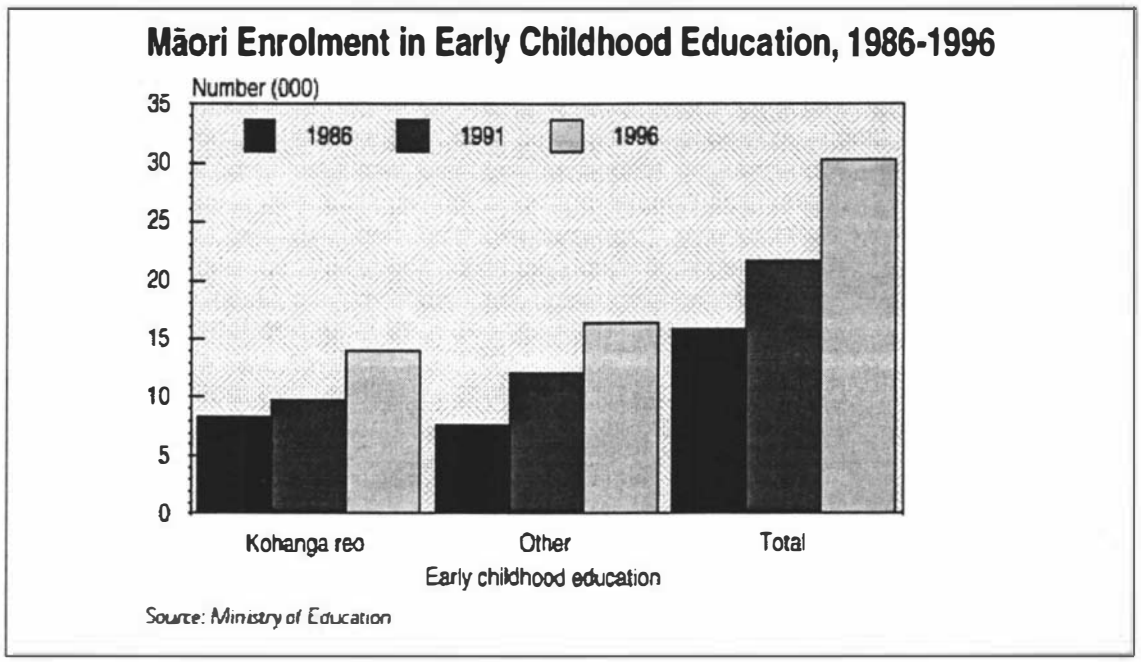


Māori unemployment rates in the 1996 census were consistently higher than those for non-Māori especially in the 20 to 40 year age bracket. The proportion of unemployed Māori in this age range was over two and half times higher than that for non-Māori.[16]

MAORI IN EARLY CHILDHOOD EDUCATION

Māori children made up 18.9 percent of all enrolments in early childhood education in 1996, up from 17.2 percent in 1991.[17] The figure below illustrates the growth in the number of Māori enrolments in early childhood education between 1986 and 1996. The largest change between 1991 and 1996 was due to Te Kohanga Reo[18] enrolments, accounting for 51.3 percent of the growth in early childhood enrolments. Since their initiation in 1982, Kohanga reo have played a major role in the education of Māori children. In 1996, Kohanga reo was the single largest provider for Māori with 46.3 percent of Māori children enrolled in early childhood education attending one of 767 Kohanga. This compared to 21.6 percent enrolled at kindergartens and 19.3 percent at childcare centres.[19] Table 5.3 compares Māori enrolment in Kohanga Reo with other early childhood education.

FIGURE 3.3



The rate of growth in Māori enrolments in early childhood education over the 1991-1996 period exceeded that of non-Māori, 39.7 percent and 24.5 percent respectively.

Despite this, in 1996 participation rates for Māori children remained lower than those for non-Māori. Ethnic differences in participation varied with age, the smallest gap in 1996 was for those aged less than 2 years (3.9 percentage points). For the 2-4 year age group the gap widened to 29.3 percentage points.[20]

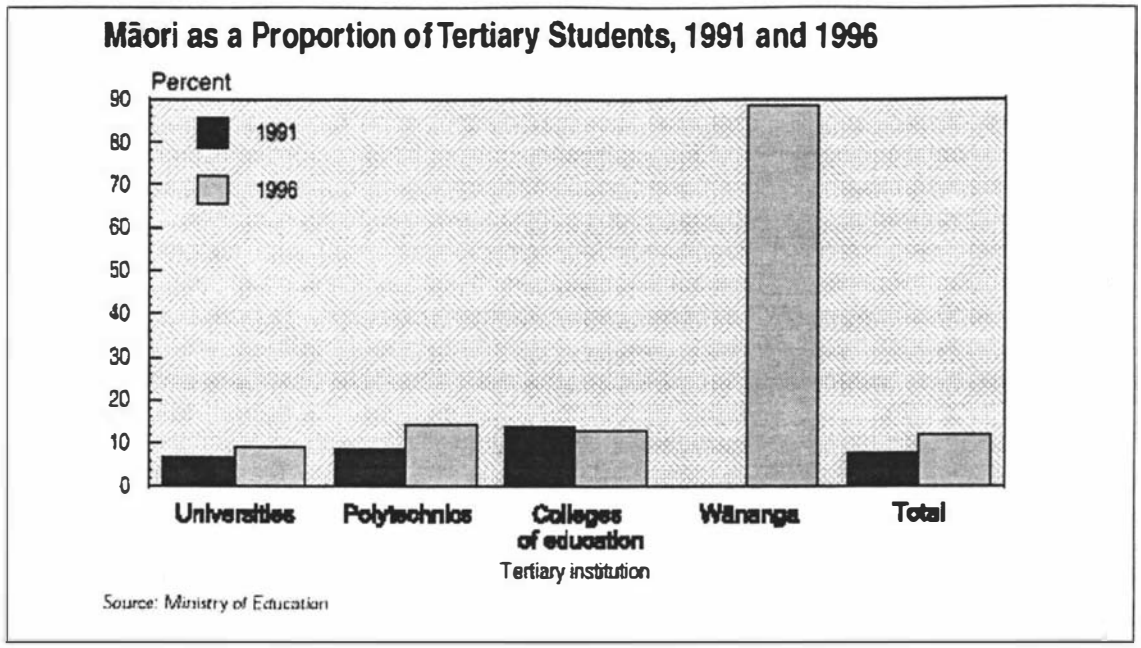
MAORI IN EDUCATION

Young Māori today are more likely than in the past to stay at school beyond compulsory attendance age and more likely to leave with qualifications. There has also been a considerable growth in the numbers attending tertiary education. Between 1991 and 1996 the number of Māori enrolments more than doubled while non-Māori enrolments increased by 27.2 percent.

Much of the growth in Māori enrolments over the 1991-1996 period was due to large increases in the numbers studying at polytechnics and colleges of education. Part of this increase may be due to the shift of some community based programmes to polytechnics (such as nursing) and to a recruitment drive for teachers.[21]

In 1996, just over half of Māori tertiary students attended a polytechnic, 37.6 percent were at universities, 6.6 percent at colleges of education and 3.0 percent at Wananga. The majority of Māori teacher trainees are in the primary sector; 81.7 percent compared to 63.0 percent of non-Māori trainees. This may be due to the growing number of Kura kaupapa and increased Māori-medium education in mainstream schools, as former Kohanga reo students move into the primary education system. Figure 3.4 outlines Māori as a proportion of other tertiary students.

FIGURE 3.4



The above figure shows the change from 1991 to 1996 in the proportion of tertiary students who are Māori. As a proportion of all tertiary students they increased from 7.8 percent to 11.9 percent over the period.

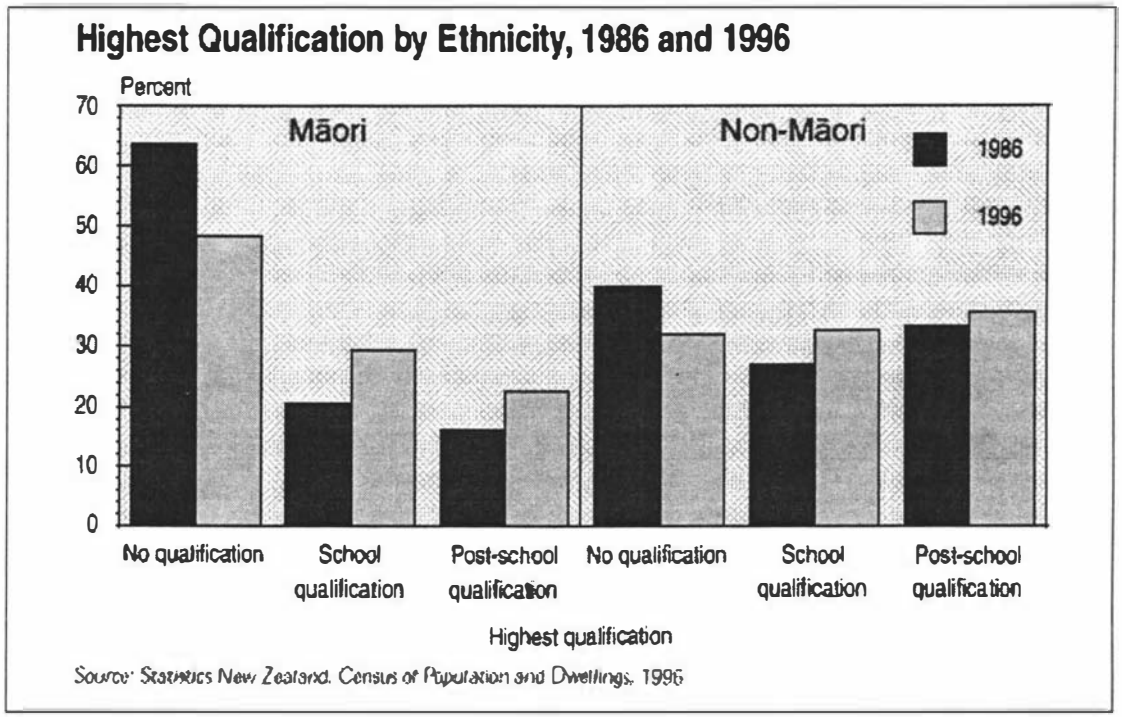
In 1996, Māori made up 9.1 percent of all university students, 14.2 percent of polytechnic students, 12.9 percent of college of education students and 88.3 percent of wananga students. The number of Māori students enrolled at wananga has risen from 261 in 1994, a year after wananga were first set up, to 734 in 1996.[22]

MAORI EDUCATION ATTAINMENT

Improvements in the attainment of formal qualifications have been greater for the Māori population aged 15 and over than for non-Māori over the 1986-1996 period, as shown in the figure 5.5.[23] For example, the proportion of Māori with a post-school (tertiary) qualification increased from 16.1 percent in 1986 to 22.6 percent in 1996. The comparable increase for non-Māori was from 33.3 percent to 35.5 percent. At the same time the proportion of Māori with no qualification decreased by 15.2 percentage points while for non-Māori the decrease was 8.0 percentage points. Despite these changes, in 1996 a higher proportion of non-Māori had a post-school qualification than a school qualification or no qualification,

whereas Māori were more likely to have no qualification. Table 3.5 outlines highest qualifications by ethnicity.

FIGURE 3.5

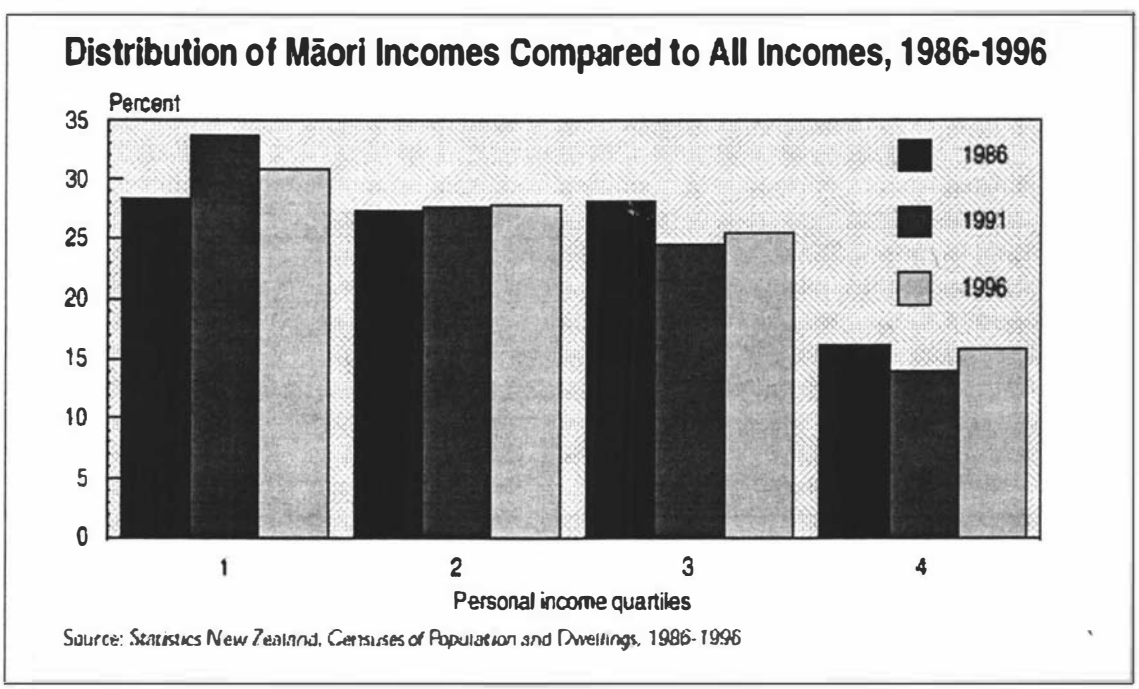


The type of highest tertiary qualification gained by Māori varies with age. In 1996 youth aged 20-24 years were the most likely age group to have gained a basic vocational qualification (5.9 percent). Some of these people will have not yet completed their education and may continue on to gain higher qualifications. Māori aged 35-44 years were most likely to have an intermediate or skilled vocational qualification as their highest tertiary qualification. Men were considerably more likely to have this type of tertiary qualification than women; 6.9 percent of all Māori men compared to 2.7 percent of women. Māori with a degree made up the smallest proportion, representing 2.6 percent of the population aged 15 and over. This is possibly a result of the greater proportion of Māori enrolled at polytechnics, although polytechnics now offer degree equivalent courses. It also reflects the fact that increased Māori participation in university programmes has been a fairly recent phenomenon: the number of Māori graduates more than doubled over the last 5 years, from 751 in 1991 to 1,571 in 1994.[24]

MAORI INCOME LEVELS

Income levels are often used as a measure of social and economic well being. Income is an important measure because it provides an indication of the economic status of individuals. One way of comparing the distribution of Māori and non-Māori incomes is to rank the incomes of the total population from highest to lowest and then divide the ranked incomes into four groups of equal size, known as quartiles. If Māori and non-Māori incomes were equally distributed, 25 percent of Māori and 25 percent of non-Māori would fall into each of the four quartiles.[25] In 1996, 30.9 percent of Māori were in the lowest quartile and 15.8 percent in the top quartile. The proportion of Māori in the lowest income quartile increased from 28.4 percent in 1986 to 33.8 percent in 1991, before dropping back to 30.9 percent in 1996. This suggests some deterioration in the Māori incomes relative to all incomes between 1986 and 1991, followed by an improvement between 1991 and 1996. Figure 3.6 shows the distribution of Māori incomes compared to all incomes.

FIGURE 3.6



As with the total Māori population, Māori men are over-represented in the lowest income quartile.

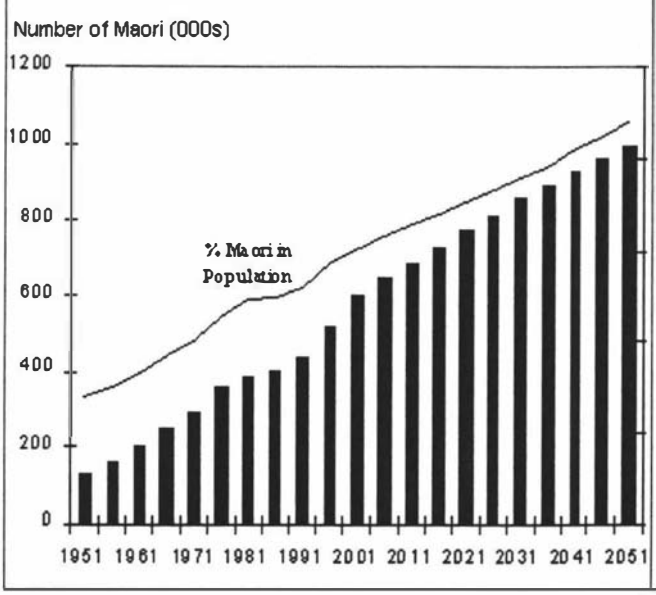
In 1996, 35 percent of Māori men were in the bottom income quartile, compared to 23.6 percent of non-Māori. Māori men were under-represented at the other end of the income distribution, being around half as likely as their non-Māori counterparts to be in the top quartile. Māori women were over-represented in the bottom three quartiles and under-represented in the top income quartile in 1996. At that time, 28.2 percent of Māori women were in the lowest income quartile and 18.0 percent were in the top income quartile. However, while Māori men and women were both over-represented in the lowest quartile, Māori women were in a better position relative to their male counterparts. While 28.2 percent of Māori women had incomes in the lowest 25 percent of women's incomes in 1996, 35.0 percent of men had incomes in the lowest 25 percent of all men's incomes.[26]

THE FUTURE FOR MAORI

After European settlement started in New Zealand, Māori went through some five decades of catastrophic losses largely through disease. In the 1890s levels of life expectancy had declined to 24 years for women and 28 years for men. This decline was checked early in the 20th century. Even then growth continued with quite a remarkable demographic recovery.[27] Figure 3.7 outlines the projected growth of the Māori population from 1951 to 2051.

FIGURE 3.7

Growth in the Māori population over time.



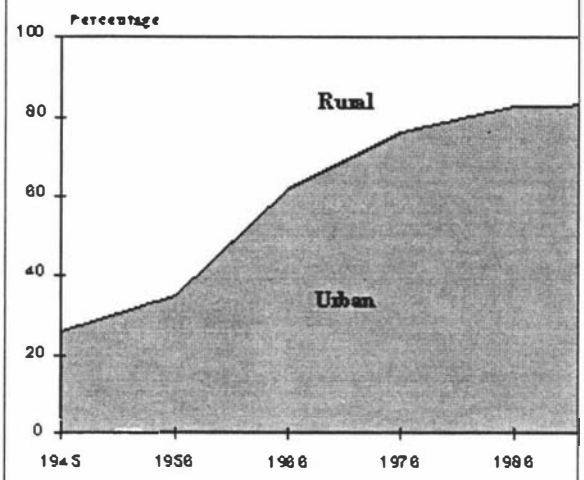
- Over half a million people 15% of the NZ population – identified as Māori in 1996.
- The Māori population is projected to reach one million by the middle of next century and over 20% of the total population.

URBANISATION

From a mainly rural population that was somewhat invisible in public policy before World War II, Māori moved in search of work following the war in a rapid urbanisation process. This saw a shift from around 25 percent of Māori being urbanised in 1945 to some 75 percent by the mid-1970s. The increasing visibility of Māori more firmly drew the wider public's attention to their long experience of distinctly poorer outcomes from education and paid employment and to their health and housing. Table 3.8 outlines the progress of Māori urbanisation from 1945 to 1996.[28]

FIGURE 3.8

Māori Urbanisation



- The Māori population underwent rapid urbanisation after WW II.
- 83% of Māori lived in urban areas in 1996, compared with only 25% in 1945.

Along with urbanisation, Māori shared in the post-war baby boom, a strong boost in births resulted in fully one half of all Māori being under 15 in 1961. Since then, Māori have experienced a dramatic decline in fertility, although by comparison with non-Māori, young motherhood has continued in significance.[29]

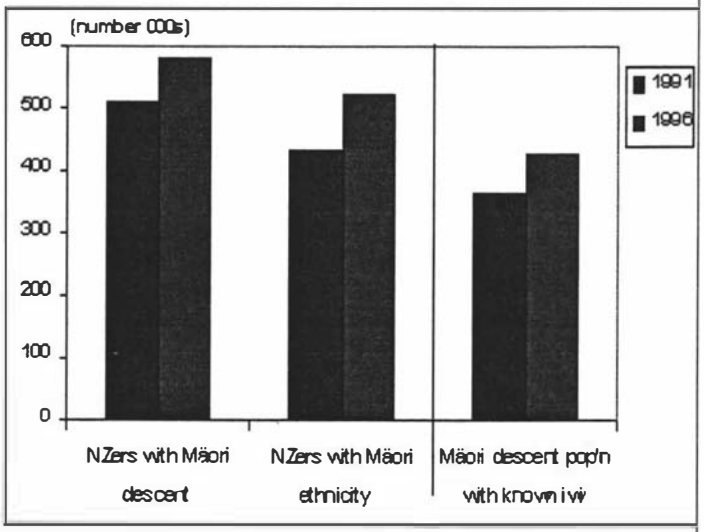
Māori urbanisation and the accompanying massive demographic changes have had huge consequences for social structures and communities. The post World War II urbanisation of Māori produced improved life expectancy and high fertility rates which dramatically changed the profile of the Māori population. In the midst of the urban environment tribal structures were not favoured and were adverse to the

assimilation process. By the time official recognition was given to tribal development[30], third and fourth generation urban migrants had lost connection with meaningful elements of Māori heritage including tribal territories, wider extended family and Māori language. Some became well integrated into their new environments and were able to function comfortably in mainstream New Zealand but many others became isolated not only from their tribe, but from society in general. Many iwi now have a minority of members living within their traditional territories. One quarter of all Māori do not report their iwi ancestry in official data, probably because that knowledge may have been lost.

Figure 3.9 outlines Māori descent, Māori ethnicity and iwi affiliation in 1991 in comparison with 1996.

FIGURE 3.9

Māori descent, Māori ethnicity & iwi affiliation 1991 & 1996



- Three out of four New Zealanders with Māori descent could name at least one of their iwi in 1996.
- Numbers of New Zealanders with Māori descent, Māori ethnicity and known iwi affiliations have all increased since 1991.

A YOUNG MĀORI POPULATION

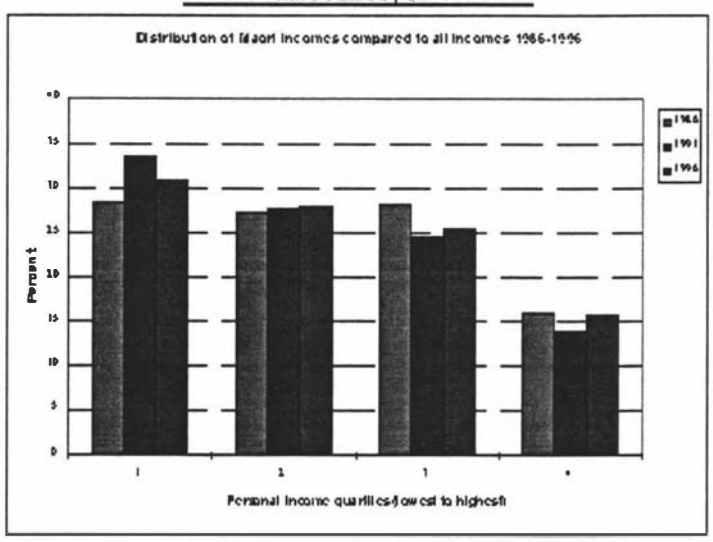
Māori are much younger as a group in the New Zealand population. They will provide a large minority of new entrants to the workforce after 2010 and will be a significant influence on economic performance.[31] This demographic change will lie alongside a large increase in the older Māori workforce over the next two

decades. Young Māori have long had a significant chance of being unemployed in teenage years.

In 1992 nearly half of all Māori teenagers in the labour force were recorded as unemployed.[32] This constrains expectations of any significant structural improvement in the income distribution of Māori in the medium term. At the same time that young Māori have a one in three chance of being unemployed (significantly influencing the chances of a strong market based economic advancement for Māori) they are growing as a share of the total young workforce. Māori are now more likely to be self-employed, following a trend in this direction in the economy overall perhaps stimulated by labour market and other public changes. They are also over-represented in the unemployment figures, and concentrated in industries most at risk from the global economy or from technological change. Again, this may make those currently employed vulnerable in the future. Figure 3.10 compares Māori incomes with all other incomes in 1986, 1991 and 1996.

FIGURE 3.10

Māori Incomes, 1986 – 96



- Māori people are over-represented in the lowest 25% of incomes.
- Māori personal incomes relative to all incomes have not improved in the last decade.

Māori could benefit by encouraging a large share of the younger generation to adapt quickly to technological advantages of the future. But benefit will only

come as long as that age group is as well equipped as contemporaries in other population groups. Māori children are concentrated in the lower income decile households, with consequently reduced educational prospects. It is not possible to estimate whether higher level education outcomes are dominated by differences in the economic position of Māori households resulting from market income earnings, but economic position influences tertiary attendance rates quite significantly.

As with non-Māori, women are more likely than men to gain a school qualification. Moreover, while the number of young Māori remaining in education in their late teens rose strongly during the 1980s, it has fallen since 1992. This is perhaps associated with the rise in young Māori employment, after a sharp fall in the 1980s, but is a significant setback in improving educational outcomes. Young Māori may experience further disadvantage because of less access to the internet and relevant training.

The proportion of Māori enrolling at a tertiary institution more than doubled from 1991 to 1996 and the proportion of Māori with a post-school qualification grew significantly. However, non-Māori are still more likely to send their children to pre-schools, the rate of Māori participation at tertiary is still lower than that of non-Maori, while patterns of enrolment at institutions and levels of study show gender differences often similar, but more pronounced, to those for non-Māori.

THE BURDEN OF DISEASE

Determining the burden of disease has been a world-wide interest in order to estimate the economic social and human consequences of poor health. When years of lost life, as a result of disease or injury, are combined with year equivalents lost to disability, the resulting measure is known as disability adjusted life years (DALYs). One DALY represents the loss of one year of healthy life.

The risk factor analysis is based on the proportion of each disease outcome that would not occur if the risk factor were to be eliminated. Attributable fractions are calculated using standard population attributable risk methods, which combine

the age-specific prevalence of the risk factor with the relative risk for the disease outcome. The overall contribution of each risk factor is then calculated by adding together the contribution of the risk factor to each disease or injury outcome. Attributable fractions are not mutually exclusive. The contributions of different risk factors to disease burden are not independent of each other and cannot be added together, unlike the shares of the same risk factor across different diseases.[33]

Several assumptions underlie the risk factor analysis. In the absence of data to the contrary, relative risk estimates for Māori and Pacific peoples are assumed to be similar to those of the European or other ethnic groups. Risks are also assumed to be dichotomous but in reality, risks tend to be continuously distributed. Recognising only two or three categories therefore loses some information, but is a necessary step in order to align prevalence and risk categories. Since current prevalence is used, no allowance is made for the time lag between exposure to a risk factor and the onset of the corresponding disease.[34]

By tightly focusing on the fatal and non-fatal outcomes of disease and injury, the burden of disease approach provides a quantitative method for comparing and ranking different diseases, injuries and risk factors. However, this approach has limited ability to incorporate and quantify the impacts of factors outside a relatively reductionist frame. This has three important limitations. Firstly, the burden of disease approach currently quantifies the effect of proximal risk factors only. Social, economic and cultural factors generate patterns of ill health which the burden of disease analyses could include in the same way as for risk factors but data on exposure and relative risk are not yet available. The exclusion of social determinants of health simply reflects the fact that the necessary data to include these factors is currently unavailable.

Secondly, the burden of disease analysis may have limited applicability for prioritising different treatment and prevention strategies to reduce the health inequalities affecting Māori and Pacific peoples. Prioritisation will be possible for strategies that target one, or several, discrete risk factors, injuries or diseases, such as

breast cancer screening or smoking cessation strategies. The approach cannot be easily used to prioritise strategies that have more general impacts on health, such as those aimed at increasing primary care effectiveness or community development. Inability to prioritise these strategies within the burden of disease framework does not imply that such strategies lack policy relevance.

Finally, the burden of disease approach assumes a relatively narrow and reductionist construct of health. A more holistic view would be more compatible with Māori understandings of health and would allow a wider range of policy options to be considered. The burden of disease approach is, nevertheless, relevant to Māori health policy development and evaluation. The approach is compatible with many prevention and treatment services that remain focused on specific diseases, injuries and risk factors. It is compatible with existing Māori health goals and targets, many of which are disease and risk factor-focused. At the same time, it should be emphasised that the burden of disease approach described here is only one input to the process for selecting and prioritising strategies to reduce ethnic inequalities in health.

CONCLUSION

This chapter has presented a range of demographic facts to illustrate the contemporary Māori situation. Māori educational participation, incomes, and other measures are useful indicators of Māori well-being. Maori who are of Māori descent, but not solely of Māori ethnicity, have outcomes distributed similarly to non-Māori, while those with sole Māori ethnicity are concentrated significantly among those with poorer health, income, and educational outcomes.

Maori with strong ethnic and cultural identity, sustained through knowledge of whakapapa (genealogy), constant interaction with whanaunga (extended family) or other forms of access to te ao Māori (the Māori world), live with high levels of self confidence and motivation. Māori vitality and exuberance is limited only by self-belief. This chapter has presented information, though not conclusive, to stimulate debate and encourage future speculation on Māori socio-economic

development. As stated in the Methodology section of Chapter One, Māori data analysis is significantly limited because the collection of Māori specific information is a relatively new development in Aotearoa-New Zealand.

Closing the gaps between Māori and Pākeha does not necessarily mean the same futures, but perhaps more important is sharing a comparable capacity to respond to the emerging and foreseeable national and global challenges, and an ability to benefit similarly from them. Over the last two decades, where public policy has been dominated by short-term solutions, such as a focus on work training rather than longer-term education, the intergenerational impact may not be permanent. Often the performance of programmes is monitored, rather than the achievements of population cohorts, and success or failure to the programme without understanding the context within which it applies. Māori development strategies operating within non-Māori constructs, or the narrow confines of a sectoral operation, are a good example of this.

An accurate picture of Māori health status is dependent on reliable data from various sources. Given Māori health measures are expressed in comparison with non-Māori, resulting in a series of statements about the ways in which each ethnic group differs, it assumes that Māori need to aspire to similar standards as those of non-Māori. Although there are some indications that socio-economic status of Māori and non-Māori are converging; there are still significant differences. The danger with exemplifying such Māori health measures is the manner with which they are interpreted. It is far too easy to assume that they represent personal failure rather then system failure and in doing so, exacerbating a sense of dejection and discouragement. What needs to be determined for the future are the characteristics which underlie the ability of Māori to adapt, recover and sustain positive development.

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[1] Durie, M.H., (1998), *Whaiora – Māori Health Development.* (Second Edition) Oxford University Press, Auckland, p.123.

[2] Ministry of Health, (1996), *The Health and Disability Sector.* Briefing papers for the Minister of Health, Wellington, p.16.

[3] Ministry of Health, (1996), p 22.

[4] Statistics New Zealand, (1998), *Census of Population and Dwellings 1986-1996 - New Zealand Māori Now.* Wellington, p3.

[5] Statistics New Zealand, (1998), p4.
[6] Statistics New Zealand, (1998), p.3.
[7] Statistics New Zealand, (1998), p.4.
[8] Statistics New Zealand, (1998), p.5.
[9] Statistics New Zealand, (1998), p.6
[10] Sporle A, Pearce N. (1999), *Impact of changes in the death registration process upon Māori mortality statistics*. NZ Medical Journal, pp. 112, 411–12.
[11] Statistics New Zealand, (1998), *Census of Population and Dwellings 1986-1996 - New Zealand Māori Now*. Wellington, p.36.
[12] Statistics New Zealand, (1998), p.36
[13] Statistics New Zealand, (1998), p.37
[14] Statistics New Zealand, (1998), p.43.
[15] Statistics New Zealand, (1998), p.44.
[16] Statistics New Zealand, (1998), p. 44.
[17] Te Puni Kokiri – Ministry of Māori Development, (1998), *Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori,* Wellington, p.16.
[18] *'Māori Language Nests'*: total immersion Māori language early childhood education centres – A national strategy for the revitalisation of the Māori language.
[19] Te Puni Kokiri – Ministry of Māori Development, (2000), *Progress Towards Closing Social and Economic Gaps Between Māori and Non-Māori*, Wellington, p.6.
[20] Te Puni Kokiri – Ministry of Māori Development, (2000),p.7.
[21] Statistics New Zealand, (1998), *Census of Population and Dwellings 1986-1996 - New Zealand Māori Now* Wellington, p 31.
[22] Statistics New Zealand, (1998), p. 31.
[23] Statistics New Zealand, *(1997), Demographic Trends*. Wellington: Statistics New Zealand, p. 32.
[24] Statistics New Zealand, (1998), *Census of Population and Dwellings 1986-1996 - New Zealand Māori Now*. Wellington, p 34.
[25] Statistics New Zealand, (1998), p.45.
[26] Statistics New Zealand, (1998), p.47.
[27] Statistics New Zealand, (1999), *Demographic Trends,* Wellington, p.3.
[28] Statistics New Zealand, (1999), p.4.
[29] Statistics New Zealand, (1999), p 5.
[30] The Ministry of Māori Affairs, (1988), *Te Urupare Rangapu,* Wellington, p 23.
[31] Statistics New Zealand, (1999), *Demographic Trends,* Wellington, p.8.
[32] Statistics New Zealand, (1999), *Demographic Trends,* Wellington, p.8.
[33] Durie, M.H., (2001). *Mauri Ora – The dynamics of Maori Health* Oxford University Press, p 17.
[34] Durie, M.H., (2001), p. 17.

CHAPTER FOUR

MĀORI HEALTH DEVELOPMENT

Māori health issues are so complex they cannot be fully understood without recourse to the broader concepts of Māori development and developments within the health sector. In terms of Māori health there have been major advances both in health status and Māori participation within the health sector. Durie (2001) outlined three goals that have been pursued:

1. gains in health status;
2. early intervention and prevention of ill health;
3. greater participation in all aspects of health policy and delivery.[1]

Arising from those goals three strategies have emerged. First, the recognition of Māori perspectives on health have made it possible for Māori to inject a greater sense of ownership over health and to see themselves as key stakeholders in the broad health arena. Second, Māori leadership in the health sector has become more evident. Māori health professionals are taking a greater lead in more than just the clinical arena. Māori involvement in health management and health policy is evident at all levels as well as purchasing activities. Many Iwi have implemented health strategies and large urban Māori authorities have incorporated health care into the range of social services that they already provide. The third major strategy has been the development of dedicated Māori health services. Initially the main focus was on health promotion and liaison with mainstream services, but many community and Iwi groups have established comprehensive primary health care centres, disability support services, and specialist services such as alcohol and drug services and other mental health services.

Whether these strategies will lead to greater health gains remains to be seen. It will also be difficult to assess since gains in health depend on several factors, many of which are external to the health sector. Nevertheless, increased Māori

involvement in health has created an enthusiasm and an awareness that was not readily evident prior to 1980.

There are some signs that despite continuing disparities between Māori and non Māori standards of health, early intervention is practised more frequently and access to health services has improved.[2] This was not the first time Māori health had experienced an apparent resurgence from health reforms.

EARLY MĀORI HEALTH DEVELOPMENT

After the First World War (1914-1918), and the influenza epidemic of 1918, the New Zealand Government implemented a new era in the way Māori health matters were handled. A commission of enquiry into the influenza epidemic in 1919 identified flaws in the public health system and recommended restructuring of the Department of Public Health. The Public Health Act of 1920 reorganised the Department of Health into seven divisions and included the establishment of a Māori Hygiene Division.[3]

According to Lange (1999) one of the Māori health strategies employed included the revival of the Māori Councils expressly as Māori Health Councils, although it was a continuation of existing practices.[4] Funding shortages and concerns about duplication of roles already conducted by medical officers and district nurses lead to the disbanding of the Division in 1930. The new political agenda was driven by the need for a better integrated health system, or mainstreaming. There was no longer any recognition of need for Māori leadership in the development and implementation of health policy as it concerned the Māori population.[5] Earlier Māori participation in the health reforms was motivated by the possibility of racial extinction but by the 1930s such annihilation was no longer possible.

Encouraging Māori to gain maximum advantage from the national hospital system was a consequent policy focus that continued through most of the twentieth century.[6] For varying reasons Māori utilisation rates were consistently lower than

those of non-Māori but utilisation of the health care system did steadily increase. A good example is the number of Māori births in hospital which rose from 17 percent in 1937 to over 98 percent in 1970.[7] As the twentieth century proceeded, medical advances and increasing Māori recourse to medical treatment steadily reduced the list of diseases that either killed or did not respond to medical care. The Māori population became more biologically able to resist new viruses and bacteria and this contributed to decline in some categories of mortality.[8]

According to Dow (1999) early twentieth century New Zealand was also a period of prosperity which brought economic development to many Māori communities, increasing incomes and raising living standards in areas such as housing and diet. Policy reformers were well aware of the importance of improving Māori economic base.[9] However, there is more to Māori health than helplessness against the onslaught of germs or inability to afford adequate food or shelter. Other attributes such as attitudes, practices and situations determined by cultural heritage, and by social, economic and political circumstances had enormous influences on health. [10]

Even in the absence of reliable Māori health data, it may be confidently asserted that Māori health improvement was accomplished by reforms that commenced in 1900. Not only was the threat of numerical extinction banished forever but the health of Maori people made a demonstrable advance which has continued. Certainly Māori health standards were very low but the reforms, limited though they were by financial and other inadequacies, did herald a successful campaign against low Māori health standards. Clearly, the work of the reformers was a new factor since only limited steps to enhance Māori health status had taken place before 1900.

What happened in the early decades of the twentieth century may have marked a new departure. For the first time, obvious health improvements were the outcome of conscious community effort and levels of Māori health were visibly lifted. Another important feature was that Māori people themselves were willing for

the first time to work actively for the improvement of physical wellbeing. Until then Māori had usually failed to respond to suggestions that disease could be countered by adapting their ways of life. Defeat and displacement from tribal lands took away Māori will to live in a world promising only a foreign future and left Māori easily susceptible to poverty and disease.[11]

Changing Māori perspectives to health were influential but for Māori, the reforms since 1900 were a productive step towards regaining their rightful place in Aotearoa - New Zealand. More than a century later, Maori health development still depends heavily on Māori perspectives of health.

A MĀORI PERSPECTIVE OF PUBLIC HEALTH

From a population health perspective, health is defined quite broadly. The World Health Organisation (WHO) has defined health as a state of complete physical, mental and social well being.[12] Good health is a significant factor in enabling people to participate fully in society and provides some of the *"means by which people can pursue their goals in life."*[13] This definition coincides with the Māori concept of whanaungatanga (family dependence) or kotahitanga (collective unity), whereby personal health and the health of family and community are closely linked.

Understanding and accepting that there are different cultural interpretations of health is central to the ability of a health service worker to meet the specific health needs of other ethnic groups. The word 'hauora' is often used as the Māori word for 'health' however it has a broader meaning than physical well being and includes aspects of wairua (spiritual), whanau (family) and hinengaro (mental) as well as other cultural elements such as language, land and environment.[14] Different cultures value the various aspects of good health in different ways.

Understanding the concept of Māori health development is clearer from a public health perspective. One definition of public health is the three 'P's - preventing, prolonging and promoting or, "the science and art of preventing disease,

prolonging life and promoting health through organised efforts by society"[15]. Public health is therefore applicable at central and community levels. Public health activities are diverse and can include preventing communicable disease, encouraging avoidance of high-risk behaviour, increasing public knowledge of health and facilitating early management of chronic progressive illness, such as diabetes and high blood pressure. Public health is also concerned with the delivery of health services. In major urban centres public health is mainly practised through specialist and centralised services but it is usually only evident when a health crisis occurs. National quarantine, food regulations and immunisation programs are examples of centralised public health. In remote rural areas public health activities are usually incorporated into general health services and are delivered through small community clinics. A Māori health perspective is drawn from the same understanding but is based on Māori models of health.

MĀORI MODELS OF HEALTH

There are currently many models of Māori health and though each has its own characteristics they have similar or overlapping attributes. Often described as traditional Māori approaches to health, Māori models of health are actually views of Māori health that are in accordance with contemporary Māori thinking.

A model, that gained wide spread acceptance as a Māori health perspective, was the four-sided construct known as whare tapa, or a four-sided house. It was first presented in 1982 as part of a training session for fieldworkers in the Māori Women's Welfare League at the Rahui Tane Hostel in Hamilton.[16] The model compared health to the four walls of a house, all four being necessary to ensure strength and symmetry though each representing a different dimension: Taha wairua (the spiritual side), taha hinengaro (thoughts and feelings), taha tinana (physical side) and taha whanau (the family).

Simply stated the whare tapa wha concept of health consists of an interaction between these four dimensions. It is a well-known model and has been much publicised. Analysing Maori models of health is not an objective of this study.

However, the impact and influence they have had on Māori health development is of interest to this research.

Māori models of health have had a major role in Māori health development because they redefined health in Māori terms. Māori interest in claiming a positive role in shaping health services is accelerated when models of Māori health are introduced. They are simple but that is also their appeal. When Maori dissatisfaction with the health sector becomes apparent, Māori models of health provide a constructive alternative. They are an alternative option made even more attractive by Māori defined attributes. They are Māori interpretations that provide an understanding of Māori health and rest on Māori values.

Māori models of health also provide attributes that cannot be gauged through simple health measures such as weight or blood pressure. Spiritual and emotional factors, though much more difficult to measure, are regarded as equally important. If there is one point to be made about Māori models of health it is that they have provided some necessary frameworks for advancing Māori health development while giving Māori a sense of ownership over health and more importantly, they have kindled Māori interest in health.

THE MĀORI HEALTH POLICY GUIDELINES

Māori models of health achieved formal expression within the New Zealand health sector when the Māori health policy guidelines were eventually published by the Ministry of Health in 1994. Three years earlier, in July 1991, the Minister of Health, Hon Bill Birch, announced the Health Reforms. In 1993 the reforms were introduced. The reforms are examined in detail in the Chapter Five, Crown Policies for Change. This section examines a component of the reforms namely, the Māori health policy guidelines.

The main attribute of the new direction for the health sector was separating the health purchase and provision roles and resulted in the establishment of four Regional Health Authorities within New Zealand with a specific role of purchasing

health services within their specific regions. One of the underlying incentives was to move away from centralised control in Wellington and to allow a regionally managed and administered health sector to prosper. Consequently, the Department of Health was reconfigured towards a strategic policy function and one of their roles was to develop and publish the annual Health Policy Guidelines for Regional Health Authorities (RHAs). Within the document were the Māori Health Policy Guidelines for RHAs. The policy guidelines, and in particular the Māori health guidelines, were often referred to as the toothless tigers of policy health directives. They were meant to identify specific areas where the Government required Regional Health Authorities to respond with key purchasing intentions for health services in their areas. However, they were fundamentally flawed because they had no legal impetus, could not give rights to any third party, and were not accompanied by additional funding.

The Policy Guidelines were to identify specific areas where the Government required Regional Health Authorities to respond in health purchasing intentions for health services. The RHAs would respond by highlighting any significant changes to the volume, range, or delivery of health services to be purchased in the following year. Both documents would then be used to form a Funding Agreement for each Regional Health Authority. The Funding Agreement, once agreed upon, became the legally binding document, for which the Regional Health Authorities could, in theory, be held accountable. It was from that document that the RHAs formulated contracts with provider focussed outputs that health service providers were contracted to deliver.

For a range of reasons this scenario was even more difficult for Māori providers because of the inherent contradictions. While Māori health perspectives had been duly recognised, the performance measures generally failed to capture Māori understandings. Outputs, the focus for accountability between providers and RHA's bore little resemblance to Māori understandings. How Māori have managed provider outputs is a key objective for this thesis and is central to the change

management aspects of the study. They are analysed further in Chapters Six, Seven and Eight.

What was even more difficult was the fact that Ministry of Health expectations of the policy guidelines and RHA interpretations of policy guidelines, often resulted in two very different perceptions and the outcome was usually an unsatisfactory compromise for both parties. In spite of all the faults, flaws, problems and dilemmas the 1991 health reforms caused in the health sector it can be said with some confidence that aspects of Māori health have benefited from them especially in areas such as increased Māori participation and provision in the health sector. Māori health continued to be a priority throughout the 1990's at all levels of the New Zealand health sector. Continuing disparities in health status between Māori and non-Māori supported this momentum but increasing research on socio economic determinants of health provided an extra sense of urgency to the Māori health cause.

SOCIO-ECONOMIC DETERMINANTS OF HEALTH

Māori health development is directly related to general standards of living, which are commonly defined by employment, education, income levels and housing. Greater inequalities in income are associated with groups in society suffering from multiple disadvantages including significantly poorer health. Health and life expectancy have always been influenced by socio-economic status, even though the causes of illness and death may have changed. Systematic variations in health persist in the most egalitarian societies, but the degree of equality across and within societies is affected by political and socio-economic factors.[17]

In Australia the health transition which has taken place in many developing countries has not happened in the same way for the indigenous population. The Australian Aboriginal people have high levels of early and late stage dominant disease groups and infections remain rampant. Diarrhea and respiratory infections are major problems amongst young children and are compounded by nutritional deficiencies. Ear and chest infections, rheumatic heart disease, skin sepsis, scabies and post streptococcal glomerulonephritis (throat infections) affect all ages and

further retard children through missed schooling and residual ill-health including deafness.[18]

Over the last thirty years the incidence of diabetes, heart disease, hypertension and renal disease, commonly referred to as lifestyle diseases, has increased and is still a major cause of concern amongst Australian Aborigine. Infection in the presence of these disorders is especially dangerous and difficult. Impaired nutrition, genetic factors along with changes in diet and activity is all contributory factors to lifestyle diseases. There are also higher then average rates for incidence of mental health, substance abuse, mainly tobacco and alcohol, violence and accidental injury however these latter problems are not just limited to Aboriginal Australians.[19]

Factors that determine health in any context are complicated and varied. There are also risks in making general statements on health determinants particularly because national health data reflect averages and tend to mask data from minority groups. In 1996 factors that contributed to the health situation of Australian Aboriginal were described by Professor John Mathews in an Annual Report to the Menzies School of Health Research, Darwin, Australia. In brief, Prof. John Mathews concluded:

> *"ill-health arises from adverse physical, social and economic environments interacting with recognised biological causes of ill-health and ill-understood adverse effects of dispossession, displacement and marginalisation."*[20]

Obviously many of the problems contributing to the health status of Australian Aboriginal are preventable and in fact, similar infections were widespread throughout New Zealand Māori earlier in the century but are now comparatively less frequent. Professor Mathews also goes on to state that many of the solutions to Aboriginal health status "lie in providing more equitable and acceptable social and

economic environments."[21] This is largely outside the scope of health services and health professionals except as collaborators and advocates. Social and economic progress requires generic community development, which is best driven from within the community, but with support from outside. Chronic ill health and premature death can drain the energy of communities, which would otherwise be used for promoting realistic and effective change.

Community development is essential for comprehensive resolution to the root causes of poor health.[22] In the situation of Aboriginal health status a sense of injustice compounds the urgent need to reduce the current toll from avoidable illness and the negative impacts on community and individual well being.

The need to address disparities in health status between Aboriginal and non-Aboriginal Australians can be effectively promoted on a needs based argument under the rationale that improving the health status of Aboriginal people is better for all Australians. For New Zealand Māori, the needs based argument is also applicable but the obligation on the state to address Māori health issues, in a way that makes sense to Māori, is enforced by the Treaty of Waitangi.

ADDRESSING HEALTH DISPARITIES

There are a number of ways that Māori health, or Māori well being, might be measured. One of the most frequent involves comparing Māori living standards with those of non-Māori, and then identifying a range of health disparities. Disparities between Māori and non-Māori give some indication of the gaps between Māori individuals and other New Zealand citizens.

For as long as it has been possible to address ethnic data there has been consistent evidence that serious gaps exist. Māori health disparities data are used for a range of Māori health imperatives including rationalising the allocation of health funding to Māori health initiatives, validating the need for more Māori health research and, substantiating Māori health as a national health priority. On almost any

socio-economic indicator such as health, education, employment, income levels and home ownership, Māori performance is substantially lower then that of non-Māori.[23]

However, although health disparities data identify major inequities in health status, using non-Maori New Zealand as a bench mark does not recognise the dynamic achievements of Māori society over time, or more significantly, the health gains Māori have made this century. For example, in 1900 Māori life expectancy was approximately 32 years, in the year 2000 it was 71 years.[24] In 1929 the infant mortality rate was 94 per 1000 live births but in the year 2000 it is approximately 18 per 1000 live births.[25] Deaths from tuberculosis were 37 per 1000 in 1945 and now they are have been virtually eliminated. Equally significant is the fact that Māori population increased from 42,000 in 1896 to 580,000 in 1996. This is not to say that there are no substantial Māori health problems, in fact there has been deterioration in some areas such as mental health, cancer and respiratory disease, but the point is that any assessment of Māori health should not always be seen along side non-Māori statistics. Comparisons over time and between different groups of Māori may actually be more useful as indicators of progress.

In 1992 a report was prepared by the Public Health Association which described in detail the social and economic factors influencing the health of New Zealanders. It concluded that: *'these factors influence health status more strongly than any aspect of clinical care and that fundamental causes of health inequalities should receive more attention from policy makers'*[26]. In the United Kingdom (UK) the notion of good health for all has been at the heart of the National Health Service and is outlined in a green paper released by the UK government in 1998 entitled *"Our Healthier Nation"*. This paper argues that the highest public health priority in the UK is dealing with conditions such as poverty, unemployment and other structural factors that are the fundamental causes of health inequalities[27]. When discussing health disparities between Māori and non-Māori there needs to be a clear consensus on the two main themes: what is meant by health and, what inequalities are most significant?

Gillett and Campbell (1993) broadly defined health as " *a means by which people pursue their goals in life*"[28]. This is a holistic view of what many people generally refer to as their quality of life but it does serve to emphasise the understanding that health is more then just illness. The measures of poor health are generally identified by the occurrence of disease and injury. There are also important causes of variations in health such as access to, and the provision of, good quality medical care. This is particularly significant for Māori health in New Zealand and a lack of access has been one of the triggers for a growth in health services provided by Māori for Māori. It is expected that this trend will help close the gap between the health status of Māori and non-Māori.[29] These are important considerations in planning health policy and health services and are also relevant to discussions of equity and justice. However, in this section of the thesis the focus will be on the social, cultural and economic environment that influences health such as income and housing.

There is little doubt that disadvantage is indeed a substantive cause of poor health. Disparities in health status are one example of the social, cultural and economic determinants, which result in disease and injury, but to focus only on disparities in health may disregard other determinants that are consistently present within the population.

Reducing disparities in health status and improving health are not necessarily the same thing. Health interventions may improve the health of the population on average but it may benefit those with good health status more than it does those with poor health status. Such interventions would serve to increase disparities and adding to the burden already carried by disadvantaged groups. Alternately some interventions could reduce disparities but actually lower the existing levels of health status in the process. Maximum health gains and reduced health disparities are inextricably linked and in practice there are major concessions in order to achieve both goals. This section looks at the question of why public resources should be allocated to reducing health disparities. This is particularly relevant because change

management for Māori health development is partly about a series of strategies for reducing disparities in health status between Māori and non-Māori.

Any research on the process of addressing health disparities inevitably leads to debate about the issue of fairness. In March 1998, a report was prepared for the National Health Committee on a health determinants programme which argued that New Zealand should reduce inequalities in health status. One of the issues discussed was fairness. Many would agree that trying to reduce health disparities is fair because good health should not be dependent on a persons socio-economic status, but in doing so there needs to be agreement on which health disparities are actually unfair. Equity is an issue of fairness and indeed justice, but it is not the same as equality. The question of which health inequalities are unfair is central to the debate about prioritising Māori health issues. In order to fully comprehend the necessity of implementing strategies for reducing health disparities there needs to be some level of agreement on why public resources should be allocated to reducing health disparities between Māori and non-Māori.

In 1992 the Ministry of Health made a clear policy statement to this end in a document entitled *'Whaia te ora mo te Iwi'* which stated that Māori should enjoy 'at least the same level of health status as non-Māori'[30], though it was not absolutely clear why that conclusion was reached. The 'lack of justice' argument tends to be determined by a moral judgement that compares disparities in health with inequalities in other areas. This is more compelling when the issue of personal responsibility is least relevant, for example child health. Health disparities are unfair when sufferers bear little responsibility for the position they are in especially when the poor health status is clearly avoidable. If an individual is responsible for actions that have lead to loss of health, then the resulting inequality in health status could not be described as unfair. Health variations that are the result of individual lifestyle choices should therefore not be regarded as inequitable. On the other hand, choice over lifestyle is not a simple matter. Generally those with fewer resources have less control over lifestyle decisions.

According to Woodward and Kawachi, the type of inequalities which are unfair are those that are generally centred around *'opportunities'* or, *'inequalities in opportunities for good health.'*[31]. This perspective has a number of attractive points. Firstly, it emphasises differences in health status that can be remedied and secondly, it acknowledges that individuals do carry a certain responsibility for their health. Finally, it implies that we should concentrate on reducible inequalities in health, where people who suffer them have little or no responsibility. The difficulty with debate on this issue is that people tend to hold different views on the extent to which individuals are responsible for their own health actions. This argument can be extended to a point where it ceases to be a useful concept. For example, if an adult continues to eat red meat in the face of evidence that it contributes to heart disease and then has a heart attack, is the case 'self inflicted'. Or, does a motorist who drives a car with high level exhaust impurities deserve a greater degree of self blame when he develops lung cancer later in life? Nonetheless, in spite of the potential for debate on addressing health disparities between Māori and non-Māori there has been a large measure of agreement that, for whatever reason, disparities are not acceptable in a modern nation.

MĀORI PROVIDER DEVELOPMENT

In 1993 the New Zealand Government recognised three major strategies for improving Māori health. The first involved linking initiatives on Māori socio-economic status with Māori health. The second was to enable Māori to manage their own health including services and priority setting for the development and delivery of Māori health services. The third, involved enhancing the ability of mainstream services to respond to Māori.[32]

In ensuring Māori receive the most effective services the four Regional Health Authorities (RHAs) were advised to take an integrated approach to improving Māori health status by: developing contracts with appropriate Māori providers to deliver health services for Māori, developing new and existing Māori organisations to ensure they are able and have the opportunity to contract for the provision of health services and, to contract with providers who recognised Māori aims and

aspirations, training and development needs of Māori staff, and greater involvement of Māori staff within an organisation.[33]

The Māori Health Group, Te Kete Hauora in the Ministry of Health targeted the importance of identifying ideal market conditions and incentives, which would then create an environment of equal opportunity for Māori and non-Māori providers. Such an environment would encourage Māori and non-Māori providers to develop innovative and culturally appropriate services. Services provided by Māori for Māori were perceived as achieving direct and effective gains for Māori health.[34]

In accordance with this a Strategic Management Plan for Māori Health from 1994-1999, *Te Ara Tohu*, one of the roles of Te Kete Hauora required it to *"deliver advice on strategies to increase the opportunity for providers of culturally appropriate services to enter the market."* [35] This became known as the Māori Provider Development project within the Ministry of Health. A case study of the Māori Provider Development project is outlined later in this chapter.

The Regional Health Authorities were required *"to increase access to services by Māori, decrease disparities in health status between Māori and non-Māori and to give greater weight to achieving Māori health gains."* [36] The Ministry of Health through the policy guidelines to RHAs was able to inform the purchasing strategies of the RHAs. One of the early outcomes from these strategies was the rapid growth of Māori health provider organisations. Between May 1993 and May 1996 the number of Māori providers in the health sector increased by more then 400% and many of those providers held multiple contracts especially in urban centres such as Auckland.[37] The four Regional Health Authorities quite appropriately established different approaches to Māori provider development within their regions and these were reflected in the range and diversity of Māori provider initiatives that were funded.

One of the most notable features of Māori provider development at that time was that there was no one approach within, or between, the four Regional Health

Authorities. With the 1997 amalgamation of the RHAs to the Health Funding Authority (HFA) it was likely that some merging of strategies would occur, particularly in management and administration, but the regional characteristics would probably remain the same. In 1996 the four Regional Health Authorities were implementing Māori Provider Development strategies in ways that were particularly relevant to their regions. One of the strategies was integrated care. A case study of the Māori Provider Development project is outlined in Chapter Seven, Māori Health Service Providers.

INTEGRATED CARE AND MĀORI HEALTH

The concept of 'integrated care' was drawn from a system operating in the United State of America (USA) known as 'managed care'. The American equivalent of an Integrated Care Organisation (ICO) is a Health Maintenance Organisation (HMO) and over the last fifteen years HMO's have dramatically established, expanded and consolidated their share of a highly cost conscious American health market. In the USA managed care has generally been successful for three reasons. Firstly, it allows better co-ordination between primary and secondary health care services leading to better quality care. Secondly, it is consumer focused and enables greater flexibility for addressing the specific needs of the region it operates in and finally, it costs less then competing health models and allows more innovative approaches to health care delivery.[38] Though there are many other attributes, and frailties, synonymous with integrated care in the United States, these two points are relevant to the Māori health situation in Aotearoa-New Zealand. For these reasons in particular, integrated care is applicable to Māori.

A Māori Integrated Care Organisation (MICO) would have the capacity to co-ordinate the provision of health care services within a specified budget, that are designed to meet the specific needs of Māori clients who are registered with the organisation. MICO's have the potential to give Māori greater control over health resources. The registered population criterion allows the opportunity for Māori to gain their fair share of health resources for meeting their own health needs through the provision of comprehensive quality health care. More importantly, integrated

care could be the conduit for greater self determination, by empowering Māori to become both the purchasers and the owners of their own health services. When Māori integrated care was first promulgated into the realm of Māori health professionals it was initially based upon two dimensions:

- the inclusion of cultural perspectives within a health service; and
- the linking of health services with other services.

The difficulty with these two broad aims in the public sector of New Zealand society is that in some situations they are contradictory, while in others they are quite appropriate. Māori health professionals have long argued that the inclusion of a Māori perspective within a conservative health service leads only to a token Māori acknowledgement. A health service with these attributes still continues to function along western lines but no significant modification is implemented. Many believe that the introduction of a Māori perspective creates an illusionary Māori presence serving only to justify further inactivity while at the same time placating Māori demands for greater input.

For Māori, frustration centres around the issue that too much focus is on process and input with very little consideration of actual health gains and outcomes. This is central to the issues outlined in the hypothesis and is another example of how the aspirations and objectives of Maori health planners and providers are frustrated and compromised by politically imposed health policies. This point is particularly relevant in relation to the issue of mainstream enhancement, or in the case of this thesis, change management for improved service delivery. While there is merit in these claims it is also true that efforts to develop workable systems within mainstream have brought positive results which have been of benefit to Māori and non-Māori alike. Innovative schemes initially located within hospitals and other institutions were indicative of Māori health interests prominent in the 1980s. Such schemes were seen as ways of addressing New Zealand's negative encounter heritage and avoiding institutionalised racism.[39] This issue is examined in detail in Chapter eight, Mainstream Enhancement.

CONCLUSION

Māori health development in the 1990s has been characterised by three broad themes:

1. the recognition of Maori perspectives on health,
2. the increased visibility of Māori leadership in the health sector, and
3. the development of dedicated Māori health services.

This chapter has outlined Māori perspectives of health which have provided platforms for accelerating the advancement of Māori health development in a manner that was easily understood by Māori. Māori leadership and involvement in the health sector has become more explicit and includes the establishment of a Māori health policy group in the Ministry of Health and the subsequent Māori health policy guidelines. Māori health professionals have taken greater leads both inside and outside the clinical arena and Māori involvement in health management, policy, purchasing and provision has become evident at all levels of the health sector. These were evidenced in many forms such as the establishment of an association of Māori medical practitioners, a National Council of Māori Nurses, Māori health purchasing units and the accelerated development of Māori health service providers some of which hold multiple service contracts. Dedicated Māori health services have become synonymous throughout the health sector and continue to prosper and grow.

Māori health development is a process of using trials and discoveries from the past to inform the energies and initiatives of the present, and plan priorities and strategies for the future. It is about Māori ambition in the face of overwhelming odds and the progress of a people, committed to the heritage and culture of their ancestors, while ready and able to chart their own course into the future.

Māori activities in health are not unique to Māori and are very similar to other indigenous health movements around the world who in the last few decades of the 20th century have expressed major concerns with the performance of health professionals and many of their basic assumptions. Māori health development

includes a comprehensive range of health areas and is equally concerned with the effective delivery of mainstream health services to Māori people.

For Māori, health service providers in New Zealand are one mechanism through which the Crown can meet its Treaty commitments to Māori health. Management programmes for improving the delivery of health services to Māori are therefore important. This thesis addresses issues that have arisen in the wake of increased Māori health service provision.

Māori health development is a collective Māori process. In the past there has been a tendency to blame individuals for their own misfortune but Māori health is more complicated than illness, injury or lifestyle. Māori people, like many other ethnic groups, belong to whanau, hapu, iwi; though not always functional, Māori communities and a nation that are a reflection of the values and policies therein.

Māori individuals do not have a great deal of personal control over their social and physical environments therefore their lifestyles will inevitably be as much a comment on the whole of society as on them as individuals. This is not to say that there is no individual responsibility for health amongst Māori only that there is collective accountability and any form of Māori health development must also address those needs. Rather than punishing those who lead unhealthy lifestyles, we need to agree on public policies which convey a sense of order in a changing environment and at the same time encourage Māori whanau and communities to nurture each other.

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[1] Durie M.H., (2001), *Mauri Ora – The Dynamics of Māori Health.* Oxford University Press, Auckland, p 257.

[2] Reid, P. (1999), Nga Mahi Whakahaehae a te Tangata Tiriti, in Peter Davis and Kevin Dew, (eds.), Health and Society in Aotearoa, Oxford University Press, Auckland, pp. 84-93.

[3] Cowie, K., (1992), *The Health Department 1914-1918: Changes resulting form the Influenza Epidemic and the First World War*, BA Hons (History) Unpublished Thesis, University of Otago, pp. 92-93.

[4] Lange, R., (1999), *May the People Live - A History of Māori Health Development 1900-1920*, Auckland University Press, pp 256 - 257.

[5] Maclean, F.S. (1964), *A Challenge for Health: A History of Public Health in New Zealand*, Wellington, pp 202-04, p 207.

[6] Rose, R.J., (1972), *Māori and European Comparisons in Mortality*, in Pomare, E. et al (1995) *Hauora: Māori Standards of Health III*, Wellington, p.16 .

[7] Rose, R.J., (1972), in Pomare, E. et al (1995), p.18.

[8] Rose, R.J., (1972), in Pomare, E. et al (1995), p.18.

[9] Dow, D.A., (1999), *Māori Health and Government Policy 1840-1940*, Victoria University Press, p 95.

[10] Pomare, E., & De Boer, G.M., (1988), *Hauora: Māori Standards of Health, A study of the years 1970-1984*, Wellington.

[11] Best, E. (1934), *Māori Medical Lore: The Māori* (Second Edit), Wellington, p. 38.

[12] Seedhouse, D., (1993), *'Ethical Issues in Defining Core Services - Discussion Papers.* National Advisory Committee on Core Health and Disability Services, Wellington, p 13.

[13] Seedhouse, D., (1993), p 13.

[14] Durie M.H., (1998), *Whaiora: Māori Health Development.* Oxford University Press, Auckland, p 68.

[15] Last, J.M., (1998), *A Dictionary of Epidemiology.* 3rd Edition, London HMSO, p134-5.

[16] Durie M.H, (1998), *Whaiora: Māori Health Development.* Oxford University Press, Auckland, p 69.

[17] Barwick, H., (1992), *The Impact of Economic and Social Factors on Health.* A Report prepared for the Public Health Association of New Zealand, Department of Health, Wellington, New Zealand, p 32.

[18] Bagshawe, A., (1997), *Public Health for Health.* Menzies School of Health Research Annual Report 1996-1997. Darwin, Australia. p47.

[19] Mathews, J., (1996), *Menzies School of Health Research Annual Report 1994-1995.* Darwin, Australia. pp10-16

[20] Mathews, J., (1996), p16.

[21] Mathews, J., (1996), p 17.

[22] Mathews, J., (1997), *Menzies School of Health Research Annual Report 1996-1997.* Darwin, Australia, p 5.

[23] Te Puni Kokiri, (1998), *Progress towards closing socio-economic gaps between Māori and non-Māori.* A Report to the Minister of Māori Affairs, Ministry of Māori Development, Wellington, p 3.

[24] Durie, M.H., (1998), *Whaiora Māori Health Development.* Second Edition, Oxford University Press, p.62.

[25] Maclean, F.S., (1964), *Challenge for Health – A History of Public Health in New Zealand.* RE Owen, Government Printer, Wellington, p.205.

[26] Barwick, H., (1992*), The Impact of Economic and Social Factors on Health.* A Report prepared for the Public Health Association of New Zealand, Department of Health, Wellington, New Zealand, pp 6-9.

[27] Townsend, P.; Davidson, N., (1982) *Inequalities in Health.* Hammondsworth, Middlesex: Penguin, pp 6-8.

[28] Gillet, G., Campbell, A., (1993), *Ethical Issues in Defining Core Services - Discussion Papers.* National Advisory Committee on Health and Disability Services, p 9.

[29] Durie, M.H., (1994), *Whaiora: Māori Health Development*, (Second Edition), Oxford University Press, Auckland, p 43.

[30] Ministry of Health, (1992), *Whaia te ora mo te iwi – Strategic Māori Health Policy*, Wellington.

[31] Woodward, A.; Kawachi, I., (1998), *Why should we reduce Health Inequalities?*, A paper prepared for the National Health Committee, Wellington School of Medicine, Wellington, pp 22-23.

[32] Ministry of Health and Te Puni Kokiri, (1993), *Policy Guidelines for Māori Health 1993/94.* Wellington, p 3.

[33] Ministry of Health and Te Puni Kokiri, (1995), *Policy Guidelines for Māori Health 1994/95.* Wellington, p 30.

[34] Te Kete Hauora, Ministry of Health, (1995*), Nga Matatini: Strategic Directions for Māori Health, A Discussion Document.* Wellington, pp 15-17.

[35] Te Kete Hauora, Ministry of Health, (1994*), Te Ara Tohu - Strategic Management Plan for Māori Health 1994-1999.* Wellington, p 12.

[36] Ministry of Health, (1996), *Māori Health Policy Guidelines for Regional Health Authorities - 1996/97.* Wellington, p 12-14.

[37] Ministry of Health, Te Kete Hauora, Māori Health Group, (1996), *Māori Provider Development Project Status Report.* Wellington, p 6.

[38] Weiner, J.P., (1990), DM. GP *Budget Holding in the UK: Lessons from America.* Kings Fund Institute: London, pp 41-44.

[39] Durie, M.H, (1991), *The Bicultural Continuum - The Treaty of Waitangi in New Zealand Society.* Study Guide 2, Te Putahi a Toi - School of Māori Studies, Massey University, Palmerston North, p13.

CHAPTER FIVE

CROWN POLICIES FOR CHANGE

The privatisation of the public sector, and its realignment with a business model, characterised Crown policies following the 1984 election. By the mid 1990s it was apparent that New Zealand was going further than most other western countries in embracing private sector business methods for reforming public sector services. Although the use of business methods brought significant gains in service delivery and financial performance, while attracting international interest and acclaim, public unease and voter unrest also accompanied this period of change. Drawing on lessons of public sector agencies and Māori health policy, it has become apparent that public sector reforms need to be grounded in a broad framework that can accommodate multiple interacting variables rather than an ideological belief that business methods are always good, and conventional bureaucracy is always bad.

PRIVATISATION

During the 1980s and 1990s, governments around the world had increasingly turned to private sector business management methods in efforts to improve services and lower costs to tax payers. Principles and practices from business management and economics have been used to transform the delivery mechanisms for public services in the United Kingdom, Australia, United States, Canada and, especially since 1984, New Zealand.

Variously known as *'new public management'* or *'reinventing government'* this type of public sector reform was built on theories of economic rationalism. [1] Governments replaced established bureaucratic forms with business structures. Some services were privatised, and others were either contracted out or subjected to market testing. Staff numbers were reduced and the lifetime working security of the bureaucratic era was replaced with limited term contracts and accountability for results. Salary packages for public sector executive's rose substantially, although they were still not on par with their private sector colleagues.[2]

Some countries embraced these approaches with immense enthusiasm. However generally, European governments were less willing and expressed concern with the adverse social effects that flowed from the new style. At the same time from the early 1980s, Governments around the world were searching for different ways of managing public services that would lead to reduced expenditure and enhanced effectiveness. New Zealand followed in the wake of this international trend. The impact for Māori was not surprisingly substantial, although not necessarily bad.

THE ECONOMIC REFORMS - 1984 & 1993

After the 1984 election, New Zealand moved quickly to reshape its system of public sector management and crown policy development. The consequent redesign significantly altered the working lives of central government employees, who in 1984 numbered 240,000, but by 1998 were less than 70,000.[3] The welfare of civil servants was by no means a major driving force behind the reforms but their large number was a cause for concern. What the Government was trying to control was the escalating state expenditure. Reducing the size of the state was seen as one means for reducing the crippling overseas debt incurred by previous Governments in more care free days.

The change in public sector management attracted so much interest from governments all around the world that in 1994, twenty-five international delegations visited the New Zealand Treasury to learn from the experience.[4] From 1992-94 New Zealand's system of Government was rated in the World Competitiveness Report as being the most effective performer among the 22 OECD countries.[5]

In concept, the New Zealand reforms were a local adaptation of economic rationalism common in Western economies in the 1980s. The radical changes made immediately after the 1984 election was practically forced by a mounting foreign debt, declining terms of trade and an economy that was almost insolvent.[6] The Government sought to apply business methods to the organisation and delivery of public sector services. This was a major departure from previous methods of public

administration, which drew heavily on hierarchical models of industrial capitalism overlaid on a system of democratic government.

In summary the major principles for change adopted in New Zealand's public sector included:

- introducing accountability based on results, or outputs rather than inputs
- enabling 'managers to manage' by freeing them from centralised bureaucratic control
- breaking down large organisational structures into a variety of smaller organisations and contracting out to the public sector
- separating policy advice from delivery of services and creating competitive pressures for delivery of services
- using short-term employment contracts and performance appraisal payments to encourage improved management outputs.
- deregulation industries and professions that were previously tightly controlled.[7]

Many Governments advocated these principles during the 1980s but New Zealand adopted them comprehensively for three reasons. First, at that time there was strong bipartisan support from most political parties. Second, the countries political system comprised a one house national Parliament that did not have the checks and balances synonymous with many other parliamentary systems and finally, as mentioned before, the New Zealand economy was almost insolvent. The last reason galvanised the Government into a sense of urgency and immediate if not precipitous action. All government factions understand the dilemma of an insolvent economy and this issue alone would have strongly contributed to bipartisan support from all parties.

Changes in the financial management system resulted in reporting structures that included the annual drafting of a full balance sheet of Government assets and liabilities. Although there was significant bureaucratic pride in achieving this considerable task there were also concerns about the cost associated with a virtual

'job creation program'[8] for accountants, as well as the cost effectiveness of controls required by Treasury and the Audit Office.

Allied with the new financial system was the provision of funding for outputs rather than inputs. This was applied at all levels of the public sector and was particularly significant in the health sector when the purchaser/provider split was introduced. Such a move meant public sector agencies would have to focus on results instead of trying to make the existing internal hierarchy justify whatever means it served. The intention was also to give public sector staff clearer ideas of what the organisation did and why they did it, which ultimately meant a greater focus on planning. In reality, however, the planning process was often seen as an empty ritual with unnecessary paperwork and an exaggerated focus on short-term results.[9]

In many instances the integrity of agency planning was undermined by politically imposed percentage funding cuts, which affected all public sector agencies regardless of past performance. The danger of placing too much emphasis on outputs had the potential to detract emphasis from effectiveness. Issues regarding effectiveness of public service generally become items for the 'too hard basket'. The Ministry of Health Māori Provider Development project was one such example.

After the signing of the Government Coalition Agreement between the National and New Zealand parties on the 6th of December 1996, the Ministry of Health was directed to spend $30M on Māori Provider Development over the following three years.[10] The subject had already been a focus for the Ministry of Health in the previous three years and had seen the number of Māori providers increase from 21 in 1993 to 154 in 1996.[11] Although the number of Māori providers operating in the health sector had increased dramatically the majority of clients who came to utilise the services were in fact non-Māori.[12] Assumptions were made that increasing the number of Māori providers would increase the amount of Māori utilisation and participation rates in the health sector. Māori workforce issues also became apparent especially in areas of management and accountability. The emphasis in this case was on increasing the number of Māori providers with no real

evidence of how effective they would be. In addition, developing a Māori workforce capacity to match the new policy was itself a major problem.

By far the most dominant interventions used for reshaping the public sector were structural. Table 4.1 outlines the areas where public sector agencies were radically restructured:

Table 5.1 – The Restructuring of Public Sector Agencies.[13]

FROM	TO
Organisations reporting to Cabinet Ministers with combined roles of policy and operations.	A core of smaller policy focussed ministries with separate operation and service roles provided at a distance from the daily political overview.
The provision of support services by central agencies within the government system.	The purchase of support services from public and private sector suppliers on a competitive basis.
Organisation by processes and geographic boundaries.	Organisation by purpose and client groups.
Hierarchical functional structures.	Core and network structures.

At the inception of the reforms in 1984 the Treasury identified the features of an effective management system as clear objectives, appropriate incentives for performance, clear accountability, delegation of authority and, responsibility to the most appropriate level [14]

FROM BUREAUCRACY TO BUSINESS

The shift from the language of bureaucracy to the language of business management was a relatively quick and easy transition. Management slogans such as 'let the managers manage' and 'manage for results' became the common parlance and quickly gained status as a new dominant logic. In less than a decade there had been a successful challenge to the bureaucratic paradigm that had held sway for over

half a century. However, speed of change and the lack of serious opposition within Parliament were not necessarily indicators of widespread public support.

From a management perspective, the assumption that there is a universal set of management principles that can be applied even in the public sector setting, is highly contestable. Such a premise is very much drawn from American management theories on economic rationalism and it is no accident that the New Zealand reforms have been almost totally sourced from the United States.

Theories based on economic rationalism make general assumptions that economic rewards and sanctions are critical elements for influencing peoples behaviour towards the pursuit of organisational effectiveness. These assumptions are not only highly debatable; they undervalue the impact of social issues and the influence of leadership, values and commitment to organisational success. Furthermore, they do not appreciate Māori principles of interconnectedness, mutual obligations and the survival of future generations. A public sector working bureaucracy is held together by a collective social conscience and strong motivation to do some public good. A Māori public sector bureaucracy is the same but it is also intrinsically driven by an ethnic affiliation with the target group and an innate understanding of their needs.[15] Public sector managers, unlike their private sector colleagues, often express a desire to contribute to a democratic principle, rather than an economic bottom line. This issue is examined further in Chapter six– From policy to purchasing.

This section does not critique public sector management but looks at alternative ways of viewing change management within public sector organisations. It suggests the possibility of different solutions for different circumstances as opposed to the one-size fits all certainty promised by universal management assumptions. The dynamics of contemporary change in public sector organisations can be better understood by analysing inputs and outcomes and the process for deciphering what public services are required.

THE 1991 HEALTH REFORMS

This section looks at the 1991 health reforms in relation to complete privatisation of New Zealands public sector. The reforms are also examined further in chapter six.

In retrospect, the structural changes to the New Zealand public sector did assist in the removal of impediments to effectiveness, such as the contracting out of expensive services that the State was not providing well, or which could be provided better and cheaper elsewhere. Commercial structures were introduced into areas previously considered impossible like Work and Income New Zealand (WINZ), which developed a limited number of organisation outputs, fewer layers of management, and the permission for local managers to manage and not continually refer to agency rules.[16] The national office provided support, direction for best practice procedures and a venue for developing new ideas to help clients. WINZ was one example of Crown agency restructuring but in 1991 the Minister of Health proposed a series of drastic reforms for the New Zealand health sector that were to revolutionise the health sector beyond recognition.

The 1991 health reforms were, at the time of inception, not unexpected. As mentioned in the previous section, indications within the public sector had shown a move towards greater economic efficiency, user pays, open competition and a reduced role of the state.[17] 'Unshackling the Hospitals' a report published in 1987, by a committee chaired by businessman Alan Gibbs, had recommended as series of changes to reduce inefficiencies and bring hospital spending into a more accountable framework. Although the report was not immediately outlined by the government, the general approach taken provided some impetus for the 1991 reforms.

In summary, the 1991 health reforms made recommendations for changes to treatment services, public health services, roles of the Public Health Commission and the establishment of a Core Services Committee but by far the greatest planned change was the separation of the funder and provider roles.[18]

Four regional health authorities (RHAs), which in 1998 became a single national Health Funding Authority (HFA) before being discarded in favour of 21 District Health Boards, were charged with purchasing health services from public or private sector interests and had primary responsibility for funding all treatment services. Contrary to the previous Area Health Boards, which had vested interests in favouring their own services, the RHAs were to be technically neutral and more able to focus on efficiency objectives, at least in theory.

Initially, the reforms were greeted by Māori with scepticism and received very little enthusiasm. Many tribes had worked hard on building relationships with Area Health Boards and had made progress in terms of participating in service delivery. The intended changes included part charges for hospital care, out-patient visits, diagnostic tests, and were surrounded by commercial overtones which appeared to place yet another barrier between Māori and quality healthcare. The free market had not led to more jobs and higher incomes so why would a market led health sector be any different?

Access to quality healthcare is only one part of the health scenario. Māori health is inextricably linked to other influences such as employment, adequate income, educational achievement, appropriate housing and parenting that addresses the emotional needs of children. The 1991 health reforms gave no early indications that these wider issues would be addressed nor had the reforms been preceded by Māori consultation.

Nevertheless, with the announcement of the proposed restructuring to the public health system, the elected area health boards were immediately abolished. Initially the Health Commissioner replaced them but once the legislation was passed, four new Regional Health Authorities were established, the Boards were disestablished, and major hospitals became Crown Health Enterprises.

Like other western industrialised countries around the world, New Zealand had found it increasingly difficult to meet the cost of health care. These difficulties

had arisen out of several complex health sector issues including the growing cost of technology and pharmaceuticals, increasing demand, demographic pressures such as an ageing population and of course, economic recession.[19] Major deficiencies in the provision of health care were evident and could be identified into three broad areas.

First, the level of Government expenditure on health had increased without proportionate improvement in health status and in fact, increasing disparities in Māori health status in some areas. Second, individuals had insufficient incentive to adjust their lifestyles to reduce risk of certain forms of ill health or accidents that could be limited. Finally, with the State and its agencies not only funding health care but providing health care, there was no scope for efficiency in service provision which the Crown believed would be possible if services were devolved to providers who then competed for delivery.

On the other hand there was also a chance that the reforms would offer opportunities Māori health workers had not seen before. Many Māori, particularly those who had worked in health for a long time, were dissatisfied with existing health services and recognised new opportunities for innovative roles in delivering services to Māori. Scathing criticism of the Area Health Boards had been rampant, particularly for the practice of retaining services to Māori under board control and for minimal funding allocations to Māori health. Opportunities for Māori to participate in new health services without having to depend on Area Health Board good will attracted greater attention from interested Māori tribes. Providers were now able to tender for a range of core health services directed towards Māori needs.

THE IMPACT OF THE HEALTH REFORMS ON MĀORI

Limited deregulation of the health sector, especially in primary healthcare, was a significant result of the health reforms. This issue was quickly recognised by Māori as an opportunity to enter an area with high numbers of Māori clients but low numbers of Māori staff. Having gained experience over the preceding decade, but still cautious of the competition, many Iwi were confident about tendering for services from the RHAs. Even in the early stages of the reforms a number of major

contracts were signed between the RHAs and Māori for not only the delivery of services, but also for policy development, planning and co-purchasing.

Given Iwi representation in the health sector had existed long before the health reforms, Māori participation could not be described as a new interest. In most cases the reforms allowed iwi to expand Māori health plans and programs already in place. In the midst of area health boards being discarded and crown health enterprises established, Iwi and a range of community organisations were continuing to show a strong interest in the health of Māori people. For Iwi Māori, the structure of the health sector was of secondary importance to the facilitation of direct participation and greater levels of autonomy.

PUBLIC SECTOR CHANGES AND MĀORI DEVELOPMENT

Māori approaches to Māori development have been historically holistic insofar as they do not recognise public sector demarcations between social, cultural and economic areas. Attempting to modify concepts of Māori development to fit within government sectors has been a challenge for many Māori and they have often walked away from discussion tables in sheer frustration. Public sector strategies also tend to mask the fact that Māori well being may depend less on the delivery of health and social services than on macro policies that relate to employment, housing and education. Good health owes as much to good housing, a decent job and education as to health services.[20] The impact of public sector changes on Māori policy in the 1990s is examined further in chapter six, From Policy to Purchasing. In general, the public sector move towards mainstreaming meant major changes for Crown agencies. One Crown agent that was particularly affected by the restructuring was the Ministry of Māori Development – Te Puni Kokiri.

The Ministry of Māori Development - Te Puni Kokiri

In 1990 there was a change to a National Government. Winston Peters was appointed Minister of Māori Affairs and immediately began redirecting Māori policy. He appointed a working party that produced a document heralded as a new exciting strategy for Māori entitled *'Ka Awatea' (It is Dawn).*[21] It contained

significant departures from previous Māori policies including a stronger emphasis on reducing disparities between Māori and Non-Māori and a reduced focus on Iwi as a mechanism for Māori progress. It was never clear whether the government fully accepted *Ka Awatea* as Māori policy but as a result of the document, the Ministry of Māori Affairs and the Iwi Transition Agency were disestablished and replaced by a single agency the Ministry of Māori Development – Te Puni Kokiri.

Te Puni Kōkiri's key functions were prescribed in the Ministry of Maori Development Act 1991 and have been further enhanced by Government since then. Under the Ministry of Maori Development Act 1991, Te Puni Kokiri had a responsibility for promoting higher achievement by Maori in the areas of education, training and employment, health and economic resource development.[22]

Within the legislative framework established by the Ministry of Maori Development Act 1991, Government then directed Te Puni Kokiri to provide high quality policy advice on:

- the Crown's relationship with iwi, hapu, and Maori, and
- the Government's objectives, interests and obligations relating to Maori.
- this covers advice on:
- strategic leadership
- the Government's objectives, interests and obligations relating to Maori.
- intervention and risk management of Crown/Maori issues.[23]

In reality the Ministry of Maori Development Act (1991) was a further move towards mainstreaming. It was synonymous with public policy in the 1990's and resulted in a reduced role and budget for the Ministry of Māori Development. Mainstreaming would move the focus to sectors and defy the notion of integrated development, a key component of Māori development. This is not to say that mainstreaming would make departments and ministries less responsive to Māori. In actual fact, departments were increasingly required to quantify gains for Māori and demonstrate strategies for addressing the specific needs of Maori.

Māori development in the public sector is not simply a process of bringing together separate Crown agencies. Māori development is based on policy integration and is philosophically different from the sectoral emphasis of social policy development and formulation.[24]

In New Zealand, social policy is monitored according to outputs which are provider focussed quite simply because it is easier to monitor. It is much easier to gain information about clinical interventions than it is to measure outcomes from people who use health services. Here-in lies another example of the frustration outlined in the hypothesis. Like others concerned with results, many Māori consider that effective social policy must be based on outcome measures, or more specifically, Māori health gains and not the provider focussed outputs that the Government so willingly embraces. The development of outcome measures so that progress can be charted in a meaningful way is common sense though poses methodological problems. The outcome measures preferred by Māori are those which recognise the importance of being Māori in a cultural and lifestyle sense as well as being able to demonstrate gains in health status.

Throughout the health sector Māori health policy driven by politically imposed change has been adjusted, adapted and manipulated, so that provider focussed outputs can influence Māori health gains. The frustration for Māori health planners and providers has been comprehensive but the momentum has been maintained. How Māori have managed this process through a mainstreaming political period from 1991 to 2001 is a key issue in this thesis. Several examples, experiences, results and outcomes are examined and analysed as key themes in chapters six, seven and eight.

CONCLUSION

As the new millennium begins, a new era of Māori health development is emerging. It is partly a continuation of the last decade although there are indications of some new Māori health trends and addictions such as problem gambling. Generally, Māori health development seems less concerned with health from a Māori

perspective and more focussed on achieving the best possible health gains for Māori. One change, which has emerged from the health reforms, is a significant shift away from the dominant influences of over regarded health professionals and their institutions, towards health services that are consistent with the values and priorities of Māori communities.[25] Few would deny that new opportunities for Māori have been significant but there is also potential for Māori to be punished by a health system that values contestability at the expense of interested, but comparatively inexperienced, Māori health groups.

What also needs to be recognised is that no individual strategy will address the many dimensions of Māori health and parallel strategies should not be seen as incompatible and therefore easily dismissed. Māori do not live in a single cultural void and their lifestyles do not conform to an individual stereotype. Māori political intervention, Māori purchasing power or Māori provision of health services may well be appropriate in some situations and, mainstream health services will need to be able to meet Māori health needs. There is no single prescription.

Māori health issues are increasingly focussed on the broad context of health and the obligations on health funders and policy developers to ensure Māori health needs can be successfully addressed by Māori health strategies. Māori health goals are not always identical to those of the Crown and consequently they are not well expressed within the context of health reforms.

Health services are a component of social and economic development. Māori development is based on a philosophy of integration, which combines public sector interests such as health, employment, education and housing, all of which are considered part of the same Māori development plan. If there is one comment that might be made about Crown policies for change such as the 1991 health reforms, it is that a greater impact on Māori health status could have been achieved if the reforms were supported by corresponding shifts in other Crown policy areas. Unemployment, educational under achievement and poor housing are more relevant to Māori health than strategies for delivering better health services to Māori. This is

not to say that there have not been major gains for Māori health as a result of the Governments Māori health objectives, it is simply to suggest that an unfair burden is placed on Māori health providers if they are expected to improve standards of health within environments that are simply not conducive to good health.

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[1] Osborne, D.; and Gaebler, T., (1992), *Reinventing Government – How the Entrepreneurial spirit is transforming the public sector.* Addison Wesley, p.45.

[2] Osborne, D.; and Gaebler, T., (1992), p.45.

[3] World Economic Forum & Lausanne's Institute for Management, Geneva, (1995), *'The World Competitiveness Report'.* An annual report based on data about economic performance of OECD countries. A 129 item questionnaire to 16,500 business executives, public officials and opinion leaders world-wide, p 67.

[4] World Economic Forum & Lausanne's Institute for Management, Geneva, (1995), p 68.

[5] World Economic Forum & Lausanne's Institute for Management, Geneva, (1995), p.67.

[6] Boston .J.; Dalziel .P.; and St John .S., (1996), *'Redesigning the State in New Zealand'.* Oxford University Press, Auckland, p 6.

[7] Osborne .D.; and Gaebler, T., (1992), *'Re-inventing Government – How the entrepreneurial spirit is transforming the public sector'*, Addison Wesley, p.30.

[8] Boston, J.; Dalziel, P.; and St John, S., (1996), *'Redesigning the State in New Zealand.'* Oxford University Press, Auckland, p 8.

[9] Boston, J.; Dalziel, P.; and St John, S., (1996), p10.

[10] National Party / New Zealand Party, *'Government Coalition Agreement'*, p.188.

[11] Te Kete Hauora - Māori Health Unit, (1996), *'The Māori Provider Development Project Status Report'*, Ministry of Health, Wellington, p.2.

[12] Te Kete Hauora - Māori Health Unit, (1996), p 4.

[13] Boston, J.; Pallot, J.; and Walsh, P., (1996), *'Reshaping the State – New Zealand's Bureaucratic Revolution'*, Oxford University Press, Auckland, p 16.

[14] Boston, J.; Pallot, J.; and Walsh, P., (1996), p 18.

[15] Ministry of Health, Te Kete Hauora – Māori Health Group, (1996), *'Māori Bureaucratic Hypothesis - Strategic Planning Hui'*, Portland Towers, Wellington.

[16] New Zealand Employment Service, (1990), *'New Zealand Employment Service Annual Report'.* Wellington, p.78.

[17] Hospital and Related Services Taskforce, (1988), *'Unshackling the Hospitals.'* A report prepared for the Minister of Health and Finance, Wellington, pp 21-23.

[18] Cheyne, C., Obrien, M.; Belgrave, M., (1997), *'Social Policy in Aotearoa New Zealand.'* Oxford University Press, Auckland, p.225.

[19], Cheyne, C., Obrien, M.; Belgrave, M., (1997), p 222.

[20] Core Services Committee, (1994), *'Core Services for 1995/96'*, National Advisory Committee on Core Health and Disability Support Services, Wellington, p.24.

[21] Peters, Hon W., (1991), *Ka Awatea – 'An evaluation report for the Minister of Māori Affairs'.* Wellington.

[22] Ministry of Māori Development, Te Puni Kokiri, (2001), *'Strategic Business Plan'*, www.tpk.govt.nz, p 2.

[23] Ministry of Māori Development - Te Puni Kokiri (2001), www.tpk.govt.nz, p 4.

[24] Durie, M.H., (1995), *'Principles for the Development of Māori Policy'.* A paper presented at the Māori Policy Development AIC Conference, Wellington.

[25] Core Services Committee, (1993), 'The *Best of Health 2'.* National Advisory Committee on Core Health Services, Wellington, pp 16-18.

CHAPTER SIX

FROM POLICY TO PURCHASING

For the Crown, policy must make sense in economic, social and of course political terms. In turn Māori policy should have some evidence of a Māori philosophical base and a framework centred on a Māori worldview.[1] If not then Māori health policies will be constructed from a health sector focus with only marginal recognition of Māori values and aspirations. In chapter two, Māori approaches to development were outlined as holistic in so far as they do not emphasise demarcations between social, cultural and economic areas. Attempts to accommodate Māori policy within Government constraints have often been both futile and frustrating for all parties concerned. Well managed cohesion between Crown sectors in terms of priorities, funding criteria and joint ventures are often needed for Māori health policy development and delivery rather than the sectoral approaches that tend to characterise the way Government operates.

MĀORI HEALTH POLICY

A range of social policies directly or indirectly impact on Māori health. The design of policy, which enhances or reaffirms Māori wellbeing, is therefore pivotal for Māori people. In developing policy that has Māori health implications the Ministry of Health (2001) outlined a number of principles for the consideration of policy makers:

Principle 1

Whānau wellbeing is pivotal to the wellbeing of Māori people.

Principle 2

The recognition and upholding of the Treaty of Waitangi is fundamental to the wellbeing of whānau.

Principle 3

All aspects of the economic, political, social and cultural position of its members affect whānau wellbeing individually and collectively.

Principle 4

Whānau wellbeing is dependent on the social and cultural values and beliefs of the whānau being respected and valued.

Principle 5

Whānau is the most direct source of support and encouragement, which contributes to the wellbeing of its members.

Principle 6

Whānau experience diverse realities and operate in a range of settings, which must be recognised during policy, programme and service development processes.[2]

These principles illustrate the Government's objective of reducing and eliminating health inequalities that affect Māori whānau. The most obvious commonality is the focus on whanau, or family, well being. There are many complex factors that contribute to a poor health status amongst Māori and as a population group, Māori have on average the poorest health status of any group in New Zealand.[3]

In order to improve health status, reduce health inequalities and increase control over the direction and shape of their own institutions and communities greater emphasis on whanau health and well-being is warranted. Consideration must be given to two areas. First, there must be comprehensive endeavours to build on existing strengths of Māori whānau to achieve whānau health and wellbeing. Whanau development is best considered in the wider context of Māori development. But unlike Māori development, where the scale is national, tribal or regional, whanau development is more closely related to the everyday lives and experiences of Māori people. Whanau development touches individuals in a direct way and correspondingly has more immediate potential for improving Māori health.[4] Second, there must be active effort to reduce inequalities in Māori health priority areas. It is increasingly untenable for New Zealand society to accept glaring inequalities in living standards. Māori are significantly disadvantaged on most socio-economic indices and this has major implications for health services and strategic directions for

Māori health. Given the focus of the Ministry of Health is obviously the health sector, any form of whanau development must incorporate concerted efforts to address the wider range of Māori health priority issues. As a principal source of strength, support, security, and identity, whānau play a central role in the wellbeing of Māori individually and collectively. Māori health policy must therefore be able to embrace the range of policy areas in social and economic dimensions.

AN INTER-SECTORAL POLICY APPROACH

The process of inter-sectoral policy development can enable co-ordinated and consistent policy outcomes. The inter-sectoral approach requires government agencies to work collaboratively and co-operatively across traditional barriers during the development, implementation and monitoring phases of policy work. Such an approach can ensure that Government investment in areas that impact on health is optimally located and effectively used.

From the interviews in this study, at all levels of the health sector, there was overwhelming support for an inter-sectoral approach to the development and implementation of public health policies that impact on Māori wellbeing. All respondents stated that they would support Ministry of Health work on Māori wellbeing at an inter-sectoral level. Other important themes that emerged from interviews included:

- supporting the need for effective policy development that is holistic;
- policy must reflect diverse realities that are underpinned by Māori values and beliefs as a basis for health gain;
- policy must address both individual and collective whānau approaches;
- the development of a responsive policy framework aimed at reversing the disadvantage position of Māori;
- policy must nurture the whānau structure as an informal mechanism for fostering Māori health development.[5]

Most policies for Māori are decided through the State either by Cabinet or by state departments and Crown entities. Social and economic policies are characterised by clear sectoral delineation which is contrary to Māori aspirations for an integrated approach to policy development where Māori development is the central focus. Even though most Crown agencies have Māori advisers and policy analysts, and despite the presence of Te Puni Kokiri, policies for Māori are shaped by the state and approved by executives who sit clearly within separate sectors and have limited motivation to incorporate Māori priorities. The emphasis is on developing sectoral policies and then adding a Māori view, commonly referred to as the mainstreaming approach. One form of mainstreaming was the establishment of strategic Māori policy units with representation at the executive management level. In 1993, a strategic Māori health policy unit was established in the Ministry of Health.

THE MĀORI HEALTH POLICY GROUP – TE KETE HAUORA

Since 1993 The Ministry of Health has had a specific policy group dedicated to Māori health, Te Kete Hauora (TKH). Established in response to a review undertaken by Parata and Durie[6] (1993), TKH was established in the then Department of Health to assist meeting the organisation's objectives for Māori health. It was also a response to the desired outcome of Government to improve Māori health status to at least the same level as that of non-Māori.

The core business of Te Kete Hauora (Ministry of Health, 1996) involved assessing the impact of health sector policy on Māori health; the current and future operating environment for Māori purchasers and providers; policies and processes for achieving effective service provision for Māori, and the development of effective mainstream services for Māori.[7] It included ongoing strategic leadership and policy advice on Māori health improvement and development such as:

- the strategic framework for Māori health improvement and development including clarification of Treaty of Waitangi issues;
- the linkages between Māori health and other areas of Māori development;
- improving health gains and outcomes for Māori;

- significant emergent issues in the sector that affect Māori; and leadership and support in the implementation of Māori responsiveness strategies in the sector and the Ministry of Health.[8]

The establishment of Te Kete Hauora was seen as advantageous to both the Ministry and Māori for two reasons. First, it provided an appropriate conduit for Māori to access a strategic bureaucracy. Māori providers in particular found the positioning of Te Kete Hauora within the Ministry of Health reassuring.

> *"No doubt about it, having Te Kete Hauora there is better than not having them. It is much better dealing with another Māori who has some understanding of Māori health than dealing with someone who can't even pronounce your name. In the old days it was an absolute waste of time even contacting the Ministry."*[9]

Efforts by the Ministry of Health to proactively develop internal mechanisms for addressing Māori health were indeed evident and did not go unnoticed by Maori.

> *"I went to the powhiri for Kim Workman when he was appointed as the first General Manager of Māori Health and many of the whaiokorero (Māori speeches) recognised his appointment as a positive step by the Ministry to address Māori health. I was not so confident. I wanted to see whether he and TeKete Hauora were going to be used, or abused by the very Ministry that had just appointed him. In retrospect, I think its been a bit of both"*[10]

The second reason Te Kete Hauora was seen as an advantage was its ability to ensure the Ministry met its Māori health priorities, at least in theory. However, the existence of Te Kete Hauora itself sometimes seemed justification enough for other sections of the Ministry to disregard Māori health issues and default to Te Kete Hauora. The dilemma had to do with the relative advantages of a separate Māori unit, as against a diffused Māori effort. Was a central Māori focus more useful than a dispensed effort or would longer term objectives be better achieved by avoiding a centralised Māori unit, so that the organisation as a whole could tackle Māori issues? Parata and Durie had considered both approaches but opted for a critical Māori mass as more important than a devolved model.

> *"I realise that we are sometimes seen by other sections of the Ministry as a way out for them. If they have Māori health issues they tend to try and pass them off to us. I've even heard talk of us being referred to as the 'too hard basket' section."*[11]

For Māori staff in Te Kete Hauora the scenario of holding the Ministry accountable for Māori health was a difficult one. Many expressed a feeling of being torn between dual perspectives of accountability.

> *"Māori who work for the Crown are often caught between a rock and a hard place which we refer to as dual accountability. We have to be accountable to the Crown because that's who pays us but we also try to be accountable to Māori because that's who we are. I would like to say that we all do this but in reality I think some do and some don't know how."*[12]

"How can you be accountable to Māori when you work for the Crown? – well you do things differently. You work much more within the sector and across other sectors, you prioritise consultation, you use Māori networks especially whanau, hapu and iwi affiliations, you make yourself easily accessible, you accommodate Māori criticism and you set up Māori forums that keep you informed about what is happening in the health sector. Inside the Ministry, you help your colleagues address Māori health issues in their own sections but you don't do it for them. It is a very different type of management to that of my non-Māori colleagues and in all honesty I don't believe they understand it or appreciate it."[13]

For Te Kete Hauora, the priority within the Ministry of Health was to manage Māori health policy advice and not to be perceived simply as a repository for cultural advice. Not all Māori staff at the Ministry of Health worked in Te Kete Hauora but one of the key objectives of Te Kete Hauora was to form networks for them.

"Its only common sense really. We are limited enough as it is so you must utilise every Māori human resource you can. One of the most impressive management skills in the health sector is the innovative and integrated way limited Māori human resources are utilised and managed."[14]

Though Te Kete Hauora had many different roles one of its major functions was the management of health policy projects.

MĀORI HEALTH POLICY PROJECTS

One Māori health strategy agreed to by Government was Māori provider and workforce development. The intended outcome of this strategy was to strengthen the capacity of whānau, hapū, iwi and Māori organisations to provide government contracted services to their communities; and strengthen the Māori provider workforce to develop innovative solutions that contribute to the goal of improved outcomes for Māori. The objectives of the strategy were to:

- invest in the enhancement of the organisational capabilities of Māori providers for the provision of government services;
- provide an environment in which agencies could set and report on qualitative targets for improving Māori outcomes;
- support Māori providers to deliver services across sectoral boundaries;
- improve the long-term viability of whānau, hapū, iwi and Māori organisations to deliver government services to their communities; and
- promote and support Māori provider workforce development using a bottom-up approach that enhanced provider capability.[15]

Two work areas resulted from the strategy. One work area was improving government contracts with Māori providers and the co-ordination between government agencies. The other work area was a requirement for each funding agency to assess the capability of its Māori providers and provide assistance to improve their capability, as required.

When the health reforms were actually implemented in July 1993, major structural changes were required in the New Zealand health system. As already noted, the main feature was a separation of the purchasing and provider functions. The rationale to justify the new changes were outlined in detail when the reforms were initially announced two years earlier, but reaction from health services at the provision level was largely negative. The perception was that such a move only erected yet another barrier between providers and their funding. An extra level

within the health sector was seen as a further example of Vote Health funding not being spent on the delivery of health services.

Ten years after the initial announcement some indications of the impact the 1991 health reforms had on the health sector have been derived from health services that experienced the whole process. These experiences and outcomes make interesting viewing when compared with objectives outlined in the original 1991 proposal including the contracting environment, the integration of primary and secondary funding and the resulting degree of competition. The impact on the quality of services, the accountability process for providers and expenditure trends since the restructuring took place, are all high interest areas for Māori health and are worthy of further comment.

THE HEALTH REFORMS

On the 31st of July 1991, the Minister of Health, Hon Simon Upton, released detailed proposals for a major restructuring of the New Zealand health system. Presented in a document referred to as the 'Green and White Paper'[16] was a proposal to separate the purchasing and providing functions that had previously been performed by 14 Area Health Boards across the country. For practical political reasons the Area Health Boards were immediately disbanded. The general election was to be in November 1993 and given that the Labour Party was unlikely to support the reforms it was imperative to implement the changes before that date. Although a deadline had been set, to appease health sector apprehensions and to ensure continuity of health services, the change was not accelerated and some caution was applied throughout implementation of the change process. Two years later the new structure was introduced but it was not an easy transition and the process was characterised by a period of frantic change management activity. Although it was introduced on 1 July 1993 as originally planned, the finer details for operating an open market in the health sector continued to evolve and in some cases, a protracted process of trial and error ensued.

After the first year of implementation there was no surprise when a process of roll over arrangements were applied to most health sector contracts. Early experiences and progress looked promising but was tainted by an awareness that these indications could not be indicative of longer-term trends because comparable baseline data simply did not exist.

MĀORI HEALTH POLICY AND PURCHASING

The relationship between the Māori health policy agency and the health purchasing body was contentious from the start. It was marked by numerous areas of confusion and uncertainty in relation to roles and responsibilities for each party. Māori health policy developers canvassed in this study were both positive and negative about their relationships with health purchasing agencies. Ministry of Health policy developers felt the hierarchy structure from policy down to purchase and then to provision showed clear lines for delegation much like a management structure.

> *"We (The Ministry of Health) are the funder and we provide direction through policy. How and what the RHA's purchase for Māori must be guided by the Māori health policy guidelines we produce. We then monitor what they do."*[17]

> *"The Ministry of Health is the highest office in the New Zealand Health sector. Management direction must come from us."*[18]

This was not a view held by Māori managers in the Regional Health Authorities. From their perspective the Ministry of Health was a Crown policy agent with a role of providing policy advice only.

> *"The Ministry are there to provide policy advice, but that is all. We know the needs of the regions. We work*

in them and with them. We are the interface for the Crown so we are providing the leadership in the health sector."[19]

RHA managers felt Māori providers preferred personal deliberations and that these were the basis of sound and successful relationships. The usual forms of contact from the Ministry of Health to Māori providers were telephone and postal communications and usually only to request information. The RHA's felt Māori management meant dealing directly with Māori providers to develop and maintain positive working relationships.

"We set a priority of implementing effective consultation with Māori. In one year we held over 50 consultation hui and developed a comprehensive overview of what Māori health needs were in our region. If you ask the Māori providers who is leading Māori health in the health sector, I don't think they will say the Ministry."[20]

Although both the Ministry and the RHA conducted different roles within the health sector for addressing Māori health needs both appear to have prioritised the comprehensive management of people as a component of managing Māori health policy and funding.

MĀORI HEALTH FUNDING

The primary document for establishing policy and funding arrangements between the Ministry of Health and each purchasing body in the New Zealand health sector was known as the Annual Funding Agreement (AFA). The AFA was negotiated between the two parties. It outlined what health services the purchaser would purchase, or contract, according to what the Ministry of Health had agreed to fund. How the purchasing body managed this situation proved to be interesting.

"The trick was to make the Funding Agreement sufficiently ambiguous so that the RHAs could freely interpret it. Because of this it sometimes felt like the Ministry did not know how to cope with us."[21]

Māori health priorities such as provider development had to be incorporated into the AFA. Māori purchasers had to do this in such a way that justification was explicit.

"The Ministry said 'Grow Māori providers'. How do we do that? We identify needs. We identified a huge gap in primary care and pre-primary care from which we developed 8 Māori health priorities. The main focus was the need to develop the capacity of Māori communities to address their own health needs."[22]

Very few Māori health service providers existed prior to the inception of the health reforms. The few that did exist were mainly part of a Māori health strategy, such as the Māori cervical screening programme, or were positioned within larger mainstream health services. The health sector environment had been very different to the newly proposed system.

"Māori providers that existed prior to the reforms were not well focussed. A grant funding system existed and in actual fact it was very patronising."[23]

A major issue for those Māori providers was the sudden introduction of accountability. Some had managed long term relationships with the old Department of Māori Affairs where reporting processes were minimal if not non-existent. These providers were not well equipped to incorporate the new business acumen and were resistant. The RHAs were not prepared to manage a relationship where funding had almost become a formality.

> *"I was not prepared to continue contracting any Māori provider simply because of their history. If they did not fit within the new philosophy of the health sector then they had to change. We were prepared to help them with that but some were still not willing."*[24]

Monitoring was a major issue at all levels of the health sector for a range of reasons.

> *"It is very difficult to monitor the RHA Funding Agreements but from the Ministry's point of view it must be done. We need to be able to see what we are getting for the money we are funding. We can't just assume that what is in the Funding Agreement is exactly what exists. Unfortunately this puts us in an awkward position with regard to the RHAs. On one hand we need them to work with us and on the other hand we are critically judging what they do."*[25]

The irony of the situation was something of which both parties were very aware.

"How can the Ministry monitor us when we are meant to be working together? Our roles overlap. Much of what we do is largely a result of them and most of the time it is imposed upon us by the Ministry."[26]

In turn monitoring Māori providers by the RHA's was another issue made difficult by limited human resources. Different management strategies were adopted.

"We cannot watch Māori providers all the time. We adopted a policy of accountability where funding was put at risk. If their effort to meet the criteria and sustain their funding is greater than our effort to monitor them then that is considered a monitoring outcome."[27]

Though controversial from the perspective of Māori providers, forcing providers to adhere to stringent contract reporting criteria allowed health purchasing management to monitor contracts with what limited resources were available.

The sheer nature of the health sector structure was often the cause of difficulties for Māori health workers. Political influences that were completely unpredictable became yet another complication.

"The RHA and the Ministry were in a contestable relationship. The politicians actively sought our opinion. We equipped ourselves with people who understood the

economic ideology of the new right. We were better equipped than the Ministry."[28]

Though both managed their responsibilities in the health sector much depended on their ability to assess their particular policy and purchasing needs in collaboration with each other. The RHA's adopted different strategies to assist in the Māori health purchasing process. One such strategy established by Northern Regional Health Authority was Māori co-purchasing.

MĀORI CO-PURCHASING ORGANISATIONS

When the Northern Regional Health Authority (NRHA) conducted an assessment of Māori health needs in their region a number of Iwi, and urban Māori groups, expressed an interest in assuming a purchasing role, not through the health care plans that were publicised when the health reforms were first announced, but through other avenues. After the 1996 general election, the National - New Zealand First Coalition Government attempted to increase the role of state in health services by reducing the number of purchasers and creating a single health funding authority. Health care plans were no longer the main objective and other variations of health purchasing were emerging in the form of budget holding, managed care, integrated care organisations and Māori co-purchasing organisations known as MaPO.[29] Three Māori co-purchasing organisations were implemented: Tainui MaPO based in south Auckland, Taitokerau MaPO based in Whangarei, and Ngati Whatua MaPO (Tihiora) in central Auckland. They allowed Iwi groups to participate in purchasing decisions, albeit under the control of the RHA.

"Establishing the MaPO was good for us and Iwi. We were able to work closely with them to help us address their needs as well as utilise our limited human resources. It was an effective way for us to collaboratively bridge the gap and manage the relationship. Don't forget the reforms created a

whole new environment so it was quite a dynamic and exciting time for all of us."[30]

For those Iwi that established a MaPO it was particularly significant in terms of their specific long term health plans and ambitions:

"I would have to agree that the establishment of the MaPO by the RHA was excellent for us. It provided us with a conduit through which we could accelerate our long term health goals for the Iwi. Even the timing was good because we were negotiating our Treaty settlement back then too. That's not to say that we would not have done what we wanted to do for Iwi health without the MaPO, only that it helped."[31]

The benefits were not always explicit but all parties felt there were more advantages in having the MaPO managing relationships rather than dealing directly with each other on a Crown to Iwi basis:

"The MaPO structure allows us to be more than just consulted on Māori health purchasing decisions. We actively participate. We assist with negotiation, contract formulation, relationship management and even monitoring mainstream enhancement. We even deal with the Ministry on behalf of the RHA. Last year the Ministry came here to review Māori health purchasing strategies in our region and we went with them. That helps us work better and the RHA are able to get on with more strategic purchasing work so it helps them too."[32]

"This structure is also much more acceptable to the Iwi. Even on the surface it looks more inclusive. It's the next step up from Māori consultation and for us it provides another conduit for iwi, hapu and whanau development."[33]

Māori co-purchasing has assisted health development goals of Iwi and experiences of Māori interviewed have been positive. Another more ambitious form of Māori involvement in health purchasing is Māori integrated care.

MĀORI INTEGRATED CARE ARRANGEMENTS

There are essentially two avenues through which iwi and Māori organisations are able to develop integrated care organisations, the provider route and the purchaser route. The provider approach involves community controlled models which include iwi and Māori organisations seeking funding to establish a range of primary and/or community care services, for an enrolled population.[34] One example amongst many is Te Whānau o Waipareira Trust, which is in west Auckland. This organisation is an example of a 'by Māori for all' approach which addresses the needs of the entire population that organisation serves, with a particular focus on Māori whānau.[35]

The other approach involves setting up new funding organisations which enable Māori to exert influence or control over purchasing decisions.[36] One of the first examples of this is a Māori Integrated Care Organisation in Wanganui called Taumata Hauora Trust (Taumata). Established in 1997 by the current Chief Executive, Linda Thompson, a long time Māori health campaigner and previous president of the National Council of Māori Nurses. Taumata was originally established under the first approach but progressively moved towards becoming a new funding organisation to control purchasing decisions.

Essentially, whether the route be provider or purchaser, it is evident that there are many Iwi and Māori groups and organisations that have established the infrastructure on which integrated care configurations can be built.

Health Care Plans

This model is the most ambitious approach to integrated care for Māori and would represent a move towards the United States managed-care model. The model represents an opportunity for the future in which iwi Māori groups and organisations are directly funded from government rather than through the purchaser. Such an organisation would have a high degree of autonomy to shape the services for the people served and would also take on many of the current roles of the funder. This responsibility would cover all aspects of health and disability support and social services for a specific population including areas such as housing.[37] This model would effectively achieve Māori aspirations for autonomy and self-sufficiency and the development of services managed by Māori.[38]

In 2001 the health sector had moved towards the health care plan approach but with a definite model of Māori cultural values and practices. Taumata Hauora Trust was one of a number of Māori Development Organisations which had progressed from an integrated care model to a health care plan model. The health care plan model offers varying approaches and opportunities for further development in Māori health. Taumata Hauora chose an inter tribal approach to purchasing and budget holding not only in Māori health but in a variety of other social sectors including education, welfare and social development.[39]

Another form of this is the single Iwi approach of Tainui, Ngai Tahu, Te Rarawa and Raukawa. These Iwi claim tino rangatiratanga, or self determination, in social development as a part of absolute authority to ensure other aspects of their tribal development. The inter tribal and single Iwi approaches to purchasing, and budget holding for integrated care have their commonality in the ultimate goal of

more autonomy and control over health and social wellbeing of either their enrolled populations, or their tribally registered memberships.[40]

At a whānau level, the benefits of health care plan models would include removing most of the access barriers described earlier in this thesis. A particular registration issue that requires careful attention is the need for a flexible system, which recognises the current reality for many Māori who are living outside their tribal regions. In such a model, iwi Māori registered consumers must be able to access services from providers outside their identified integrated care organisation in times of emergency. Māori, particularly those who are highly mobile, are likely to need this type of flexibility from a model of this kind. A proposal would require the development of a reciprocation system between integrated organisations to ensure equitable funding mechanisms. It is essential that this model be managed as one in which barriers are removed, rather than created, to enable effective health care delivery, which will facilitate Māori health gains.

For Māori, the aim of an integrated care approach is to increase access to and co- ordination of services delivered to Māori. In most models of integrated care, the organisation carries or shares the financial risk with the government. The danger here is determining what extent of risk should Māori integrated care providers carry? If the risk they were to carry was too high, the services might simply be set up to fail.[41] At this stage, this is not a question this thesis can answer due to the absence of accurate data on the real level of health need amongst Māori.

CONCLUSION

Although the possibility of a Māori health body, which would develop policy and purchase on behalf of Māori without dependence on the RHA, or the HFA, did not eventuate within the focus period of this thesis, the need for Māori representation at the policy and purchasing levels of the health sector was accepted and implemented by the Crown.

While much of the focus on Māori health has been on the delivery of health services, Māori have been aware of the importance of participating in the formulation of health policies at both the national and regional levels. To some extent, the 1991 health reforms have facilitated other forms of Māori participation, including joint ventures and Māori co-purchasing, which have allowed for increased Māori input into Māori health policy at least at a regional level. At a national level, the Ministry of Health, the National Health Committee, the Ministry of Maori Development - Te Puni Kokiri and the Health Funding Authority, had the most influence on Māori health policy and purchasing, and, although there is consultation and Māori input into each, the need for an independent Māori body which can develop policy and purchasing on behalf of Māori will continue to represent a significant challenge to the relationship between Māori and the Crown.

The Governments objectives for Māori health placed major obligations on Crown agencies. Strategic Māori health policy, Māori advice and consultation, provider and workforce development and establishing new Māori health systems and structures have all been identified as critical to the reforms process, at least in Māori eyes. This section has illustrated that the Crown did not necessarily take into account the full range of Māori objectives or the plans of Māori health organisations. Although there is a substantial overlap, Māori health goals are not identical to those of the Crown nor were they best articulated in the context of the health reforms. Much of the frustration for Māori health planners and providers outlined in the hypothesis stemmed from this reality although it should be said that the reforms did offer opportunities never before experienced by Māori.

Māori health development should not be based on a Māori imitation of state structures and roles. It is not simply about adding a Māori dimension to the construction of a new health sector and because it is based on the concept of Māori development, it has an inherent holism and is philosophically different from the sectoral emphasis which pervades social policy formulation. That of course is problematic, since the public service model is geared to sectoral delivery systems.

Ensuring that Government objectives for Māori health were correctly interpreted, and then properly met, was a critical issue at the inception of the health reforms and increased Māori involvement and participation at all levels was a means to implementation. However, it is far too early to tell, or even assume, that an increase in Māori participation will achieve Māori health gains. But what is more likely is that it will assist rather than impede any progress towards Māori health gains.

If there is one outcome that has been consistent with Māori health policy and purchasing since the reforms it is that Māori involvement, participation and opportunities for self management in the health sector have been more active than at any other time in the past. Though Māori experiences have not always been positive, all interviewee's in this research acknowledged that Māori health strategies will improve and uncertainty will decrease if current levels of Māori participation are maintained, or increased.

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[1] Durie M.H., (2001), '*Mauri Ora – The Dynamics of Māori Health'*. Oxford University Press, Auckland, p 255.
[2] Ministry of Health, (2001), *He Korowai Oranga, The Māori Health Strategy*, Wellington.
[3] Health Funding Authority, (1998), *'Māori Health Gains Operating Groups Report to the HFA Board October 1998–2000'*. Wellington.
[4] Durie, M.H., (1994c), *'Kaupapa Hauora Māori: Policies for Māori Health'*, Te Ara Ahu Whakamua: Proceedings of the Māori Health Decade Hui, Te Puni Kokiri, Wellington, p.132.
[5] Senior Māori Health Manager Interviews (1997 - 2001), Ministry of Health, Regional Health Authority, Health Funding Authority and District Health Boards, Wellington, Auckland, Hamilton & Dunedin.
[6] Parata, H., Durie, M., (1993), '*Māori Health Review*', Ministry of Health, Wellington.
[7] Ministry of Health, (1996), *'Our Health, Our Future – Ministry of Health Strategic Business Plan'*, Wellington, p.122.
[8] Ministry of Health, (1996), p.123.
[9] Manager of an Urban Māori Health Service Provider, Auckland, (1999).
[10] Senior Māori Crown Agency Manager, (1999), Ministry of Health, Wellington.
[11] Senior Maori Health Manager, (1997) Ministry of Health, Wellington.
[12] Senior Maori Health Manager, (1997) Ministry of Health, Wellington.
[13] Senior Maori Health Manager, (1997) Ministry of Health, Wellington.
[14] Senior Maori Health Manager, (1997) Ministry of Health, Wellington.
[15] Ministry of Health, (1996), *Māori Provider Development Project Status Report,* Te Kete Hauora – Māori Health Policy Group, Wellington, p 6.
[16] Upton, S., (1991), *Your Health and the Public Health: a statement of government policy*, Wellington.
[17] Senior Māori Health Manager, (1996), Ministry of Health, Wellington.
[18] Senior Māori Health Manager, (1996), Ministry of Health, Wellington.

[19] Senior Māori Manager for a Regional Health Authority, (1997).
[20] Senior Māori Manager for a Regional Health Authority, (1997).
[21] Ex Senior Māori Manager for a Regional Health Authority, (2000).
[22] Ex Senior Māori Manager for a Regional Health Authority, (2001).
[23] Ex Senior Māori Manager for a Regional Health Authority, (2000).
[24] Ex Senior Māori Manager for a Regional Health Authority, (2001).
[25] Senior Māori Manager for Ministry of Health, (1997).
[26] Ex Senior Māori Manager for a Regional Health Authority, (2001).
[27] Ex Senior Māori Manager for a Regional Health Authority, (2001).
[28] Ex Senior Māori Manager for a Regional Health Authority, (2001).
[29] Durie M.H., (2001), *'Whaiora - Māori Health Development'*. Oxford University Press, Auckland, p 157.
[30] Ex General Manager, Northern Regional Health Authority, (2001), Auckland.
[31] Ex General Manager, Tainui MaPO, (2000), South Auckland.
[32] General Manager, Taitokerau MaPO (1998), Whangarei.
[33] Ex General Manager, Ngati Whatua MaPO – Tihiora, (1997), Mt Eden.
[34] Ministry of Health,(1995), *Co-ordinated Care for Māori: Issues for development*, Wellington, p 17.
[35] Ministry of Health (1995), p18.
[36] Ministry of Health. (1995), p 19.
[37] Ministry of Health. (1995), p 19.
[38] Steering Group to Oversee Health and Disability Changes to the Minister of Health and Associate Minister of Health [SGOHDC], (1997) *Implementing the Coalition Agreement on Health – The report of the Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health.* Wellington, p.9.
[39] Māori Integrated Care Organisation Interview, (2001), Wanganui.
[40] Māori Integrated Care Organisation Interview, (2001), Wanganui.
[41] The Ministry of Māori Development – Te Puni Kokiri, (1994), *Mā te Māori e Puri te Maimoatanga Māori: Managed care for Māori.* Wellington. The Ministry of Māori Development – Te Puni Kokiri, (1995), *Mā te Māori e Puri te Maimoatanga Māori: Managed care for Māori – A discussion document*, Wellington.

CHAPTER SEVEN

MĀORI HEALTH SERVICE PROVIDERS

Māori providers are important to Māori health development. They contribute in two ways. Firstly, they are well placed to deliver appropriate and effective services to iwi, hapū, whānau and Māori communities. These services include local level solutions and approaches. Secondly, the development of Māori provider organisations contributes to the building of the capacity of iwi, hapū, whānau and Māori communities. The skills that are developed in delivering government services and running an organisation can be transferred to other community activities.

Provider organisations can also provide important infrastructure for community development and it should also be noted that as well as being geographic entities, Māori communities are often orientated around sports, kapahaka groups, urban Marae, Kohanga Reo, Kura Kaupapa Māori or social clubs. This chapter examines a series of interviews conducted with Māori providers. One of the issues first examined was the definition of a Māori health service provider.

DEFINITIONS OF A MĀORI HEALTH SERVICE PROVIDER

Any definition of a Māori health service provider needs to consider governance and the nature of service delivery. Māori providers, who are non-government organisations (NGOs), often deliver services within a kaupapa Māori philosophy.

As mentioned in chapter three, Government agencies themselves have their own definitions of what constitutes a Māori provider. Some focus on the nature of the services, while others focus on the ownership and governance of the organisation. Some agencies have quite explicit definitions, while others rely on self-identification or general statements.[1] This chapter will show that lack of consistency can

sometimes lead to confusion, or situations where providers may be considered Māori providers by one agency but mainstream providers by another.

Amongst Māori providers themselves there is also debate about what constitutes a Māori provider. This debate centres on whether a provider who is part of a mainstream organisation, but delivers a 'for Māori by Māori' programme or service can be considered a Māori provider, or whether only organisations that are fully controlled and governed by Māori should be defined as Māori providers, given that full control is never attainable in a contractual system. This issue is reflected in interviews with Māori working in hospital and health services and will be examined further in chapter eight, Mainstream Enhancement. Distinctions can also exist between Māori providers themselves. Iwi-based providers and other Māori service providers, who may be whānau, hapū or community based, and what this means in respect of their relationship with the Crown.

Māori providers spoken to in this study felt that being a Māori provider was about working within a Māori paradigm and being committed to Māori.

> *"You work seven days a week, 24 hours a day. You eat, drink and sleep it. If you aren't doing it for Māori, you're not on the kaupapa."*[2]

Respondents also maintained that the Ministry of Health should recognise that Māori providers have obligations that go beyond delivering contracted services.

> *"They need to develop a broader, more flexible view of providers so that instead of working with just health, you work with all the contributing factors. We're dealing with people, not issues."*[3]

Some Māori providers also wanted Crown agencies to realise that they have their own objectives and rationale for existence:

"Our position now is due only to our motivation and initiative. We are not here because they wanted us to be here. We are here because we wanted us to be here. They didn't really want us to be here, we know that."[4]

Māori providers considered that there was more to health services than just having Māori staff delivering services.

"The clinical supervisor, who's this person going to be? What does she come with in terms of knowing how kaupapa Maori services work? It's all right that she's got this degree and it's all right that she's a Maori but does she have those other things that acknowledge what it is that's different about Tauiwi health programmes?"[5]

Those respondents who operated as a Māori provider tended to base their delivery model on Māori philosophy and values. These values, as well as recognition of the whānau as the primary unit for social change, are an important element of their work.

"We actually go into the homes and have meetings with the whānau and we dig and scrape and see where we're needed most. We counsel and we advise and we awhi and manaaki the whānau and help them to come together as a whānau. Our client and their whānau. I see this really as a major role; it needed a lot more funding and a lot more recognition for the role that it is. I believe that is a successful role for a Māori provider anyway."[6]

Ministry of Health definitions of Māori providers have caused difficulties where they differ from the providers own perception of themselves.

"Particularly, one of the issues I want to raise is that we are considered to be a mainstream provider by the funder. We see ourselves as a kaupapa Maori health service. We get labeled by them yet we label ourselves as kaupapa Māori."[7]

" We get directed to a generic service and what we want to do is deliver a service to Maori. I understand that the development funding is specifically targeted for iwi organisations and iwi itself. But having said that, the money not being available for a Maori service, although we're not under iwi organisation, is not being made available to us."[8]

However, even where organisations were recognised as Māori or iwi providers, they still found that they were not able to deliver services to Māori in the way that they wanted. For example, some iwi providers were frustrated when government agencies continued to dictate the parameters for their services.

"The whole system is too restrictive. And so we want to have the freedom to develop our own programmes based on our own policies and understanding of our people's needs and understanding of how we work as an organisation with our hapū and our whānau."[9]

The Government has recognised that sustainable Māori development requires not only the delivery of appropriate social services to Māori, but also the development of Māori-governed organisations who can deliver those services and who are accountable to whānau, hapū, iwi and Māori communities. In 1997, the Ministry of Health defined Māori providers as whānau, hapū, iwi and Māori organisations who:

a. provide or intend to provide services to one or more of the following: Māori individuals, whānau, hapū, iwi or Māori communities; and

b. are owned or governed by whānau, hapū, iwi or Māori organisations; and

c. have identifiable and clear accountabilities to whānau, or hapū or iwi or Māori communities; and

d. are dedicated to meeting the needs of Māori clients.[10]

For the Ministry of Health, the Māori provider development strategy should focus on developing Māori-governed organisations. This section examines the experiences of Maori health service providers from all over New Zealand and the range of issues, problems and difficulties they must manage.

MĀORI PROVIDERS AND CROWN AGENCIES

The relationship between the Crown agency and the Māori provider is a major factor in the satisfaction Māori providers have with a contract to deliver specific health services. In contracting with Māori and iwi providers, the Treaty relationship also needs to be considered and addressed. The *Whānau o Waipareira Report* (1998) emphasised that the Treaty relationship is not exclusive to iwi and that Māori providers are often in the middle of the Treaty relationship. They are accountable to both Treaty partners, the Crown, who funds them, and the iwi, hapū, whanau or community groups who control or govern them.[11]

The significance of a relationship is also supported by international evidence. In Canada, First Nations peoples emphasised accountability among partners or equals. There was conflict because accountability in government is generally viewed as a hierarchical relationship involving a delegator who assigns responsibility to another, a delegate. It was evident there were significant differences between this concept and the one that First Nations felt would better suit their needs. However, the emphasis for First Nations was that a two-way perspective was an essential ingredient of accountability. Many participants stated improved transparency could be gained if agencies were more accountable to First Nations people.

"Government departments should be accountable to First Nations in terms of funding formulas and policies that dictate what they do and do not do. At present, this is not transparent, which makes it difficult for us to explain to our membership why some things cannot be done."[12]

Indigenous communities in Canada expressed concern about having structures imposed on them through the devolution of programmes. Penner (1992) raised this issue in Canada and argued that most literature highlights the unequal relationship between government agencies and providers. Providers are totally accountable to the agency, while the agency has no accountability back to the provider and the community that is serviced.[13]

In New Zealand, the Māori providers canvassed in this study were both positive and negative about their relationships with health sector agencies. In many areas, new funding arrangements had allowed for more 'by Māori for Māori' service delivery and they were satisfied with their relationship.

"For us, these new funding arrangements have supported our existing infrastructure and have allowed 'for Māori by Māori' service delivery to prosper. They have also contributed to the debate about the viability of service provision by Māori which was initially frowned upon even in this little community."[14]

Māori is an orally based culture. It emphasises protocols of korero ā waha, or open discussion in a face to face environment. For managers of Māori health service providers the transfer of this protocol to the working environment is important. Māori providers considered that the development of a relationship through personal contact was a service priority. Changing personnel through the restructuring of agencies was sometimes seen as a disadvantage to the service that Māori providers received. This meant having to form new relationships with different people.

"The health sector changes meant we're given three people to do the same job that one person did.. We had a relationship with the other person who was our regional worker and this person was also Maori which meant she was also culturally appropriate. Now we're going to have three people who we don't even know."[15]

Most Māori providers felt that personal deliberations formed the basis of sound and successful relationships. However, the usual forms of contact from agencies were telephone contact and postal communications and this was not a preferred medium.

"They only contact us when they have a need which is immediate and you have to respond quickly. Where is the contact about issues that matter to us like the structure of contracts and contract outputs which are developed by people with little or no idea of the service we deliver or the environment we are operating in."[16]

Having Māori staff in government agencies was important to some Māori providers. It added an extra dimension and they felt that there was a shared understanding between the two of them in these instances. Other qualities that Māori agency staff had were their ability to speak Māori and their ability to understand the kaupapa of Māori providers.

"I think with Māori regional workers or with Māori workers wherever they are, they have this extra dimension that you won't find in any other worker in New Zealand. It's that they have a cultural background and they bring it with them into their work and this is what makes the difference. Especially when you're working with Māori and the

kaupapa is Māori. You have to have people who actually know what the kaupapa is about. That's the whanaungatanga that we talk about. Our regional worker was like this. I mean, I don't know how we would have gone if for instance a Pākehā person came to see us and talk to us."[17]

It was not only working with a Māori staff member that was important to providers but that staff member's ability to provide competent advice. This included having a good understanding of their agency's contracting processes and the provider and their work, being prompt with queries and responding to phone calls and messages.

Another issue for some Māori providers is the unequal relationship in terms of the Treaty of Waitangi. When agencies contract with providers using the Treaty as the basis of the relationship, there are expectations about how the relationship is conducted. In particular, iwi have higher expectations of a Crown iwi partnership. Their general understanding is that partnership means an equal relationship as opposed to an agency provider relationship. Their expectations are that agencies will be aware and proactive in demonstrating a Treaty partnership with them, and not tell them what to do without allowing for discussion. In other words, as the Waipareira case demonstrated, there is a difference between a Treaty based relationship and an agency provider relationship.

"The whole agency contracting process really flies in the face of the so-called partnership approach with iwi. It is not a partnership approach. It is very much about here is the contract, we will purchase these things from you at this price. Do you want it or don't you want it? [18]

" One time they rang us to say we have this much money left over (and it wasn't much.) What health

programme can you deliver for that much? And
then they behave as if they are doing us a favour. "

Based on research interviews conducted in this study Māori providers consistently identified a need to have closer working relationships with their funding agencies. Personal contact is considered to be an essential element for a successful working relationship between any Crown agency and a contracted Māori provider, but the key is in the acceptance of a partnership, premised not only on a contract for services but also a commitment to a shared vision.

MĀORI HEALTH PROGRAMMES AND SERVICES

Partly as a result of frustration and misunderstandings with existing health services, Māori health programmes and services were developed. The 1991 health reforms assisted in the establishment and development of these services and though initially many were within or alongside mainstream health services, eventually a wide range of Māori health programmes and services were established.

By Māori for Māori Services

'By Māori for Māori' issues included the development of programmes that use Māori health and wellbeing philosophies and practices in the delivery of their programmes and services. Examples have included the revival of traditional cultural healing practices such as mirimiri and the increasingly explicit use of rongoa Māori. This revival reflects the diverse health needs of Maori. It also indicates that Māori will access various configurations of traditional and mainstream providers to meet the full range of their health and disability needs.[19]

The scope for addressing the barriers Māori encounter in seeking to access information, advice, resources and services has improved with the increase in the number of Māori providers. 'By Māori for Māori' providers have achieved a balance between the treatment of illness, and health promotion activities that are whānau, hapū and iwi focused. Resourcing these providers is necessary to ensure that Māori aspirations for Māori control of services by and for Māori can be realised.

Tikanga Māori Health Services

Māori have developed a number of health services, which have tikanga Māori as an integral part of their service. They include primary health care, child health services, healthy lifestyle programmes, and combinations of these aspects into comprehensive social and economic development programmes. The following examples describe some of those programmes and services.

'By Māori for Māori' reflects the diverse realities of Māori, and the examples are potential models for Māori to develop their own approach to resolving their own issues. However, the economic, political, social, cultural and community conditions which characterise the history of these examples may be vastly different from those of Māori in other locations. Therefore, Māori need to evaluate the examples for differences and/or similarities before adopting a particular example as a model for dealing with their situation. Many 'by Māori for Māori' groups, organisations and initiatives have reshaped their business focus to a 'by Māori for all' approach.[20]

This approach benefits Māori in that all families have their needs met through a Māori delivery approach, which promotes Māori norms, values and beliefs. In order for Māori health gains to continue and improve, it is important that existing 'by Māori for Māori' programmes be adequately resourced and monitored for performance.

Rapua te Oranga Hinengaro

Rapua te Oranga Hinengaro is a community-based, iwi-controlled service for Māori who suffer from psychiatric illness. This service uses tikanga Māori as its guiding principle. It was developed under the guidance of kaumātua concerned about the substantial increase in psychiatric illness among whānau, and the apparent inability of mainstream mental health services to address this problem.[21] The Rapua te Oranga Hinengaro service is an extension of the bicultural mental health services in the Auckland region. The service focuses on the needs of the client and their whānau and is delivered in the places where the clients feel most comfortable such as a marae or at home.

Rapua te Oranga Hinengaro recognises the impact of cultural alienation and the breakdown of cultural traditions on the mental wellbeing of their clients. As part of their work, kaumātua seek to assist clients to rediscover their ancestry and reconnect them with whānau, hapū and iwi. This reclamation of cultural heritage, whakapapa and tikanga has enabled some clients to map out a path to recovery based on their cultural heritage.[22]

Tipu Ora

Tipu Ora currently operates in the Te Arawa, Mataatua and some parts of the Ngai Tahu areas. Tipu Ora is a holistic well-child care programme which focuses on delivering health care programmes for parents, caregivers and tamariki.[23] A lack of access to care, a poor knowledge of good health measures and isolation are common problems faced by young Māori parents. Tipu Ora has responded to these problems by using kaitiaki (guardians) who are experienced in child care, are well-versed in tikanga and who are able to guide young parents in raising their children. The kaitiaki visit the homes of new parents to provide support, education and instruction in parenting skills.

The Tipu Ora programme has led to a dramatic reduction in the Māori SIDS rate and has increased immunization and breastfeeding in the areas covered by this service. The programme has succeeded in reducing the prevalence of smoking by pregnant mothers and there are positive early indications that they have achieved increased birth weights.[24]

Te Roopu Matehuka

Te Roopu Matehuka is the national organisation of Māori diabetes workers. It is developing a whānau approach to diabetes care and ensures that diabetes services are appropriate and safe for Māori. To successfully deal with the disease and the changes it involves, the person needs the support of their whānau. Strategies to address diabetes include developing a national strategy for diabetes that recognises the health needs of Māori. The direct threat of this kind of illness can lead to behaviour changes for the whānau as well as the individual concerned. Healthy food,

smoking cessation, exercise and drug-free lives can become the reality for the whānau. In this way, a personal health issue generates a public health whānau response.

Whare Oranga

Whare Oranga marae-based gymnasiums are the centre of Tahuna Minhinnick's vision of excellence for Māori health. As the marae is the central cultural enforcer of Māori tikanga, it is logical that it be the place to introduce healthy lifestyles.

> *"We need to create and re-introduce tikanga which facilitate exercise and good kai. In this way we are in a position to positively influence Māori people's attitude to good health."*[25]

Oranga Niho

There are significant cost and cultural barriers that Māori currently face in accessing good dental care. Te Whare Kaitiaki in Dunedin is a Māori-focused dental service that operates on Māori principles. There has been an overwhelming demand for its services.[26] There is a particular need for greater emphasis to be placed on health education in this area of dental health issues. There is also potential for an expanded role for dental therapists. There are resource problems for dental health promotion. Māori providers that include dental health promotion among their services find too often that this is not part of their contracted work[27].

MĀORI PROVIDER FUNDING

Finding adequate funding was an issue for all providers. However, there are some groups of providers for whom funding is a particularly permanent issue. Research on the voluntary workers in the health sector (Florence, 1996) observed that smaller and newer providers found it more difficult to survive under the current contracting system.[28]

Given that many Māori providers are smaller and newer than their mainstream counterparts, funding is likely to be more of an issue for them. In the 1995 Ernst and Young survey this was supported. The report found that providers servicing a predominantly Māori clientele were one of the groups more likely to be under financial stress. Although 'Not-for-Profit' providers were facing financial stress, the sector showed many signs of vitality and growth. This growth was occurring despite the fact that 53% of providers reported that their financial resources had decreased and 32% of providers reported a decreased capacity to replace assets.[29]

The survey also found that an important feature affecting the viability of a number of providers was the increasing difficulty in raising funding from non-government sources. Some of the most financially vulnerable providers were those who had increased their range of services but had struggled to access sufficient non-government funding. Māori providers also expressed concern about the use of lotteries funding to fund important community services.[30] A Department of Internal Affairs study (1997) showed the potential to raise funds from the community depended on:

- the level of wealth in a community;
- the community's attitude to the provider's clients and whether they are a group that needs support; and
- the overall inclination for voluntary giving in a community.[31]

Social service providers working primarily with Māori, based on these factors, may have limited access to additional financial resources due to the already low level of income in that population.[32] Partial funding policies of some government agencies add to this problem. If agencies are expecting the community to contribute to funding their own services, the amount it is possible to raise will vary depending on the capacity of that community. There may not always be enough capacity for this to occur, with Māori providers relying on alternative funding streams such as grants, trusts and public donations.

The Ministry of Health (1999) identified that the high transaction costs and annual budget rounds in the contracting environment were constraints for smaller community-based organisations. These organisations had insufficient certainty to plan or invest in the long term. The Ministry advocated longer-term, simple contracts to ensure providers were more accountable for outcomes, took a longer view in their relationships and investment, and incurred reduced transaction costs.[33]

The Department of Internal Affairs was also concerned about the capacity of the community to deliver because of the following constraints:

- limitations on funding for such costs as computers, rent, telephone, power bills and travel, and for community needs analysis, service evaluation and staff training; and

- the tendency of funders to provide partial and short-term funding inhibits providers' ability to plan strategically and increases the time involved in seeking resources.[34]

This is not a situation unique to New Zealand. Government under-funding is a common concern for indigenous peoples who provide programmes and services to their communities. A report by the United States General Accounting Office (1999) highlighted a shortfall in funding for all American Indian tribes with government contracts. Tribes manage federal social services through self-determination contracts and receive contract support costs to cover costs of contract management and administration from the Federal Government. Allowable contract support costs include indirect costs for tribal support services such as accounting, direct contract support costs and start-up costs.[35]

The tribes administering the contracts were not paid the US $95 million owed to them by the Government for contract support funds in the 1998 fiscal year. Shortfalls in contract support costs for tribes has been an issue for some time. Tribes were owed US $22 million in 1994 and this amount was likely to increase. The Bureau of Indian Affairs and Indian Health Service explain the shortfall as arising from their inability to meet these costs because of their own limited appropriations.

This example raises the questions of government agencies only funding providers to deliver services and not funding for administration and monitoring of the contracts.[36]

Māori providers expressed the same concerns about insufficient funding, not only in relation to the service they provided but also for Māori services in particular.

> *"We might work out that it will cost $10 to deliver the service so they turn around and give us $2. It leaves you wondering where their priorities are. And then the administration for them, as a community agency, is pathetic."*[37]

In some cases, the funding formula does not even attempt to make up all the costs.

> *"None of our contracting partners are going to pay us to do it. I mean we're not the only ones like this. There's heaps of Māori organisations throughout the country who are working out of little offices, who use their money to pay for their rent, to pay for their phone, to pay for whatever. That's where the money goes. We don't get money to pay a staff member for instance. There are 30 people who work for us here. Four people get paid. Twenty-six do it voluntarily."*[38]

Changes have also been positive as the number of Māori providers delivering services in a number of areas has increased. However, many Māori providers felt that there also needed to be an increase in resources and support for providers. Some providers felt that agencies had a lot of resources for themselves but not many for providers.

> *"They expect that our kaumātua and kuia will support us for aroha. It is expected that being*

Māori, we will have this huge whānau that will do it all for aroha and this needs to be addressed."[39]

Many Māori providers wanted their contracts to be longer term so they could plan and develop their services. Often contracts were only funded for a year, with providers having to re-apply at the end of the contract period. Added to this, they were concerned that they were not always sure where they were going to get their next year's funding from.

"What concerns me is, that there's no future, or you can't future plan if you're reliant on funding year to year whether you're gonna get it or not. You can only plan for that 12 months. End of story."[40]

"All our contracts are 12 monthly. And so how can you develop a business plan or a strategic plan when you never know one month to the next if you would still be in operation".[41]

The result of short-term funding is uncertainty. Yearly contracts also created more compliance costs for providers who spend significant time trying to secure funding to continue their service as well as meet the needs of their community.

MĀORI PROVIDER COMPLIANCE

Even the Government has acknowledged the costs incurred by providers complying with agency specifications in applying for funding and submitting reports. Compliance costs include the time and resources expended in the process of accessing, completing and negotiating funding applications, as well as the activities involved in reporting to meet the monitoring requirements of a contract. These are not new issues. In fact administrative difficulties faced by all social service providers have been well documented.

- The Department of Internal Affairs (1997) suggests that the uncertainty of contracts and discretionary funding impacts on a provider's ability to plan

effectively; contributes to time and energy spent away from clients because the provider is constantly applying for funds; and can lead to staff recruitment and retention problems.[42]

- The Department of Internal Affairs noted in its briefing to the incoming Minister (1999) that the different application processes and accountability requirements of multiple funders increase compliance costs for community organisations.[43]

- The New Zealand Community Funding Agency (1995) in a survey of the Viability of the Not-for-Profit Sector in New Zealand found that the growth in service level and quality had come at a cost, with 82% of providers reporting an increase in time spent applying for funding.[44]

- Burn (1996) has also noted increases in the costs associated with dealing with purchasers in reporting, negotiating contracts, attending meetings and so on. Some hired extra staff because of this and those who did not hire extra staff noted the decreased amount of time available to do 'hands on' work with service users. A decrease in the quality of service provision also occurred where small providers did not have the resources to meet the demands of increased reporting and other requirements of the new environment. [45]

- The Waitangi Tribunal's 1998 report on Te Whānau o Waipareira claim criticised the lack of co-ordination between government social service funders.[46]

American Indian tribes contract with the Bureau of Indian Affairs and the Indian Health Service rather than with multiple agencies. Aborigines and Torres Straight Islanders receive grants from the Aboriginal and Torres Straight Islanders Commission. In Canada funding is directed to First Nations through the Department for Indian and Northern Affairs. However, there are other departments that fund First Nations, including the Departments of Health and Human Resource Development (Office of the Auditor General of Canada). Māori providers, on the other hand, receive their funding from a range of mainstream agencies and compliance costs are disproportionately high.

In order to address the needs of their clients most Māori providers contract with two or more agencies. For many providers, applying for funding, and ensuring that this funding continued, meant completing large amounts of paperwork. Māori providers are generally not funded for administrative time.

"I am always reluctant to complete copious amounts of paper work but you have to do it because it's about funding."[47]

"It s too time consuming and you end up repeating yourself. I think they should just focus on the health issues and allow us to be answerable for those."[48]

There are varying opinions about which agency has the best contracting process. However, differing specifications between agencies are a major concern for Māori providers contracting with more than one agency.

"One agency is totally streamlined, another is totally bureaucratic and for the other, you need a thesis just to read the specs."[49]

Many Māori providers voiced the need for uniformity of processes between agencies. This related especially to the approvals and applications processes. Providers also questioned agency expectations that providers should collaborate when the agencies themselves did not.

"There needs to be uniformity of processes and standards so approval of one is approval of the lot."[50]

"There should be universal application processes that cross all agencies. There is an expectation that we, as Māori providers, collaborate so there is no duplication. They should reciprocate in the interest

of helping providers deliver service to their client groups."[51]

Of all the issues identified in interviews with Māori providers the need for effective collaborations between Crown agencies that would permeate down to provider level was consistent a message.

MĀORI PROVIDER CAPABILITIES

Most Māori providers considered that their administration, communication and accountability systems were more than adequate. Many were successful in terms of meeting both government accountability requirements as well as their own.

"We all have to be accountable if you're receiving funding of any sort and you've got to be accountable for that. We think we've spent the money well. We think that they've got value for money."[52]

However, Māori providers were concerned that government agencies did not always think they were capable of delivering programmes and were often surprised by their professionalism.

"As Māori providers we're often seen as second-class providers of health and that there isn't that amount of confidence in our services."[53]

"We have good processes and good people in place and the agency was surprised by this professionalism. We set up financial systems and everything to account for what we were doing and blew the agency away with our professionalism."[54]

On the other hand, providers stated that government agencies recognised Māori providers as a source of advice on Māori issues and often wanted to use them

for that purpose. The implication for Māori providers was that time and resources were being spent with no compensation. They complained about how they were expected to do work for 'aroha', or for the love of it.

"Government and crown agencies are the biggest abusers of the word 'aroha."[55]

MĀORI PROVIDERS AND MĀORI COMMUNITIES

Māori providers play a middle role between the government and Māori communities. In working with Māori communities, they are very aware of the needs of their people. They are usually also accountable to the local Māori community, either informally, through their work in the community, or formally, through governance structures. Māori providers therefore often have a much better view of what is needed at a community level than policy makers in central government. However, they continue to be frustrated with the lack of attention by government to their views and knowledge and the lack of consultation with Māori communities. Crengle (1998) noted that Te Whānau o Waipareira experienced frustration with the funding aspects of its 'child well-being programme', including:

- frustration that the desires and needs of the community were not being met;
- resentment that a Crown Agency was determining what activities a Maori health service provider should provide and the way they would be provided; and
- tensions between staff and management arising from trying to provide a kaupapa Māori service to meet the requirements of the community and the funder with limited resources.[56]

Meeting Māori needs at the community level requires more than just one model that fits all providers or all Māori. Durie (1995) originally referred to this aspect as 'diverse Māori realities'.

"Take cognisance of the diverse social and cultural realities within which Māori live. Gains in the provision of services for Māori are more likely to be

realised when a coherent picture of Māori realities can be painted. Until then, it is important to avoid drawing conclusions that are based on limited understanding of actual situations or idealised constructions of what should be. In other words, being Māori in the 1990s cannot be assumed to be synonymous with the conservative expectations of a traditional cultural heritage."[57]

This is an internationally supported view. In Canada, First Nations providers feel that programmes designed by government do not reflect the needs of the community. This is often because the only thing that has changed about the programme is the delivery agent (Penner (1992), Long and Boldt (1992)[58]. In order for services to work appropriately in the community, Voyle and Simmons (1999) argue that community projects should support and be based on self-determination and empowerment within that community.[59] The implementation of any programme should utilise and expand the resources available to the community. The problem is that currently there is limited consultation with the community on the design and delivery of programmes.

Determining needs for the delivery of services is generally done by government agencies in consultation with community groups and other key organisations. Agencies tend to have different processes to determine where funding goes and why. Māori providers gave some positive feedback about the process of assessing needs in their communities, though they were concerned about whether they really had any input. They felt that funding was generally determined in Wellington with little community consultation.

"You've got your policy makers in Wellington, you've got your policy makers up in Auckland, and the data they're picking up is not from what we're experiencing as a provider."[60]

"What I find gets up my nose is that a lot of these decisions are made by people in Wellington who don't give really care about what we do up here."[61]

Māori providers felt that services and processes were determined by agencies before they consulted with the Māori community, and that consultation was often perfunctory and served no real purpose. They commented that there was limited consultation and that whatever consultation occurred might change delivery and the eventual outcome only slightly, if at all. Any changes were limited by the strategy that the Government already had in place. Māori providers wanted to see real consultation with the community for they felt that the community knew what the issues really were.

"It's sad that the Agencies are not consulting us, the community, as to what the needs really are. It just seems to be obvious common sense."[62]

"I really think that the Ministry is like all the government departments, they sit out there making decisions for us Māori and all the only input that we have really is when they occasionally do some monitoring."[63]

The other side of consultation is that some providers considered that they were over-consulted and, as one provider put it, over-researched. The issue is that if government agencies were listening and were committed to positive outcomes for Māori, providers would not have to be continually consulted.

"I get hōhā when I am asked to do this time and again. Māori must be the most researched people in the world. The material is already there, the Government has the material, and it needs to give us the funding. Fund us according to our statistics.

They say we are the most under-resourced and over-represented."[64]

Some Māori providers also felt that the funding did not really provide for the needs in the community.

"Because at the end of the day, the Government is saying "these are your people, you take them and you do what you want with them". And they proceed to give us 5 cents to do it in when there's a lot going on in the whānau and the whānau dynamics are in a terrible state."[65]

Providers in rural and provincial areas commented on the different needs in their areas and how these were not being met. Geographic isolation and the distribution of funding based on population meant that funding often did not take these factors into account.

"I don't believe that the funding allocation to the West Coast takes into consideration the geographic isolation and the distribution of the population with the agency, the West Coast is generally lumped into the Canterbury area it has always been the population-based criteria and it puts an organisation like ours at a distinct disadvantage cause it does not cover the full cost of the service."[66]

"The funding for this area is big but it never grows. It actually diminishes every year. We can't look to purchase or provide any other services outside the services that we're already providing, because there is no funding to pay for those services. We usually run them for nothing."[67]

Based on the interviews in this study, there was a major concern held by Māori providers. The perception is that decisions made in Wellington show little regard or understanding for Māori communities. Māori providers are too often required to deliver what government agencies think is best, rather than what is best for their community.

MĀORI PROVIDERS AND MĀORI PROVIDER DEVELOPMENT

For Māori health, progress was made when the Ministry of Health acknowledged the need to fund Māori provider development. As outlined in the previous chapter, the Regional Health Authorities, and later the Health Funding Authority, was the implementation agency for this strategy. The fund had $10 million (GST inclusive) available for Māori provider development in the 1999/2000 financial year.[68]

The Ministry of Māori Development, Te Puni Kōkiri, also received funding in Vote: Māori Affairs for the delivery of a provider development programme called Tahua Kaihoatu, though this was targeted at more than just Māori health service providers. In the 1999/2000 year, $3.4 million was allocated to successful applicants to complete training as agreed in a contract between providers and Te Puni Kōkiri. This funding is ongoing. The Budget 2000 Closing the Gaps package also included new funding of $14 million over four years to the Children, Young Person and their Families Service (CYPFS), for Iwi and Māori provider workforce development.[69]

The Department of Internal Affairs briefing (1999) highlighted the fact that many community organisations struggle to build skills in such areas as project planning and monitoring, managing budgets, supervising volunteers and fundraising.[70]

This is another issue reflected within international research. First Nations in Canada, through the Office of the Auditor General (1996), gained the authority to administer government programmes. At the same time as the devolution of these programmes, they also had to acquire the necessary skills to deliver the programmes.

However, some felt that the devolution process had left them with fewer resources than the Government had used to administer these same programmes. They often had to learn jobs and skills without the benefit of training. They also felt that the Government's objective in devolution was simply to reduce expenditure and that, in effect, First Nations were being set up to fail. This was often referred to as the 'dump and run' approach.[71] It is a scenario not uncommon to Māori health service providers in Aotearoa New Zealand.

Māori providers are frequently concerned about funding for training, staff development, being able to pay appropriate salaries, as well as retaining or attracting high quality staff members.

> *"The only way we can get them is by offering the same wage that they're getting in the Pākehā system, which is currently about $60,000 a year. What Māori provider can get that much money to second one of those people over to us so that we can meet the criteria of these tenders?"*[72]

Funding from agencies tended to focus on the programme without any funding for Māori providers to learn new skills and improve performance.

> *"There's nothing about workforce development or anything like that in our contracts. You just get the same money. You can only get extra money if you agree to extra outputs."*[73]

Providers highlighted the difficulty of accessing funding for their development needs.

> *"The agency gives money for office equipment this year. Can't be computer hardware or software. Can only get desks. It is hard even when money is slotted aside for Māori development. It is so difficult to get money from the agency even when*

money is put aside for Māori providers, targeted at Māori development. In order to tap into criteria, it was so difficult, we had to try three times to get money for business initiatives but at the of the day we felt that it wasn't worth the headache and trial to go there to access money."[74]

Māori providers also wanted to network more amongst themselves. There were examples of providers who had decided to do this without the help of the agencies. There were also concerns about competition being fostered between providers which the Crown fostered, when what they wanted was to work more co-operatively together.

MONITORING MĀORI PROVIDERS

New Zealand's accountability system for government agencies is managed using a number of monitoring mechanisms including quarterly performance reports on purchase agreements, half-yearly reports and an annual report on financial results and outputs.

Any advantage in the system is invariably on the side of the Government agencies and can include allowing Crown agencies greater flexibility. However, within this flexibility, there is a need to see results and outcomes from projects. Schick (1995) considers results important in the New Zealand context. He states that monitoring performance against targets is a vital part of the New Zealand accountability system. These accountability arrangements support the Health Ministers obligations to report to Parliament on public money spent. The role of providers within the accountability framework is to provide documentation to agencies of their performance against stated targets in contracts, or outputs, which feed into broader departmental reporting.[75]

For Māori health service providers here-in lies the problem. The recognition of a Māori cultural framework that has accountability back to their community is

important for Māori providers. Generally, Māori providers' expectations are that progress and performance are measured in terms of client-focused outcomes, not outputs. Outcome measures are result-based indicators that measure improvements within a target population in an area where the government purchases services. Māori providers consider that contractual arrangements should identify a means to measure improvements in the lives of service users, rather than provide information about the number of case management interventions and internal activities. More specifically they should be understandable in terms of Māori health gains.

Outcomes should also be culturally appropriate. For Māori, outcomes might focus on cultural integrity and lifestyle as well as economic advancement. Kingi and Durie (2000) highlight the importance of cultural variances when determining the most appropriate outcomes. Their report recommended that there be four domains of outcomes that reflect Māori concepts of health and well-being and are based on an accepted model of Māori health, Te Whare Tapa Whā.[76] MacDonald et. al (1997) also found that some health experts felt that outcomes were different for Māori.[77] Kingi and Durie (2000), when developing a Māori measure of mental health, commented that there had been no specific Māori health outcome measures in regular use. "As cultural factors are likely to influence perception of health and well being, they need to be considered when determining outcomes, otherwise the reliability of outcome assessment within Māori populations will provide incomplete answers."[78]

The Department of Internal Affairs (1999) also commented that the emphasis by purchasers on outputs reduced the ability of providers to modify services to meet local needs and improve outcomes.[79]

Literature on the health sector highlights the lack of ability to meet local needs. The literature concludes that many provider organisations are becoming agents of the government and their ability to respond to their communities is being compromised. This is most evident in voluntary agencies. A study carried out by Clark (1997) on the Auckland voluntary sector, found that one-fifth of the voluntary

agencies spoken to felt that their autonomy had been undermined, while 60% felt that their objectives and goals had been compromised.[80] This was because of the accountability measures stipulated in the contract.

One of the risks that providers face when they contract with government agencies is that they may lose autonomy. This is highlighted by Clark (1997), Smith (1996) and McCarthy (1995). The community group becomes 100% accountable for providing a service when they are under contract and strict guidelines are imposed on them to deliver the service. Their loss of autonomy to the agency may come when they start providing services in line with agency philosophy and lose what essentially makes them part of the community.[81]

This contracting framework has further problems for Māori, which have been identified by Durie (1985) as:

- the fragmented approach to development inherent in the government's sectoral efforts;
- the use of inappropriate outcome measures; and
- the imbalance between Māori-centred services and mainstream services.[82]

Crengle (1998) stated that Te Whānau o Waipareira had difficulties with the performance assessment requirement of a child wellbeing programme they operated. The funder assessed performance solely by counting the number of checks undertaken at the times specified by the National Well Child Schedule. This failed to capture the broad range of activities undertaken by Te Whānau o Waipareira and the organisation's focus on the whānau. As a result, there was stress on the staff as they were delivering facets of a service that they were not funded for.[83]

This issue is also highlighted within international research. In Canada, First Nations recognised the importance of effective accountability and the need for audit. However, the Office of the Auditor General of Canada (1996) felt that neither First

Nations nor the government agencies had a good understanding of the other's objectives. First Nations stressed the need for an improvement in the current reporting regime, which had limited value. They felt the reports and audits served the needs of the federal government more than they served the needs of the First Nations and their membership. They felt an audit should be more than just a collection of statistics and that there needed to be an increased focus on results, in addition to a simplification of the processes required.[84]

The Australian model of providing services to its indigenous people is not based on contracts but on a system of grants. Fletcher (1992) argues that these give Aboriginal communities a degree of autonomy. However, the ultimate control of the money is still with central government.[85]

Māori providers wanted an accountability system that recognised outcomes that were more in line with what the Māori providers were trying to do. In line with Māori providers trying to provide holistic services, they would like to report on outcomes that made sense to their clients. Māori providers interviewed in this study felt that the monitoring system does nothing more than allow them to tick the box to demonstrate the completion of specified tasks.

> *"I don't think that they have a very good cultural audit so what's their cultural framework in terms of the response, the way in which, the standards that we have. We expect that all our workers are of a particular standard. We expect that we've got a quality plan that we submitted to them and that they will actually recognise and acknowledge those things in terms of the way in which we work as Māori."*[86]

Māori providers considered that contracts specified a number of things for reporting purposes but nothing on accountability to their clients. They felt that they were accountable not only to the government but also to their community.

"It's just number crunching and means very little in terms of the service that we are providing. They're not making a responsible effort in evaluating the social outcomes of this health programme; they're just purchasing numbers."[87]

"It is a concern that government policies are fiscally prescribed - it's in conflict with the way that we actually want to deliver at a whānau and hapū level."[88]

In relation to holistic services, Māori providers were concerned about the Government's focus on outputs as opposed to outcomes. It would be better to focus on outcomes that recognise Māori priorities and perspectives.

"Because I think if we did it on a needs basis which is outcome driven, what we would probably find is that the community would be able to put in some sorts of models that are more in line with how Māori do the mahi. If it's going to be in an holistic model, then you'd be able to work the way that you want to work rather than having to work with separate contracts and separate people that don't see any of it coming together."[89]

Many of the output measures were not seen as providing any meaningful information about clients.

"Very clinical model, nothing to the satisfaction of what we would like to develop. We have approached them about it and there's nothing happening about developing outputs that are 'real' in terms of the people who are working."[90]

Māori providers expressed frustration with the inability to plan long-term. Based on the interviews in this study, Māori providers identified two specific issues regarding Crown monitoring. First, Māori providers value accountability but the understanding of accountability for the Crown is different to that of the Māori provider. Government agencies are focused on outputs. Māori providers would prefer to focus on outcomes, or more specifically, Māori health gains. For Māori providers, outputs are viewed as procedural number counting and of little use. Second, Māori providers want recognition of Māori health frameworks within the Crowns monitoring systems. Without them the Crown systems fail to make sense to Māori providers and the whole process of monitoring and reporting is a pointless or even painful experience. In spite of this, Māori providers continue to exist, survive and even prosper. This then poses an obvious questions – How do they do it? How do Māori providers manage the process of changing provider focussed outputs into client centred outcomes, or more importantly, Māori health gains. This chapter has examined the views of Māori health service providers on this issue and other corresponding outcomes.

CONCLUSION

Chapter seven has outlined concerns raised by Māori health service providers regarding relationship management with government agencies and other providers as result of health sector changes from the 1991 health reforms. Though many gains have been made, with more Māori providers delivering programmes and services to their communities than ever in the past, the contracting process leaves room for improvement.

Contracting arrangements need to fit with the variety of communities and programmes and should be implemented according to the contracting groups level of development. Some providers will be able to deliver programmes without assistance, while others will need help. If more responsibility for the delivery of programmes is to be placed with community providers, their current capability needs to be taken into account and adequate developmental resources provided. Any change

management process involving Māori providers must include an allowance for positive development.

One of the key areas where government agencies can make improvements for Māori providers is in creating consistency in the contracting processes of the various funding agencies, with the aim of reducing compliance costs. Māori providers define their service delivery as holistic. They work with Māori clients in their totality. This often includes the client's whānau. A consequence of holistic service delivery is that providers have to contract with a number of government agencies to provide the service that they consider is required.

Too often contracting has been developed on an ad-hoc basis with a range of different agencies administering contracts. Contracting with more than one government agency through different application processes and satisfying the accountability requirements of multiple funders increases the compliance costs for Māori providers. Whole of Government contracting has the potential to both reduce duplication of effort and to move towards a model of service delivery that is community, rather than ageing, focussed.

Government agencies also need to improve their consultation with Māori communities in a way that recognises the particular circumstances and characteristics of that community. Māori providers have a key role to play in their community through the work that they do at the local level. They consider that consultation is often nominal or perfunctory, or that the policy is pre-determined and consultation is therefore pointless.

For this thesis the main issue is that accountability and reporting processes need to focus more on outcomes desired by Government and Māori communities. Current accountability arrangements focus on the outputs delivered. This approach is of limited real value to Māori providers especially in terms of tracking improved outcomes or achieving Māori health gains.

[1] Te Puni Kokiri, Ministry of Māori Development, (1997), *Review of the Ministry of Health.* Monitoring and Evaluation Branch, Wellington: p 6.
[2] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[3] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[4] *Rural Māori Health Service Provider Interview*, (1996), Northland.
[5] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[6] *Urban Māori Health Service Provider Interview*, (1998), Henderson, Auckland.
[7] *Urban Māori Health Service Provider Interview*, (1998), Middlemore Hospital, Papatoetoe, Auckland.
[8] *Urban Māori Health Service Provider Interview*, (1998), Middlemore Hospital, Papatoetoe, Auckland.
[9] *Rural Māori Health Service Provider Interview*, (1996), Wanganui.
[10] Ministry of Māori Development – Te Puni Kokiri, *Review of the Ministry of Health*, Monitoring and Evaluation Branch (1997): p 9.
[11] Waitangi Tribunal, (1998), '*Te Whānau o Waipareira Report'*, GP Publications, Wellington, pp 6-9.
[12] Office of the Auditor General of Canada, (1996), '*Report of the Auditor General of Canada on the State of Accountability Practices from the Perspective of First Nations'*, Chapter 13: p 161.
[13] Penner, K., (1992*), 'Their own place: The case for a distinct order of Indian First Nation Government in Canada.'* In Long and Boldt (eds.), *'Governments in Conflict: Provinces and Indian Nations in Canada'*, University of Toronto Press, Toronto, Canada.
[14] *Rural Māori Health Service Provider Interview*, (1996), Northland.
[15] *Rural Māori Health Service Provider Interview*, (1996), Wanganui.
[16] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[17] *Rural Māori Health Service Provider Interview*, (1996), Rotorua.
[18] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[19] Ministry of Health, (2001), *He Korowai Oranga – Māori Health Strategy: Discussion Document*, Wellington.
[20] Ministry of Health, (2001)
[21] The Ministry of Māori Development – Te Puni Kokiri, (1993), *Ngā Ia O Te Oranga Hinengaro Māori - Trends in Māori mental health: A discussion document*, Wellington: pp 22-23.
[22] Huakina Development Trust, (1994), *Rapua te Oranga Hinengaro,* Pukekohe.
[23] Ministry of Māori Development – Te Puni Kokiri, (1994), Ngā *Mahi Kakama Mātua Māori mō te Tiaki Hauora: Māori primary health care initiatives*, Wellington.
[24]. Ropiha, D., (1993), *Tipu Ora: Programme evaluation: Final report,* Department of Health, Wellington.
[25] Ministry of Māori Development – Te Puni Kokiri, (1995), *Health Through The Marae.* Wellington.
[26] Ministry of Māori Development – Te Puni Kokiri, (1995), *Oranga Niho*, Wellington.
[27] Ministry of Māori Development – Te Puni Kokiri, (1995), *Oranga Niho*, Wellington.
[28] Florence, J., (1996), *'Culture of Partnership to Culture of Contract: Child and family support services contracting with the New Zealand Community Funding Agency'.* Massey University, Albany, Auckland: p 89.
[29] Ernst and Young, (1995), *'Study on the Viability of the Not-for-Profit Sector in New Zealand'*, Wellington: p 29.
[30] Te Puni Kōkiri, (1999), '*Discussion Paper on the Review of the Māori Community Development Act 1962'*, Wellington: p 16.
[31] Department of Internal Affairs, (1997), '*The Use of Discretionary Funding by Government to Fund Innovation and Initiative from the Community'*, A Literature Review, Wellington: p 3.
[32] Statistics New Zealand, (1999), '*Māori Now*', Wellington, p 17.
[33] Ministry of Health, (1999), '*Briefing for Incoming Minister of Health - Facts about Health and Disability in New Zealand'*. Wellington ,p 6.
[34] Durie, M H (1985) 'A Māori Perspective of Health.' *Soc Sci Med* 20; (5): 483.
[35] United States General Accounting Office, (1999), '*Indian Self-Determination Contracting: Shortfalls and Alternatives for Funding Contract Support Costs'*. Testimony before the Committee on Resources, House of Representatives, Washington DC: pp 66-67.
[36] United States General Accounting Office, (1999), p 67.
[37] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[38] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.

[39] *Rural Māori Health Service Provider Interview*, (1996), Ngaruawahia.
[40] *Rural Māori Health Service Provider Interview*, (1996), Northland.
[41] *Provincial Māori Health Service Provider Interview*, (1996), Rotorua.
[42] Department of Internal Affairs, (1997), *'The Use of Discretionary Funding by Government to Fund Innovation and Initiative from the Community'*, A Literature Review. Wellington.
[43] Department of Internal Affairs, (1999), *'Briefing to the Incoming Minister'*, Wellington.
[44] Ernst and Young, (1995), *'Study on the Viability of the Not-for-Profit Sector in New Zealand'*, Wellington, p 29.
[45] Burn, I., (1996*), 'Contracting for Community Mental Health Care and the Effect of Other Changes in Government Legislation and Practice,' Public Sector;* Edit 21: pp 24-26.
[46] Waitangi Tribunal, (1998), *'Te Whānau o Waipareira Report'*, GP Publications, Wellington.
[47] *Rural Māori Health Service Provider Interview*, (1998), Northland.
[48] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[49] *Rural Māori Health Service Provider Interview*, (1996), Ngaruawahia.
[50] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[51] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland.
[52] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[53] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland.
[54] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland.
[55] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[56] Crengle, S., (1998), *'A case-study of the well child health programme Te Whānau o Waipareira.'*, Te Oru Rangahau - Māori Research and Development Conference, Massey University, Palmerston North: pp 191-199.
[57] Durie, M.H., (1995), *'Ngā Matatini Māori: Diverse Māori Realities'*, Wānanga Pūrongo Kōrerorero, 14-17 February 1995, Ngāruawahia.
[58] Penner, K., (1992), *'Their own place: The case for a distinct order of Indian First Nation Government in Canada.'* In Long and Boldt (eds.), *Governments in Conflict: Provinces and Indian Nations in Canada.* University of Toronto Press, Toronto, Canada.
[59] Voyle, J., and Simmons, D., (1999), *'Community development through partnership: Promoting health in an urban indigenous community of New Zealand'*, Soc Sci Med 1999; 49: pp 1035-1040.
[60] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland.
[61] *Rural Māori Health Service Provider Interview*, (1998), Pukekohe, Auckland.
[62] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[63] *Rural Māori Health Service Provider Interview*, (1998), Northland.
[64] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.
[65] *Urban Māori Health Service Provider Interview*, (1998), Henderson, Auckland.
[66] *Rural Māori Health Service Provider Interview*, (1996), West Coast, South Island.
[67] *Rural Māori Health Service Provider Interview*, (1996), West Coast, South Island.
[68] Ministry of Health, (1999b), *'Briefing for Incoming Minister of Health - Facts about Health and Disability in New Zealand'*. Wellington: p 9.
[69] Te Puni Kokiri, Ministry of Māori Development, (1997), *'Review of the Ministry of Health', Monitoring and Evaluation Branch*, Wellington: p 2.
[70] Department of Internal Affairs, (1999), *Briefing to the Incoming Minister,* Wellington.
[71] Office of the Auditor General of Canada, (1996), *'Report of the Auditor General of Canada on the State of Accountability Practices from the Perspective of First Nations', Chapter 13: pp 166-67.*
[72] *Provincial Māori Health Service Provider Interview*, (1996), Rotorua
[73] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland
[74] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland
[75] Schick, A (1995) *'The Spirit of Reform'*, Report prepared for The State Services Commission and the Treasury.
[76] Kingi, TK.R., and Durie, M.H., (2000), *'Hui Oranga: A Māori Measure of Mental Health Outcome.'* A report prepared for the Ministry of Health, Te Putahi a Toi, School of Māori Studies, Massey University.
[77] MacDonald, K., (1997), *'Community Healthworkers in Auckland'*. Research report for the degree of Master of Business Administration, Massey University, Albany.

[78] Kingi, TK.R. and Durie, M.H., (2000), '*Hui Oranga: A Māori Measure of Mental Health Outcome.*' A report prepared for the Ministry of Health, Te Putahi a Toi, School of Māori Studies, Massey University.

[79] Department of Internal Affairs (December 1999) *Briefing to the Incoming Minister of Internal Affairs.* Wellington. Durie, M H (1985) *'A Māori Perspective of Health'*, Soc Sci Med; 20 (5th edit): p 483.

[80] Clark, J., (1997), '*Welfare Restructuring in New Zealand: The changing relationship between the state and Auckland's voluntary health sector'* University of Auckland, Auckland: p 168.

[81] Clark, J., (1997), '*Welfare Restructuring in New Zealand: The changing relationship between the state and Auckland's voluntary welfare sector'*, University of Auckland,. McCarthy, P (1995) *'The Contract Crunch.'* In NZ Disabled. Smith, V M (1996), '*Contracting for social services: the changing relationship between government and the voluntary sector in New Zealand'*, Victoria University, Wellington.

[82] Durie, M.H., (1985), *'A Māori Perspective of Health.'*, Soc Sci Med; 20 (5): p 483.

[83] Crengle, S., (1998), '*A case-study of the well child health programme provided by Te Whānau o Waipareira'*, Te Pumanawa Hauora (ed.), Te Oru Rangahau Māori Research and Development Conference Booklet, Massey University: pp 191-199.

[84] Office of the Auditor General of Canada, (1996), '*Report of the Auditor General of Canada on the State of Accountability Practices from the Perspective of First Nations'*, Chapter 13: p168.

[85] Fletcher, C., (1992), '*Aboriginal Politics'*, Melbourne University Press, Victoria: p 46.

[86] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.

[87] *Urban Māori Health Service Provider Interview*, (1997), Henderson, Auckland.

[88] *Provincial Māori Health Service Provider Interview*, (1996), Rotorua.

[89] *Urban Māori Health Service Provider Interview*, (1998), Papatoetoe, Auckland.

[90] *Urban Māori Health Service Provider Interview*, (1996), Dunedin.

CHAPTER EIGHT

MAINSTREAM ENHANCEMENT

When the first Maori health policy guidelines were issued in 1994, the Ministry of Health stipulated that the Regional Health Authorities (RHAs) must, amongst other things, *'improve access to health disability support services for their members with lower health status with a specific focus on Maori.'*[1] A number of policy directions to guide purchasing strategies were recommended including:

- greater participation of Maori at all levels of the health sector;
- resource allocation priorities which take account of Maori health needs and perspectives; and
- the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.[2]

The mainstream enhancement policy was developed out of the last guideline and became synonymous with other mainstream health service issues including health service consumer satisfaction, effective health service delivery and cultural safety.

In New Zealand, any discussion on the subject of what defines effective health services for Māori has invariably stimulated debates on cultural safety. The debate however, has often been conducted within a climate of misunderstanding, confused objectives and media misrepresentation. Cultural safety remains a widely misunderstood concept in the health sector and indeed the wider New Zealand society. In 1993, the depth of misunderstanding was clearly illustrated when a trainee nurse at Christchurch Polytechnic failed the cultural safety component of the curriculum. The media fuelled and manipulated the debate. Not surprisingly the Christchurch Press ran editorials which likened cultural safety to *'an instrument of tyranny'* and a *'form of social engineering'* to ensure that nurse trainees conformed to *'politically correct and sensitive patterns of thought, speech and deed'*.[3]

Implications of cultural safety diminishing clinical training and tribal extremism were consistently raised by the media and generated a level of controversy not often seen within the field of health worker training. It is often said that the media only print public opinions and views. However, in this case not once was cultural safety defined for the enlightenment of readers.

CULTURAL SAFETY

Cultural safety is not a new concept. In the 1950's, a woman called Madeline Leininger introduced the notion of trans-cultural nursing practice in America. The concept introduced the idea of transcending American culture in the delivery of nursing care to people of other cultures. Leininger published a range of books and papers defining her theories and concepts of trans-cultural nursing and the blending of two worlds.[4] In New Zealand one of the first advocates of cultural safety in nurse training was Irihapeti Ramsden. Ramsden contended that all nursing interactions should be bicultural because nursing interaction can only be with one person at one time. There is only one giver of the message and one receiver. She argued the aim of cultural safety was to educate nurses to examine their own cultural realities, or how their attitudes and behaviours impinge on others. Given the nurse is also the bearer of culture that has generally been taken for granted, the nurse becomes the focus of training in cultural safety. As a result, improved self knowledge can lead to more flexible and open minded delivery of health services people from other cultures.[5]

Although in New Zealand there is a Māori-Pakeha component in cultural safety training the principles learned are applicable to all cultures. The aim of cultural safety is to improve life chances through better access to health services which is a key component of mainstream service enhancement. A secondary aim of training in cultural safety is to produce educated health professionals who will not blame victims of historic processes for the current status of poor health. The paramount values of cultural safety training are sensitivity, awareness and safe practices with people of all cultures.

Ramsden has long campaigned that cultural safety is about improving life chances through better access to health services rather than ethnography. In 1995, the cultural safety component of nurse training was approximately forty percent covering historical and social issues that relate to nursing and midwifery, thirty percent on Pākeha culture and thirty percent devoted to Māori traditions, customs, and preparation for visits to marae.[6] Preparation lectures are imperative or else negative responses are likely to be elicited from students who feel understandably threatened by a situation where they are not in control.

In 1999 a nursing degree required 3000 hours to complete of which 3.5 percent was spent on Cultural Safety, commonly referred to as 'Whakaruruhau'. Of that 3.5 percent 1.5% was social issues, one percent was Pākeha culture and one percent was Māori culture.[7] The rationale for structuring Cultural Safety in this manner was that Māori and Pākeha constitute the founding cultural elements of the country.

The purpose of cultural safety is to identify the advent of negative social indices and the barriers to improvement. Such a process requires examination of both cultures which is why Pākeha culture is analysed as part of the curriculum. Pākeha culture needs to be examined to identify its own characteristics as well as the role it played in the production of contemporary Māori society.

One reason this scenario has developed is because of the social assumption that Pākeha society is the norm and the benchmark against which everything else in the New Zealand society is measured. Pakeha resistance to cultural safety is partly a function of a perceived Māori moral advantage and confrontation with a colonial history is an uncomfortable experience.

CULTURAL COMPETENCE

Culture is essentially a convenient way of describing the ways members of a group understand each other and communicate that understanding. More often than not the nuances of meaning are generated by behaviour rather than words, and much

of the interaction between members is determined by shared values operating at an unconscious level that is normally taken for granted. Many groups have their own distinctive culture – the elderly, the poor, professional groups, gangs, the army. Although the focus tends to be on culture associated with particular ethnic groups, it should not be forgotten that in the consulting room or the hospital ward, ethnic culture is one cultural affiliation alongside others. The skill lies in being able to determine the culture that is likely to have the greatest significance in a specific context.

Cultural competence is about recognising other belief systems. Health professionals need to share the healing platform with others who do not base their interventions on scientific evidence. Rather than regarding the other healers as threats or interlopers, a culturally competent doctor would see opportunities for collaboration. For the most part, Māori accept the scientific ethos but they may also hold views that are at odds with science. Of course not all Māori patients subscribe to these values to the same extent or even to any extent. But a competent health worker will be aware of the possibility and will be careful not to impose a value laden professional manner on a patient whose expectations may be derived from other notions of well-being.

Another area where cultural competence can contribute to greater medical effectiveness lies in the social norms and organisation within different communities. While a Māori patient may be the focus of attention, more often than not successful treatment and care will depend on extended whanau and friends. In turn that will require the doctor to have some familiarity with a Māori patient's community at least to the extent that a judgement can be made about the most useful treatment arrangements that might assist with care and management. Within Māori communities there are a wide range of facilities, whānau support mechanisms, committees and health services. However, they are not identical and an effort should be made to match Māori patient need with community capacity rather than assuming that they are all equally applicable. Treatment plans that are developed without regard for whānau and community cultures run the risk of failing, not because they

are professionally and technically inappropriate, but because the community's cultural ethos is aligned to other priorities.

Cultural competence embraces many variables several of which have been discussed. Although the differences between cultural competence and cultural safety are probably outweighed by their similarities, they have quite distinct starting points and in the New Zealand health context, somewhat different histories. Both are about the relationship between the helper and the person being helped, but cultural safety centres on the experiences of the patient, or client, while cultural competence focuses on the capacity of the health worker to improve health status by integrating culture into the clinical context. This last point is important. Recognition of culture is not by itself a sufficient rationale for requiring cultural competence; instead the aim is to maximise gains from a health intervention where the parties are from different cultures.[8]

EFFECTIVE HEALTH SERVICE DELIVERY.

Ultimately, the goal of effective health service delivery to Māori people is to make gains in Māori health status in order to secure a healthier future for coming generations. But any attempt to identify a single form of health service delivery that is particularly effective for Māori people and impacts on Māori health status is fundamentally flawed for two reasons. First, as stated in Chapter 2, Māori people are so diverse it requires a range of comprehensive strategies for each specific health need. Second, strategies for addressing Māori health have their own sets of issues and considerations. No single generic framework of health service attributes could produce effective health service delivery outcomes for all of them. Health service agencies have distinctive characteristics with service delivery attributes that are unique to each and are generally only effective for that particular service.

Developing effective forms of health service delivery by any health provider requires a strategic planning process specific to a particular service. Consequently, any debate on effective health services for Māori people must be focussed. This raises questions of what constitutes a health service for Māori. Is it a service that

applies Māori health models, Māori health service providers, hospitals that service a large percentage of Māori people, health service providers with a Māori kaupapa, models of health service delivery, or health strategies for engaging Māori communities? This chapter examines these issues in regard to mainstream health services.

The need for culturally effective services is predicated on the importance of cultural wellbeing with whānau health outcomes. Further, it recognises the influence of the cultural baggage that both providers and whānau bring when interfacing in the health sector. The provision of culturally effective services that recognises diverse whānau realities means that providers will be familiar with Māori cultural values, beliefs and norms that impact on health practices and lifestyle choices and behaviour. This is necessary to eliminate the risk of inappropriate practices which cause offence, create barriers of access and marginalise participation on cultural grounds. Also, it necessitates providers being aware of the different power relationships between providers and consumers in the health sector, and the potential for providers to impose their cultural beliefs on whānau service users.

There are significant gains to be made from the various micro and macro approaches to the provision of culturally effective programme development and delivery in the health sector. Attention to minimising cultural barriers at the programme interface and the institutional level is likely to improve Māori access to and use of health programmes and services.[9] Appropriately targeted culturally effective health promotion programmes and services and increased Māori access to primary health care are likely to result in improved cost benefits in the long term. With this rationale the Ministry of Health instructed Māori health purchasers to purchase culturally effective Māori health programmes and services. This requirement had particular implications for both mainstream primary health care providers and *'by Māori for Māori'* organisations and initiatives to ensure services were accessible and acceptable to the actual and intended users of those services.[10]

MĀORI PROVIDERS AND MAINSTREAM PROVIDERS

Amongst Māori providers interviewed in this study there was conflict about what constitutes a mainstream provider. This issue was examined in Chapter Seven where the debate centred on whether a provider who is part of a mainstream organisation, but delivers a *'for Māori by Māori'* programme or service, can be considered a Māori provider or whether only organisations that are fully controlled and governed by Māori should be defined as Māori providers. Some Māori providers expressed concern about mainstream providers not having the capacity or expertise to deliver the Māori component of a service to Māori clients. There were a number of instances where Māori providers had bid for a contract in competition with mainstream providers. When the mainstream providers were awarded the contract, they came back to the Māori providers and asked them to provide the Māori component of the service for them. The Māori providers were also concerned that the mainstream providers asked them to provide the Māori component at a lower cost. As Māori providers became aware of these strategies they were being firm about ensuring that sub-contracting led to the full cost of providing the service. This is reflected in the following excerpt from an interview:

> *"When they [the mainstream agency] got the contract, after they signed it, they rang us to see if Māori providers could deliver the Māori component. I said, "These are our fees." I knew what the contract was worth and I never heard from them again. These are some of the things that they said they could deliver."*[11]

Mainstream providers were also coming to Māori providers seeking advice on how to provide culturally appropriate services. Many providers interviewed questioned why a Māori provider did not get the contract or why the agency did not check to see whether the mainstream provider could actually deliver effective and appropriate services to Māori.

"Even mainstream agencies are coming to us because their contracts are saying we have to be culturally appropriate. They suddenly have to come to Māori providers to get advice on culturally appropriate services. Why can't the agency fund the provider?"[12]

Māori providers also felt that the competitive environment of the health sector which had developed out of the reforms meant mainstream providers were competitors but the advantages were definitely with the normally larger mainstream provider.

"Before the reforms we had a co-operative working relationship with the hospital which was contracted. When the reforms were imposed we suddenly became competitors but the hospital had the infrastructure and programmes already in place which we helped put there. They ended up getting the contract but then turned around and asked us to help them deliver it for less than it was funded."[13]

If there were one consistent theme in regard to relationships between Māori and mainstream providers during the 1990s it was that the competitive environment of the health sector created, or sometimes exacerbated, a level of mistrust between them that had not often been experienced by Maori health workers before. Those more experienced Māori health professionals working in mainstream health services found the competitive environment favourable, but the experience of community workers was largely negative.

"When we realised that funding for mainstream enhancement was part of the reforms we knew that we would be strategically placed to take advantage

of it. We set about working at different levels in different roles with different parties that all worked in Māori health. Even the Maori health managers at the RHA worked with us to develop and define a proposal that would expand and establish this service. We then had to convince the Chief Executive to support this. Fortunately, and to his credit, he immediately saw the benefits."[14]

Having to manage multiple needs at different stages of development was also a scenario not uncommon to mainstream Māori health workers:

"The speed at which the reforms were developed, announced and implemented did not help either. It meant we were forced to plan, implement, manage and monitor all at once when we ourselves were still developing. The level of mainstream enhancement we were targeting made the process even harder but at least we had an infrastructure in place. Unlike some Māori providers, we did not have to establish ourselves from scratch. In fact we inherited a history of health service provision. The fact that it was not a good history of service provision to Māori only served to help our cause."[15]

Like Māori providers outlined in chapter seven, Māori providers in mainstream services had to manage complicated situations often made more difficult by the very organisation they were designed to assist.

"Managing the changes from the health reforms is complex especially since what we are trying to do is so ambitious. How do you suddenly make highly

trained health professionals more accountable to the needs of Māori clientele? How do you do this using organisational influence? How do you make people understand the concept of Māori health gains when they have absolutely no understanding of Māori people themselves? We are managing policy, practices, contracts, funding, monitoring, as well as people and often in the face of deep seated opposition from our so called colleagues."[16]

Mainstream Māori health workers interviewed in this study were both envious and sympathetic of Māori health service providers who were not part of a mainstream organisation.

"I have to sympathize with Māori providers because we are able to call on a range of resources to assist us which is a luxury they don't often have. Accounting services, payroll, human resource management, employment contracts are just some of the organisation systems we use which many Māori providers have to do themselves. But then I envy them because they are all on board with the Māori health kaupapa whereas we are just trying to get everyone here to acknowledge it, understand it and then address it."[17]

IMPROVING THE EFFECTIVENESS OF MAINSTREAM SERVICES

After the 1993 health reforms, mainstream services took greater responsibility for Māori health in many areas. For example, publicly funded hospitals and major primary health care organisations were required, through their contracts, to specify how they would identify and meet the needs of Māori.[18]

The reforms also expected public health and primary services to meet the needs of Māori more effectively. Public health services such as health protection, food safety and health promotion needed to be reoriented to ensure that Māori needs and perspectives of health were taken into account. Attention was also directed to referral patterns in primary health care where there was evidence that referral and treatment patterns for secondary and tertiary care did not always reflect the higher service needs of Māori. To address these service needs many hospitals established Māori and whānau units which focussed on ensuring the services better met the needs of Māori patients, and addressed cultural safety issues.

> *"We are the largest mainstream health service organisation in the country in a city with the highest concentration of urban Maori people. It is therefore imperative to have a comprehensive Māori health management service whose primary goal is to ensure the organisation addresses the specific needs of Māori clientele."*[19]

One of the primary objectives of these services was improving the ability of the organisation to deliver effective services to Māori clients. Given the complexity of services many mainstream providers deliver, the concept of mainstream enhancement is very broad. For many it is not simply a situation of delivering a specific type of health service:

> *"For us it is about the Treaty if Waitangi. Delivering effective health services to Māori is more than addressing Māori health needs – it is a fundamental right under the Treaty. Because there are so many different health service delivery situations within this organisation the concept of mainstream enhancement is extensive. Unfortunately most people think it's about making*

Māori patients and their whanau comfortable while they are in hospital. That is actually only a very small part of it and a lot of work is done behind the scenes just to make that possible."[20]

Frustration with misunderstanding regarding the concept of mainstream enhancement was often expressed by Māori mainstream health workers:

"The reality is that the majority of Māori go to mainstream for health services. If the reforms are to better address Māori health needs than they must target mainstream enhancement. Obviously we have welcomed this policy because it has affected our funding but managing the change has been a nightmare mainly because of inadequate funding. This organisation has been forced to sit up and take notice of us instead of taking us for granted like they did in the past. We are no longer a dial a powhiri service for this place."[21]

"This mainstream enhancement policy has meant extra responsibility which I have to admit we have sometimes struggled with such as professionalism when we lack professionally trained staff. Managing mainstream enhancement here has required parallel development. We have been contracted to develop the organisation while developing the service here itself, yet we are only funded to deliver. We are not too dissimilar to many new Māori health service providers who receive no establishment funding but are expected to deliver. It makes you wonder whether we are being

established just to capture the funding and are really being set up to fail."[22]

Even within the organisation itself mainstream enhancement was often considered the role of the Māori service only.

"I know many of the people here consider us to be a 'dial a Māori service' and when there is an issue that has anything to do with Māori, such as cultural safety, they can just get us to do it. Our role is to show them but not do it for them. That is a big ask for anyone but it also highlights the difficulty of working in this area. We are expected to be a 'Jack of all trades' and an expert in Maori health needs. Mainstream enhancement is about knowing what everyone else does and then applying a Māori health framework to it. This means we have to depend on them to a degree and hope that they see we are trying to help them. Too often we get the impressions our colleagues are reluctant and see us as a nuisance who is only creating more work for them."[23]

MODELS OF MAINSTREAM ENHANCEMENT

When the mainstream enhancement was introduced as a policy direction by the Ministry of Health in its guidelines to Regional Health Authorities in 1995, many providers were quick to recognise the advantages. One of the first to establish a strategic Māori health management service was Auckland Healthcare Services Limited (A+).

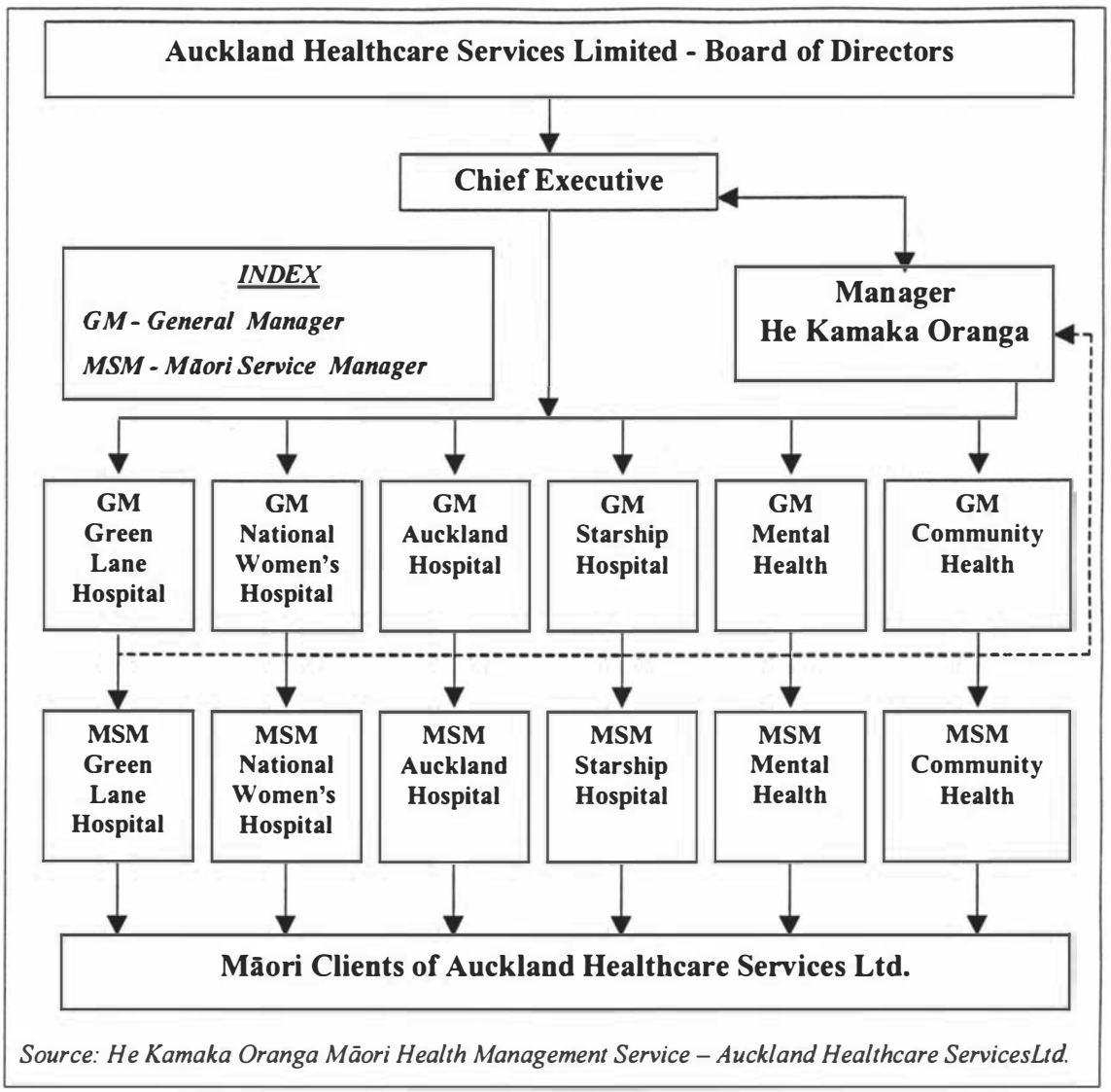
The Māori Health Management Service – He Kamaka Oranga

The Māori Health Management Service - He Kamaka Oranga was a corporate level office responsible for the integration of all Māori health needs within the management structure of Auckland Healthcare.

Its primary objective was to establish an organisation wide set of values, policies and practices that would eventually ensure effective health service provision and delivery to Maori. Auckland Healthcare Services Limited is the largest mainstream health service in the country. There are six core services based around the four hospitals of National Women's, Green Lane, Starship and Auckland as well as Mental Health Services and Community Health Services.[24] With more than 9000 staff and $80m worth of assets,[25] the integration of a Māori health framework within an organisation such as Auckland Healthcare was, if anything, ambitious. He Kamaka Oranga structure was centred around establishing Māori health services within the six core services of Auckland Healthcare. Each would have a Māori health manager and staff that would focus on addressing the delivery of the health services to Māori clients within their respective core service. Each Māori health manager would have a direct line of responsibility to the General Manager of their core service as well as an indirect line of accountability to the Manager of He Kamaka Oranga.

In this manner, all Māori health service issues would be coordinated through the Māori health management service, He Kamaka Oranga, at least in theory. Figure 8.1 outlines the He Kamaka Oranga structure.

FIGURE 8.1 *The He Kamaka Oranga - Māori Health Management Structure.*

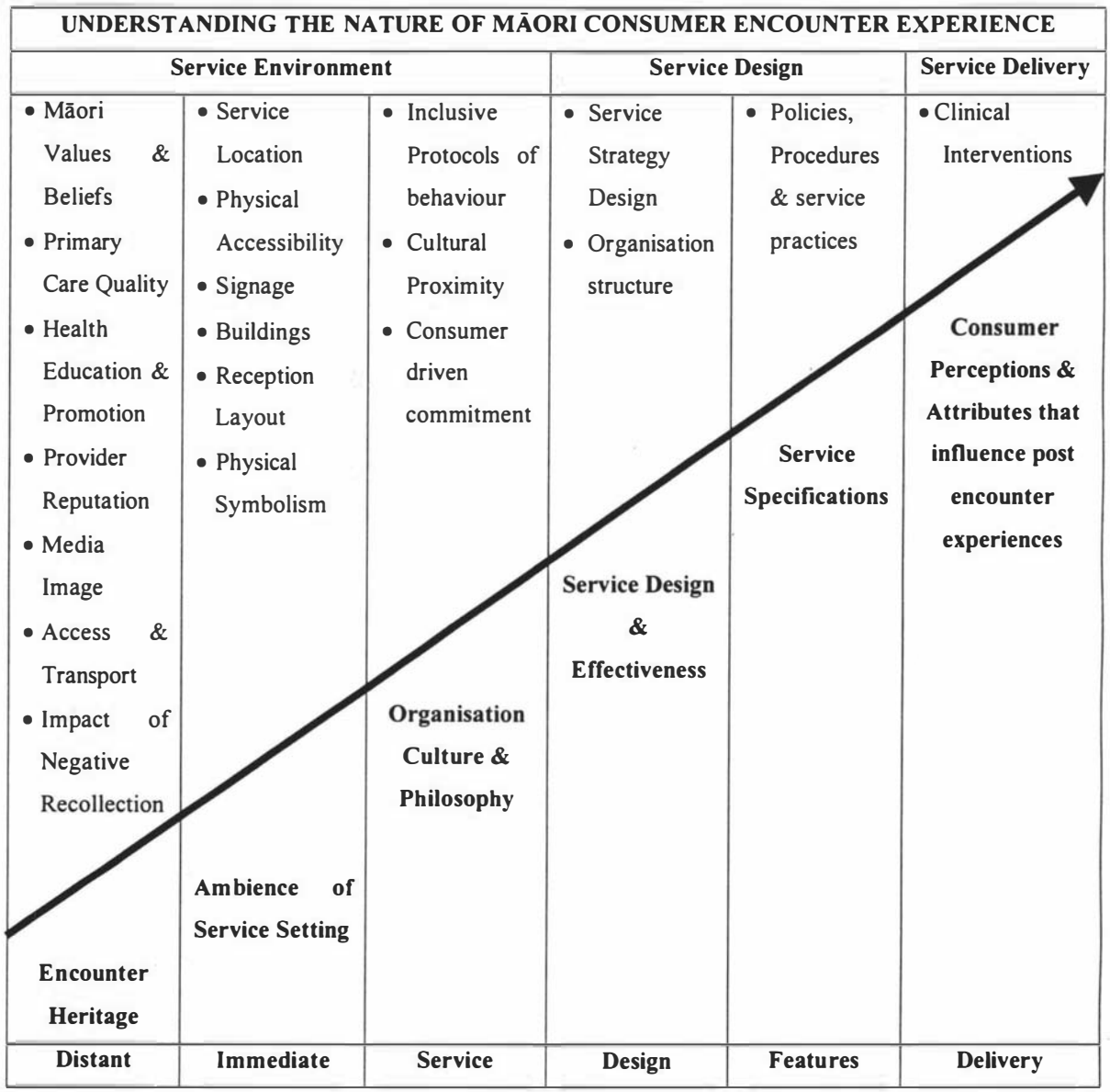


Source: He Kamaka Oranga Māori Health Management Service – Auckland Healthcare ServicesLtd.

Justification for the integration of this structure into Auckland Healthcare was based on an evaluation of Māori historical experiences with mainstream health services. A framework was developed from this analysis and became known as the 'Māori Encounter Heritage Framework.'

In brief, the framework analysed the influences on Māori behaviour within the environment of a mainstream health service provider such as Auckland Healthcare. There are six stages from pre entry through to the point of clinical intervention. Figure 8.2 outlines the attributes of this framework.

FIGURE 8.2: *The Māori Encounter Heritage Framework*



The framework operates from left to right. Each column represents different stages of engagement with the service and summarises the range of considerations that Māori clients are confronted with when using Auckland Healthcare. Each consideration can influence the Māori client and determine behaviour towards the organisation of Auckland Healthcare or anyone who represents it. Each stage and consideration can influence the impression of the service so much so that at any stage a client may refuse to participate, even if refusal is life threatening.

This framework was used as a key mechanism for influencing the change management process within the organisation. Consultation was conducted throughout the core services of Auckland Healthcare as an accelerated mechanism for understanding a Māori client mind-set and to influence staff behaviour towards Māori clientele or at least, encourage staff to accept that there are needs which are specific to Māori people they serve.

The role of the Māori Health Management Service, He Kamaka Oranga, was to implement and manage an organisation wide change process through every level of the organisation and the framework was a component of that process. The difficulties were complex and diverse.

> *"The sheer size of this organisation makes our goals even more difficult but it also highlights the need for it to happen here. There are over 9000 staff here and we have to get to them all but fortunately we have the support of the man at the top. A lot of it depends on the good faith of our non-Māori colleagues."*[26]

Māori management workforce needs were also identified as a major issue.

> *"One of the things about main stream enhancement is that you must have strong Māori leadership that is well equipped to operate at a strategic management level. Our Māori service managers are sometimes too quick to pander to the needs of our non-Māori colleagues. It is important to show them how to do it but don't do it for them. You aren't helping anyone if you do – us or them."*[27]

The He Kamaka Oranga Māori Health Management framework was a high level centralised structure which extended into the six core services of Auckland Healthcare. The need was high so implementation was accelerated:

> *"In retrospect, this organisation was not ready for us. The appropriate systems and processes were not in place when we started here and given we were on a three year contract we had no time to waste.*[28]

New positions had to be created quickly and the speed at which this happened created other issues.

> *"New positions were created without the appropriate clarity and they weren't always consistent with this office. General managers found they had Māori service managers with staff and some chose to use them in roles that they weren't meant to be used for. Unfortunately some of our Māori Managers were comfortable with that and would pander to their GMs needs. Management leadership skills were sometimes lacking and that affected our progress but that is a Māori health. workforce issue we all experience."*[29]

Planning processes were also an organisation wide issue that impacted on this service and limited its ability to be effective:

> *"If you have strong systems in place you can avoid confusion but this company lacked effective strategic and business planning processes so there were no levers to ensure consistency. We had to use*

line accountability to create consistency rather than process."[30]

This is not to say that a structure like that of He Kamaka Oranga was not needed or would not work in Auckland Healthcare. The fact that the systems in the organisation were not always effective made it appropriate for a centralised Māori health management structure to be adopted:

"If you have a responsive company than you can decentralise as long as you have systems and processes to guide people, but if it is not responsive than centralisation is more useful. When you are decentralised and there are no systems than people make up what they want to do in their own way. If you only have a small amount of resource you can potentially have six Māori service managers going wherever they want. When there is a lack of clarity for the organisation it is better to pull everyone together, especially when it is only a small number of people, all agree on where we are going and what the priorities are then address them in a much more logical fashion."[31]

In 1998 after four years of existence, He Kamaka Oranga was restructured into four key functions: Tikanga, Organisational Development, Management Strategy and Clinical Strategy with Maori health management in the middle. The previous Manager of HKO, Naida Povey, was appointed Chief Advisor of Tikanga responsible for Maori cultural values and a new Manager was appointed, Nigel Chee. A separate function became organisational development with a key issue on workforce development. Another area was management strategy and this included human resource, information systems, business development and quality. A new area was clinical strategy which had previously not been influenced much and involved

looking at assessment processes, care planning processes, treatment, support and discharge planning. The new model would integrate Māori health into all these areas and hopefully address Maori health needs in the organisation.

> *"We realised that Clinical strategy was missing from the original HKO objectives so that is where we are moving the resources. That is where our core business is and tikanga needs be brought closer to clinical strategy then it does to management. Clinicians are the people that interface with Maori consumers and at that interface tikanga Maori needs to be applied the most. If we wanted to make gains you would need to bring this advice closer to the floor. The old HKO strategy was more of a management structure only."*[32]

It was felt that the difficulty with the original HKO structure was an over emphasis on management which had a limited impact on the practical service delivery issues. This was identified when an evaluation was conducted in 1998:

> *"We learnt that the state of the organisation was bad so we gathered evidence of this. The evidence showed that the management functions were poor but the clinical functions were not receiving enough emphasis, which was an issue because that is the organisations core business. The change process we applied involved a shift towards a greater influence on clinical functions, systems and processes. We know what the key levers to change managers are, but we don't know the key levers to change clinicians."*[33]

He Kamaka Oranga was important for giving practical expression to Māori perspectives at a mainstream management level and in demonstrating examples of how Māori health needs can be incorporated into mainstream hospital service. There were of course criticisms that it was more about appropriation of Māori values and knowledge, than about better health gains for Māori, and too often Māori participation was at the periphery rather than in the core business. The cultural-clinical divide had not necessarily been bridged.

What may have been missing was effective management leadership and Māori participation at all management levels of the organisation. No amount of internal reconfiguration will make substantial difference to Māori health if Māori themselves are not actively involved. The He Kamaka Oranga structure was able to locate Māori in the management arena and although they appeared to be part of the structure they were often not party to the core clinical business. For mainstream health services there is a clear message. Attempts to implement mainstream enhancement should avoid diminishing Māori leadership, or usurping Māori initiatives, and should reconcile the gaps between cultural and clinical dimensions.

MAINSTREAM ENHANCEMENT INTERVIEWS

Among the many interviews conducted with Māori mainstream health workers there were several consistent themes which highlighted some of the difficulties in this area. Consistent through all interviews was the necessity to implement any service enhancement programme from the top of the organisation's management structure. Any such strategy which did not have comprehensive support and involvement of the most senior level management was likely to be flawed:

> *"Another important thing is the Board and executive management support. You've got to get them to sign off on the change that you need to occur within the organisation. We had to go to them and say look you need to sign off on this,*

basically it is an internal change management process that is Maori specific."[34]

Furthermore, the Board and executive management must be strong and effective leaders who are able to respond to the Māori needs regarding organisation enhancement. The change process must be comprehensive internally before any positive effects will be evident:

"At all levels, in particular at the Board in senior management, those people have to be strong leaders and they have to have the authority from the Board right through. You've got to make your board and management respond. You've got to have their support for mainstream enhancement internally to occur because if you cant get your own organisation right, there is no way you are going to be able to respond to the external people and other organisations."[35]

Once support has been established and supported then Māori health issues must be comprehensively integrated across and through the organisation.

"What you have to do is get your Board to sign off on the change management process and then you have to integrate Maori issues across every thing, horizontally and vertically. You start by introducing Maori health to all the organisations strategic and business planning. So it is very clear in the documentation that runs the organisation, that not only is Maori health a priority but this is how we are going to respond to that. Basically that is an example of the success of mainstream enhancement in a big organisation because the strategic and

business plans have Maori specifications, not just Maori plans."[36]

Several mainstream Māori health services experienced major difficulties in these areas:

"That is really hard. You have to start at the Board level. As you know in terms of lines, accountability and authority you start at the top. We always use that as leverage in our internal discussions about the Board has approved this, therefore it is an organisational wide thing. But you can't stop at that level. You need to translate that accountability to the senior management team at the very least. You have to make sure they translate that accountability to their staff."[37]

Making staff accountable for a Māori health concept they have difficulty understanding, accepting or even acknowledging was a key difficulty in the change management process of mainstream enhancement. Māori mainstream workers used human resource management systems to address the problem:

"What you need to do is model the human resource system to ensure there is Maori specificity in collective and individual performance indicators, which are then translated into the employment contracts. So we did some of that. But we had not, by the time I had left, achieved that to the extent that we wanted too. We had only manged to achieve Maori specificity in the strategic business plans."[38]

Even with Māori specific criteria in employment contracts there was no guarantee staff actions or behaviour would change but at least Māori mainstream health service had a direct mechanism for staff accountability.

Another issue identified was communication. An effective system of communication is imperative for any strategic management process.[39] If clear and consistent messages are not managed and maintained not only will progress be hindered but extra problems may well be created. Maori mainstream health workers found communication systems were too often a problem in the mainstream health service environment:

> *"You need a real effective communication system. That was really difficult for us. Acting as a change agent, if you don't have the authority to communicate across and effect that change with an effective communication system then you are pushing up hill. We always suffered from incongruent messages being sent out internally, which then effected our external performance.".*[40]

Without an effective communication system promoting a collective goal within the organisation and monitoring organisation performance is seriously hindered:

> *"One of the things about the change management process you really have to have a defined pathway, cause I'm talking about time, it does take time but you have to be quite definite about that. You need to have good internal monitoring system or mechanism that will allow you to identify along that defined pathway how well you are doing."*[41]

Many of these issues stem from the negotiation and management of the contract. Some services had very little input into contract negotiation with the RHA and the distribution of that funding once it was received by the organisation. Consequently, the RHA was not monitoring the process either:

> *"We don't even know what the total funding for our contract was. That is all handled by the Finance and they take their cut. We know what we want to do and as long as it remains a Ministry priority this hospital is prepared to finance this service but it is a continual battle for us. They are always wanting to cut funding from us and channel it to other areas. I know that there are other mainstream services that are funded for enhancement but are doing nothing more than what they have always done and that wasn't helping before so why should it be any different now."*[42]

Perhaps the most definitive issue that many interviewees mentioned was the risk and frustration involved in managing mainstream enhancement. Too often mainstream enhancement was perceived as making Māori clients and their whanau comfortable while they were receiving services from the organisation. Any change was superficial but not sustained. Ultimately the goal of a 'mainstream enhancement Māori health service' is to integrate the philosophy into all the services so that it becomes standard practice. This is reflected in the following interview:

> *"The reason I say it is a risk for Māori is because mainstream enhancement efforts so far are not effective change in my opinion. They are not sustainable change. To work in them means you often subjected to larger health agendas which are not Māori health issues. Mainstream enhancement*

efforts or changes are too often compromised. I believe what we should be engaging in is a change that is more than superficial. A change that actually means Maori issues become a normal part of every day professional life and the consideration of those issues managing and eliminating any negative issues associated with Maori health is a normal function of a professional person."[43]

CONCLUSION

Mainstream enhancement is a strategy fraught with conceptual and operational obstacles. It requires a range of difficult collaborative, integrated and interdependent policies and programmes to accommodate a Māori health perspective. It has also required a reactive management practice:

"Essentially mainstream enhancement should not be compartmentalised. It must go right through absolutely every thing, including right up through the government and its central agencies and what it does. More importantly when parties are planning their policies they need to have effective Maori input there as well, because that is all about mainstream enhancement. I reckon when you write your thesis you should be, if I can suggest, you should be talking about mainstream enhancement in the very broadest context."[44]

Several of the more experienced Māori health professionals outlined some of the advantages gleaned from extensive experience in this field of Maori health:

"I have seen many changes over the years and most have generally disadvantaged us however, the

reforms definitely created more opportunities for us to take control of our own health needs than I had ever seen before. In retrospect, I don't believe we were ready to manage it but we never have been yet we still do it. I say this because for me and many of the people I have spoken to, privatisation of the health sector has required accelerated reactionary management and not planned proactive strategic management. You would think with all my training and experience I would know better but it has always been this way in Māori health and I can't see it changing much."[45]

In the future, mainstream enhancement will need to continue to address strategies for improving the interface between clinician and Māori clientele, not only to address this particular Māori health issue, but to confront the changing nature of New Zealand society. As mentioned in Chapter Three, New Zealand's demographic profile is changing as the growth in the Māori population continues. Although accounting for some fifteen percent in 1996, by 2051 the Māori ethnic population will almost double in size to close to a million, or twenty two percent of the total New Zealand population. By 2006 Māori will make up a quarter of the total New Zealand school age population.

Furthermore, the overall ethnic diversity within New Zealand is undergoing similar change. High fertility rates, quite apart from further immigration, will lead to significant increases in Pacific Peoples. Migrants from India, China and the Asian Pacific rim will add to the cultural diversity so that by 2050 around half of New Zealand's population will be non-European. The composition of the medical profession will, in time, come to match the community profile, but for now the immediate implication is that doctors will increasingly be called upon to treat patients from different cultural backgrounds. English, while still likely to be the common language, may not be the preferred language and health providers will be

sorely tested to respond positively to consumers whose cultural and ethnic roots lie outside their own experiences. More to the point, unless interaction with patients recognises and builds on cultural realities, opportunities for gains in health may be lost. The shrinking globe as well as greater opportunities for travel to and from New Zealand, will bring a previously insular nation into a wider cultural arena. Whether practicing in New Zealand or abroad doctors will not be immune from the globalising influence; cross-cultural interfaces will become the norm; medical effectiveness will be increasingly challenged by cultural diversity; and the capacity to embrace other cultures in a confident manner could make the difference between good outcomes and treatment failures.

The Ministry of Health mainstream enhancement policy anticipated Māori would continue to require access to general health services and those health services would need to become responsive to Māori people. Many mainstream health service providers have made advances in recognising Māori cultural preferences but these efforts have too often been peripheral to actual service delivery and have had limited impact on key service issues such as acute treatment and follow up services. This is not to say that cultural sensitivity and competence is unimportant, only that it does not represent a comprehensive response to improving Māori health status. If there is one underlying theme from this chapter it is that mainstream enhancement must be incorporated into other performance indicators that have a direct bearing on Māori health, including measurements of access, consumer satisfaction, clinical choice, and ultimately health outcomes.

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[1] Health Services Directorate, (1992), *Policy Guidelines to Regional Health Authorities.* Ministry of Health , Wellington, p9.

[2] Ministry of Health, (1994), *Māori Health Policy Guidelines to the Regional Health Authorities.* Wellington, p 6.

[3] Walker, R., (1996), *'The Walker Papers - Science, Intellectual Property and Cultural Safety'.* Oxford University Press, Auckland, p179.

[4] Walker, R., (1996), p180.

[5] Walker, R., (1996), p181.

[6] University of Canterbury, (1996), *Cultural Safety Guidelines for Nurse Training.* Faculty of Medicine, Christchurch, p 13.

[7] University of Auckland, (1998), *Nurse Training Module Guidelines*, Faculty of Medical and Health Sciences, Auckland, p 18.

[8] Durie, M.H, (2001), *Cultural Competence Paper*, Australian and New Zealand Medical Boards and Councils Conference, Wellington.

[9] Ministry of Health, (1995), *Māori Health Policy Guidelines to the Regional Health Authorities*, Wellington, p 6.

[10] Ministry of Health, (1995), p. 6.
[11] *Urban Māori Health Service Provider Interview*, (1998), Mangere, Auckland.
[12] *Urban Māori Health Service Provider Interview*, (1998), Henderson, Auckland.
[13] *Māori Health Service Provider Interview*, (1998), Wanganui.
[14] *Mainstream Māori Health Management Service Interview*, (1996) Auckland.
[15] *Mainstream Māori Health Management Service Interview*, (1996) Auckland.
[16] *Mainstream Māori Health Management Service Interview*, (1996) Auckland.
[17] *Mainstream Māori Health Service Interview*, (2000) Wanganui.
[18] Ministry of Health, (1997), *Annual Funding Agreement with the Regional Health Authorities.* Wellington.
[19] *Mainstream Māori Health Management Service Interview*, (1996) Auckland.
[20] *Mainstream Māori Mental Health Service Interview*, (1997) Tauranga.
[21] *Mainstream Māori Health Service Interview*, (1998) Palmerston North.
[22] *Mainstream Māori Health Service Interview*, (1998) Palmerston North.
[23] *Mainstream Māori Health Service Interview*, (1996) Auckland.
[24] Manaia, W.L., (1996), *'A Māori Health Management Discussion Document'* He Kamaka Oranga - Māori Health Management Service, Auckland Healthcare Services Limited, Auckland.
[25] Pickup, D., (1995), *He Kamaka Oranga Scholarship Award Speech*, Auckland Healthcare Services Limited, Auckland.
[26] *He Kamaka Oranga - Māori Health Management Service*, (1995) Auckland Healthcare Services Ltd, Auckland.
[27] *He Kamaka Oranga - Māori Health Management Service*, (1995) Auckland Healthcare Services Ltd, Auckland.
[28] *Mainstream Māori Health Management Service Interview*, (1996) Auckland
[29] *Mainstream Māori Health Management Service Interview*, (1996) Auckland
[30] *Mainstream Māori Health Management Service Interview*, (2000) Auckland
[31] *Mainstream Māori Health Management Service Interview*, (2000) Auckland
[32] *Mainstream Māori Health Management Service Interview,* (2000) Auckland
[33] *Mainstream Māori Health Management Service Interview,* (2000) Auckland
[34] *A Regional Health Authority Māori Management Interview* (1997) Auckland
[35] *Mainstream Māori Health Management Service Interview*, (1995) Auckland
[36] *Mainstream Māori Health Management Service Interview*, (1995) Auckland
[37] *Mainstream Māori Health Service Interview*, (1997) South Auckland
[38] *A Regional Health Authority Māori Management Interview* (1998) Auckland
[39] Gilbert, J., Jones, G., Vitalis, T., Walker, R., Gilbertson, D., (1996), *'Introduction to Management in New Zealand'*, Harcourt Brace & Company, Australia, p 16.
[40] *Mainstream Māori Health Service Interview*, (1998) Rotorua
[41] *A Regional Health Authority Māori Management Interview* (1997) Auckland
[42] *Mainstream Māori Mental Health Service Interview*, (1997) Wanganui.
[43] *A Regional Health Authority Māori Management Interview* (1997) Auckland
[44] *Mainstream Māori Health Management Service Interview*, (1999) Auckland
[45] *Mainstream Māori Health Service Interview*, (1997) South Auckland.

CHAPTER NINE

CHANGE MANAGEMENT AND MĀORI HEALTH DEVELOPMENT

In Chapter 2, Māori health development was described as Māori defining their own priorities for health and then weaving a course to realise their collective aspirations.[1] Māori health development involves a comprehensive application of philosophical and cultural principles, social and economic positions and the integrated impact these influences have on Māori health status. This view has led to an understanding that advances in Māori health must achieve two fundamental requirements: an improvement in health status and affirmation of Māori identity.

Strategies for addressing Māori development must also be comprehensive and not limited by public sector delineations, or the compartmentalisation of public sector agencies. Māori social, cultural and economic development recognises the influence of educational failure and inadequate housing on Māori health and the futility of delivering highly sophisticated treatment procedures in isolation from other social and economic programmes. Health policies, processes and procedures are generally considered negligent when developed without due recognition of influential socio-economic factors and generic Māori development. As mentioned in Chapter 2, Durie (1992) reiterates what Māori have long identified as the overall context for improved health:

- full and active participation in society;
- access to the Māori world; and
- access to quality health services.[2]

This understanding of the Māori health development concept was the base definition for this thesis. Given that this definition incorporates the wider context of Māori development including the impact of socio-economic factors, what is the impact of change in one particular sector such as health? If the management of

change is happening in the midst of strategies targeted at a broad concept of Māori health development, then the management strategies themselves would need to be strategically planned and aligned if they are to be effective. Unfortunately for Māori health, this is not always the case.

Management is the art of ensuring resources available are used efficiently to obtain the best outcome. There are no set rules but the people, the purpose and the ways in which the objectives are achieved influence the result. It is the process of planning, organising and leading while controlling resources and activities in a co-ordinated and systematic manner so that goals are achieved.[3] A common working definition defines management as *'a goal orientated process that involves the allocation of resources and the co-ordination of the talents and efforts of a group of people.'*[4]

Change management is the process through which the human aspects of change are managed to ensure objectives are met and sustainable change can be achieved within the planned budgets and time frames. Change management is as much about the human condition as it is management theories, strategies and methodologies. An effective change manager, or change agent, must have the ability to not only influence but to captivate and inspire people so that they are able to go through the change process because that is expected, but also because they want to. It is a matter of winning the hearts and minds of all the people involved. Unfortunately not all good managers are good managers of change.

The contemporary topic of change management is commonly referred to as the corporate process for adapting to a changing environment. However, historically change management for Māori has been more about the process of human survival in a changing physical environment. In the past, Māori have shown an exceptional tenacity for survival by accommodating change and adapting to new realities. The definition of change management underpinning this thesis is 'any management driven initiative that involves change or restructuring strategies for addressing Māori health.' This can include change management collaborations with agencies outside

the health sector. By using a comprehensive definition of change management this thesis has been able to incorporate any initiative with Māori health objectives that has been managed through change, in particular, the 1991 health sector reforms. This has included management within a range of different situations including structures, Māori health policy, Māori health purchasing, changes at all levels of the health sector, changes in isolation, inter-sectoral collaborations, the enhancement of mainstream health services and Māori health service providers.

The level of achievement possible for Māori health development through change management is highly debatable and this fact alone justifies the need for more research into what is happening. This thesis has focussed as much on the process of change for addressing Māori health, as it has on the outcome of achieving Māori health gains. Much of the study examined Māori experiences with managing health sector changes in the face of their own particular needs.

HOLISTIC SERVICE DELIVERY

The Collins Concise Dictionary (1998) defines holistic as '*the consideration of the whole person in the treatment of disease*'. However, there is no shared understanding or definition in the literature about what holistic service provision for Māori actually means. In health, holistic service delivery as a term is often used to differentiate Māori provider service delivery from that of non-Māori.

> *"The Māori approach to development is holistic and does not recognise clear sectoral demarcation between social, economic and cultural areas. Employment services for example, can be structured around Māori concepts of good health, which owe as much to a meaningful job, hygienic housing and a solid education."*[5]

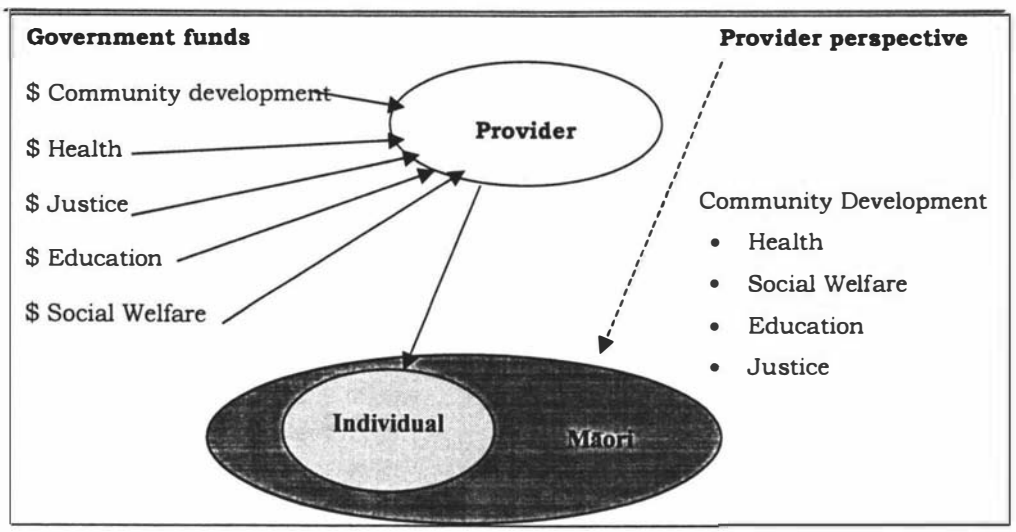
Taking into account that Māori may approach service delivery differently from conventional services is important. MacDonald et. al. (1997) identified strong agreement among Auckland health experts that being Māori made a difference.

There was considerable emphasis on explaining differences in health and social philosophies, approaches, values, lifestyles, and perceptions and making Māori a unique market segment.[6] Crengle (1998) describes the provision of holistic services, which are consistent with Māori values and belief systems, as a key feature of the Whānau o Waipareira 'well child health programme'. Two facets of the holistic approach were that:

- health cannot be viewed in isolation from other factors which affect wellbeing, such as education, employment, and social service needs; and
- the child (who receives the service) cannot be viewed in isolation from the whānau. The needs of all whānau members must be addressed in order to maximise the well-being of the child.[7]

The frustration for Te Whānau o Waipareira was that the funder's perspective did not incorporate a cross-sectoral or whānau-based approach. Māori providers agreed that the services they provide are holistic and in that respect are different from most mainstream services. They considered holistic service provision to be treating the whole person, not just the illness. Treating that person would often mean working with whānau as well. Figure 9.1 shows what Māori providers consider holistic concepts to be in the provision of services to their community. A whole of government approach to contracting is clearly preferred.

Figure 9.1 Holistic Service Delivery and Funding Providers.[8]



Many Māori providers considered mainstream health concepts to be too narrow to encompass all the elements of Māori health:

> *"Because of the whānau concept, or whanaungatanga stuff. You've got the individual as in the person that we deliver the service to, but then you've got his family to take care of as well, or their family and they've got children, they've got mothers, they've got fathers, they've got grandparents. So we're having to deal with that because those people also access the child health services. They access the adult health services, they access mental health services, they access a whole range."*[9]

One interviewee commented on the difference between Māori and mainstream concepts of holistic service provision. The distinction for this provider was that while Māori holistic services were built around working with the wairua (spirit), hinengaro (mind) and tinana (body), mainstream concepts of holistic service provision only focus on the intellect and the body:

> *"To do justice to our people we have to work in three areas for holistic well being. If one of the three is not nurtured, sickness occurs within the un-nurtured sphere. Hence the importance of a Māori service that delivers from a kaupapa Māori perspective."*[10]

Māori providers maintained that providing Māori-focused services is seen as a nuisance by some agencies and that agency specifications are restrictive.

> *"If we go down a kaupapa Māori track then we will get the door slammed in our face. Because people don't understand why it's important to do this in a particular way, why it's important to practice a*

particular way. We are having to constantly validate that all the time, and usually the answer would be "yeah do it that way, we're still not giving you money for it."[11] *The whole system is too restrictive. And so we want to have the freedom to develop our own programmes based on our own policies and understanding of our people's needs and understanding of how we work as a Māori provider with our hapū and our whānau but in terms of accountability we're prepared to say we will deliver this at the end of that period."*[12]

Māori providers often need to go to a number of agencies to gain funding to deliver services and programmes that address all Māori health needs. Multiple funding creates extra problems and requires relationship management through difficult contract criteria with several government agencies.

Māori interest in greater measures of self determination implies that Māori themselves are better placed to define their own needs and, among other things, manage their own health. This goal was epitomised by the plethora of Māori health providers, services, initiatives and strategies that emerged in 1980s and was the subject of accelerated development and establishment through the 1990s. While some were in fact controlled by health authorities, many were firmly located within Māori communities and were usually aligned with other Māori development programmes. To a greater or lesser extent they were based on Māori perspectives and subject to Māori guidance. Autonomy and self sufficiency, with reduced reliance on the state, was consistently advocated by all Māori health interviewees, alongside the linking of health with other aspects of Māori development.

BARRIERS TO MĀORI ACCESS OF HEALTH SERVICES

Māori under-utilise primary healthcare services. Māori tend to access services later than non-Māori, treatable illnesses become severe, and as a result the ability for health services to intervene effectively is reduced.[13] The reasons for these

behaviours rest in part on Māori perceived barriers to accessing health programmes and services.

With the reforms placing priority on Māori health and specifically targeted funding at service enhancement, health planners and providers worked to overcome service barriers in order to make health services more accessible and acceptable to Māori. In order to minimise barriers, integration, collaboration and co-operation between primary and secondary services was necessary.[14] Cost barriers associated with doctors' visits, dental services, pharmaceuticals, outpatient care, transport, loss of wages, and possible job loss, inhibit many Māori from seeking early health care. However, the free access policy for medical care to children under six years of age, and targeted subsidies including the community card scheme, did partly address cost barriers for some Māori.

All interviewees agreed on the negative impact of cost barriers preventing Māori from accessing services and programmes and there was also the need to extend the analysis of Māori disadvantage beyond a purely economic framework. This thesis acknowledges that the culture of poverty provides a partial explanation of the position of Māori within New Zealand and it recognises that a cause of Māori disadvantage has been the lack of control and unbalanced arrangements for power sharing. Moreover, it recognises the strength of Māori initiative and the progress made by Māori in modern times.

Therefore, as mentioned in Chapter Four, strategies designed to address barriers, without recognising the broader political and societal obstacles which compound the cost barrier effect, are unlikely to achieve optimal health outcomes for Māori.

LOCATION AND TRANSPORT

Location of, and transport to, health programmes and services was also presented as a barrier to Māori access for both Māori and mainstream providers. These issues were equally relevant for Māori in urban and rural areas. Cost of

transport in urban areas presented barriers for some Māori who lacked the resources to get to health services. In isolated and rural areas cost and geographical distance presented a similar scenario. Some Māori providers adopted mobile services to overcome these location issues.

CULTURAL WELLNESS

Determining criteria which accurately measure the cultural wellbeing of Māori is fraught with difficulty. Such criteria will be dependent on the diverse realities of individuals within whānau and whānau as a collective, and will inevitably involve both objective and subjective measures. Knowledge of oneself and, by implication, cultural knowledge is acknowledged in various Māori models as an important determinant of health status. For many Māori, self knowledge will include knowledge of whakapapa, iwi and te reo Māori.

At the 1996 Census, Māori living in the South Island were less likely to know their iwi than those in the North Island. One in every three Māori in the Otago and West Coast regional council areas did not name an iwi to which they were affiliated, compared with just one in every 10 Māori living in the Gisborne Regional Council area. Living in a rural or urban setting made little difference to the proportion of Māori who could name at least one iwi to which they were affiliated. Twenty- one percent of South Island Māori who knew the name/s of their iwi indicated that they were affiliated to more than one. For North Island Māori this figure was twenty nine percent.[15]

Use of te reo at the 1996 Census indicated that the ability of people of Māori descent to converse in Māori varied considerably by iwi. Six iwi with 1,000 members or more reported over forty percent of their members as being able to hold a conversation in Māori about everyday things. Of the larger iwi, those with a membership in excess of 20,000, forty five percent of people affiliated to Tuhoe said they could converse in Māori compared with twelve percent of those affiliated to Ngai Tahu. For people of Māori descent who did not know their iwi, seven percent could hold a conversation about everyday things in Māori.[16]

A MĀORI FOCUSSED APPROACH

Minimising barriers to access health services is likely to be achieved through a Māori -focused approach that addresses the historical and contemporary factor, that have resulted in contemporary Māori positions.

As outlined in Chapter Two, the most effective strategies for changing Māori health practices and behaviours best occur in the context of Māori development aspirations. Māori development, while aimed initially at economic gain for iwi, has become inclusive of whānau and community development. Māori focused programmes enable the inclusion and participation of both those Māori who have a close association with hapū and iwi and those that do not.[17]

A Māori focused approach, which recognises diverse realities in the development and delivery of public health programmes, whilst retaining core Māori values, will be effective in addressing the cultural barriers to Māori accessing health services. Māori are the best guides through their own world, and they are the key to promoting health messages and accessing the full range of Māori networks, alliances, communities and social structures. Programmes which are identifiably Māori, and which validate whānau and their values and beliefs, are likely to minimise many of the structural barriers that some Māori experience in the delivery of programmes and services.

The Health and Disability Commissioner has noted that according to 'Right 7(4) of The Health and Disability Commissioner (Code of Health and Disability Services Consumers Rights) Regulations 1996, '*the views of suitable persons may be taken into account by the provider before providing a service*'.[18] This means that when deciding what service to provide, the provider is able to take into account the views of Māori.

CULTURALLY APPROPRIATE AND EFFECTIVE HEALTH SERVICES

Cultural appropriateness of services has been the subject of considerable discussion both nationally and internationally. The World Health Organization

(WHO) acknowledged the issue formally in 1991, and expressed the view that *'health services need to embrace an expanded mandate which is sensitive to and respects cultural needs'*.[19] Pomare (1995) noted that cultural safety issues including attitudes of health professionals, acceptability of the provider, and cultural factors such as whakamā, will represent barriers for whānau access to services.[20] With the exception of services designed specifically by, and for Māori, the health and disability services providing care to Māori tend to be controlled, managed and staffed by non-Māori.

Although the structure of the health and disability sector does not affect Māori exclusively, it contributes to exacerbating the alienation of Māori from participating in the design, development, implementation, management and control of the systems intended to meet their health needs. The institutional processes of health agencies also act as structural barriers that require attention if optimal Māori health gains are to be realised.

The need for culturally effective services is predicated on the importance of cultural wellbeing on Māori health outcomes. Furthermore, it recognises the influence of the cultural baggage that both providers and Māori bring when interfacing in the health sector. The provision of culturally effective services that recognise Māori realities means that Māori, and mainstream, providers will be familiar with Māori cultural values, beliefs and norms that impact on health practices and lifestyle choices and behaviour. This is necessary to eliminate the risk of inappropriate practices that cause offence, create barriers of access and marginalise participation on cultural grounds. Furthermore, it necessitates providers being aware of the different power relationships between providers and consumers in the health sector, and the potential for providers to impose their cultural beliefs on Māori service users.

There are significant gains to be made from the various micro and macro approaches to the provision of culturally effective programme development and delivery in the health sector. Attention to minimising cultural barriers at the programme interface and the institutional level is likely to improve Māori access to

and use of programmes and services. Appropriately targeted culturally effective health promotion programmes and services and increased Māori access to primary health care are likely to result in improved cost benefits in the long term. This has particular implications on both Māori and mainstream primary health care providers and initiatives to ensure services are accessible and acceptable to the actual and intended users of those services.

DISPARITIES IN HEALTH STATUS

Several strategies have been adopted to address disparities in health status between Māori and non-Māori. Because of the complexities of the problems and the multi-factorial origins, there is no single method which will be sufficient to address the range of Māori health issues. It is therefore unreasonable to suppose that health services, by themselves, will be able to effect dramatic changes in Māori health and well-being.

Māori scepticism with the health reforms in the 1990s often rose from the belief that health was strongly linked to socio-economic conditions and no amount of manipulation with primary or secondary care would mitigate against the effects of unemployment, substandard housing, or low income. It can also be argued that precisely because of the socio-economic climate, Māori would be in even greater need of quality health care.

While there is obvious good sense in placing emphasis on health promotion and primary prevention, there will still be a need for adequate treatment services in the forseeable future. Ironically, with the increase in Māori health promotion and preventive services, it is likely that in the short term this will lead to an increase in the utilisation of health services by Māori through more effective case funding and referral.

MĀORI PARTICIPATION IN THE HEALTH SECTOR

Any health programme associated with strengthening the public health infrastructure requires increased Māori participation in decision-making at all levels

of the health sector. This can include management, policy development, direct service across the preventive, primary, secondary and tertiary service levels as well as Māori participation in health professions. One of the factors that can address low participation in these areas includes recruitment and retention barriers. In 1996 a New Zealand health workforce survey indicated that in 1996 there were a total of 31,199 Registered Nurses, of which 5.5 percent (1,727) were Māori Registered Nurses. In the same year there were a total of 5,827 Enrolled Nurses, of which 11.1 percent (652) were Māori Enrolled Nurses. In 1997, the results of the New Zealand Health Workforce Survey showed there were 201 out of a total of 8,224 Medical Practitioners 2 who reported themselves as Māori.[21]

It is important to note that in both these examples the figures used are from a mixed ethnicity classification. In 2001, there were no Medical Officers of Health and there were very few Health Protection Officers who identified as Māori. Low educational attainment among Māori and high academic entry criteria and performance has in some instances compromised Māori participation as qualified health professionals. Bridging programmes, such as the Māori and Pacific Island Scheme (MAPAS) and the Certificate of Health Science at the University of Auckland, are examples of positive strategies that could increase Māori recruitment and presence in this area. Retention of Māori can be achieved through policy and curriculum development that addresses structural and cultural barriers by increasing choice of health professional providers that can effectively meet Māori expectations.

From interviews in this thesis, there was unanimous support for the need to increase Māori representation at all levels of the health sector, particularly in the health professions. Others registered strong support for Māori control over decision-making, health structures, organisations, policies and procedures that provide services to Māori. Another issue that was highlighted in this area was the need for training of community health workers that will enable them to develop transportable and optimal competencies that can contribute to Māori health care delivery.

Recent years have seen the development of innovative health initiatives, programmes and services strategically targeted at achieving improvements in Māori

health. Many of these initiatives operate on a Māori kaupapa and are the foundations of a Māori health sector that will have a significant role in contributing to the improvement of Māori health outcomes and will be on the cutting edge of public health development in the new millenium.

> *"The problem with Māori development is there is no easy recipe book at any level in any sector. The actual process to effect the change cant just be picked up. That is quite difficult because you have to be innovative whilst you are engaging in the change, whilst your selling the development and monitoring and enforcing that process, whilst acting in an environment that believes that the status quo is quite sufficient thank you very much. You're trying to advocate change in the status quo environment where a lot of people are quite happy to engage maintenance function. They prefer to maintain what is regardless of the fact that its not working for Māori and its even widening disparities in health status."*[22]

The Government has identified the benefits of developing the Māori health sector as central to improving Māori health status.[23] For this sector to grow there will need to be an effective partnership established between the Crown, the health sector, Māori providers, and Māori communities. This will assist the Crown to achieve its objective in improving Māori health and go some way towards removing the disparity in health status between the tangata whenua and other New Zealanders. It will give the health sector innovative models and programmes for reducing the various barriers Māori perceive in accessing health programmes and services, and thereby advance the health of all communities. Most importantly it will return to Māori the responsibility and resource to protect their own wellbeing.

"If we can achieve that type of sustainable change, my dream is there will come a day when we don't need Māori specific positions in the health sector because everybody owns the issues associated with Māori development. What I would like to do is work myself out of this job because if I don't have to do this it means it has been satisfactorily owned and achieved by everybody. That's my dream." [24]

OUTCOMES FROM THE HEALTH REFORMS

At the beginning of this thesis the following hypothesis was presented:

"The aspirations and objectives of Maori health planners and providers have been frustrated and compromised by politically imposed policies in the New Zealand health sector."

Interviews and case studies conducted in this research have outlined Māori frustrations with this issue and in the case of the 1991 health reforms some important lessons for Māori health can be learnt from these experiences. Firstly, structural change, and the corresponding new Māori health policies, diverted too much attention away from effecting change at the service delivery level. Given that the majority of the Māori health workforce is active at the provision level, frustration with this issue was most noticeable amongst them and was evident in respondent interviews. Too often the reforms were seen to take the focus away from other more fundamental Māori health issues that are not related to structure including the appraisal of clinical performance for Māori and the improvement of implicit and explicit incentives to address Māori health needs. This proved to be a consistent source of frustration for the '*aspirations and objectives Māori health planners and providers*'.

Secondly, restructuring takes time to deliver results. Returns by way of improved outcomes are not evident in the short term and what benefits have occurred too often remain unknown. Continual restructuring is costly and disruptive. Notwithstanding the difficulties involved in comparative assessment, a greater commitment to Maori health policy evaluation is required. Restructuring proposals should be accompanied

by clearly stated measurable Māori health objectives against which the new system's performance can be monitored and scrutinised. Without this Māori health goals and objectives are once again '*compromised by politically imposed policies in the New Zealand health sector.*' Proposals for change should also be accompanied by estimates of the transitional and ongoing costs to be incurred in pursuit of the benefits. Some commitment to routine measurement of the health system would also improve the ability of Government to justify structural change. Publication of key indicators of the performance would allow Māori to engage in informed debate. A template for such assessments could include, for example: indicators on Māori client utilisation, reductions in levels of Māori ill health, Māori health inequality attributable to health services and Māori user experiences of services.

In the new millenium, New Zealand's health sector is headed back to the future. Whether that future holds the solutions to New Zealanders' Māori health aspirations is unclear. However, a commitment to rigorous evaluation of the current health sector is necessary to determine whether the future is going to be better than the past.

CONCLUSION

Te Mana Whakahaere, Te Whaiora Māori has been about change and growth in the midst of politically imposed reforms. For many interviewed in this thesis, the experience has been traumatic. Nevertheless, lessons from these experiences have been helpful and if Māori are to meet similar challenges in the future then five overlapping approaches can be deduced.

First, health sector reforms and restructuring must incorporate, or at least consider, long term Māori health strategies. This will allow existing Māori health objectives and aspirations to be considered in future restructuring and address some of the frustration outlined in the hypothesis. Furthermore, this must happen early and before any changes are implemented. Politically driven health sector changes are a reality of the health sector environment and a fact of life for all health services, but the impact of radical change is exacerbated for Māori because the infrastructures are less resilient and the scales of operation are smaller. The link between the imposition

of system-change and larger term benefits need to be clear in terms of the effect and outcomes and compatibility with broader policies for Māori development.

Second, Māori participation in health policy and purchasing must continue to grow. Māori have been disillusioned by short term policies and programmes but have emerged with greater resolve to manage the future themselves, in spite of having to exercise reactionary management practices to whatever health polices are in vogue. Māori often find benefit in programmes that are unlikely to survive Government elections or the next round of reforms and restructuring. In order to address future needs, Māori health development must be driven by longer term Māori agendas based on Māori needs rather than short term political expediencies. Comprehensive Māori participation will also reduce negative perceptions by Māori that health policies are politically imposed.

Third, inter and intra-sectoral collaborations that take into account social, cultural and economic determinants of Māori health must become more visible than central policy advice or memorandums of agreement (MoAs) between different Crown agencies. Māori development is based on integration and is philosophically different from the sectoral emphasis of social policy development and formulation. For Māori providers operating under a kaupapa Māori philosophy, and working in tandem with other facets of Māori community and tribal development, sectoral demarcation is a barrier. It is naive to think that Māori health providers deal with Māori health issues in isolation of other social concerns. A health service that operates under a Māori kaupapa cannot ignore the social, cultural and economic environments of the clients. A distinctive criterion of a Māori health service is the integration of the service with other community or tribal programmes.

Māori approaches to development are typically holistic and are not helped by sharp sectoral demarcations between social, cultural and economic areas. The practice of modifying Māori policies to fit in with Government sectors can only deliver a limited degree of success which may not be sufficient for future Māori health needs. More important, it challenges Māori to meet the requirements of the

Crown instead of facilitating the Crowns ability to accommodate the needs of Māori. It is surprising that coherence between Government departments, especially in terms of funding criteria, collaborative contracting and joint activities, was not initiated earlier as part of a Māori development agenda. Without active Crown agency collaborations Māori policies for integrated development at the tribal or community levels will continue to be implemented in a fragmented manner.

The fourth approach requires all health agencies to accept ownership of mainstream enhancement strategies. Unless there is strong support from mainstream health workers, especially those at the highest levels of the organisation, mainstream enhancement strategies will continue to operate from a point of disadvantage and will do little to address future Māori health needs Furthermore, these strategies must be actively and explicitly supported for the advancement of Māori health and not for the funding opportunities they provide, the culturally appropriate attributes they display, or the politically motivated statements they sell. While many health institutions have made advances in recognising Māori cultural preferences, too often these efforts have been superficial endeavours driven by designated Māori staff and have not been transferred to the clinical arena. In regards to the hypothesis, mainstream enhancement is an area of Māori health where frustration has been significant and politically imposed changes have caused major repercussions for Māori in such services. When large mainstream health services are faced with budget deficits and are forced to make budget cuts Māori health services are too often the first to be put under scrutiny. In the future, Māori will require access to a full range of health services and more often than not, these are likely to be mainstream health services. Māori mainstream health workers and services interviewed in this thesis have outlined a raft of issues but at the core of all their concerns was the unenviable reality of having to implement comprehensive change from positions of limited influence in a constantly changing health sector environment.

Finally, strategies for Māori provider development and Māori workforce development must be combined. Both strategies are inextricably linked yet many

initiatives tend to operate separately or the linkages are minimal. Given provider development is about expansion and acceleration of Māori health service provision, and workforce development is about developing Māori health service workers, it is surprising that both strategies have invariably been developed in relative isolation. Many of the differences are comparatively indistinguishable.

Future Māori health development will require strategies for provider development and workforce development to be integrated. The establishment and development of Māori providers was a significant outcome from the reforms. Successful in terms of numbers, it was not without its difficulties and inevitably, its flaws. The need to establish, manage and develop a health service provider that can operate in a contestable health sector is a difficult task for any organisation but for Māori, it has been made more arduous by insufficient funding for development. The difficulties stem from funding formulas and contracting criteria that are unable to accommodate a kaupapa Māori health service or recognise the developmental stages of Māori health services. These difficulties are further exacerbated by the complications of limited Māori human resources.

Māori health managers interviewed in the course of this research identified many problems with workforce development, aside from shortage, which also involved Māori staff with a wealth of valuable Māori knowledge but no other formal training or education. Accelerated tertiary training opportunities and bridging programmes will need to be created for Māori health workers who have no formal qualifications. Furthermore, greater opportunities for Māori rangatahi (youth) to be introduced into the field of Māori health research must be created and exposure to work in Māori health policy, purchasing and provision should be incorporated into the process.

The link between these five approaches and improved health outcomes has yet to be demonstrated. But if there is to be progress in Māori health than Māori focussed approaches should be given the opportunity to make a difference.

Māori have often been expected to react to social policies which others have formulated on their behalf and the 1991 health reforms were no different. This research has shown that Māori experiences were often negative. Unless Crown agencies incorporate models of Māori development, existing Māori strategies and kaupapa Māori philosophies, public sector reforms will continue to frustrate rather than accommodate the health needs of Māori people. The issues outlined in the hypothesis will continue to exist and stifle efforts for Māori health development. Māori will have to continue managing public sector change in a reactionary manner complicated further by incompatible structures, inappropriate criteria and insufficient funding. The challenge is for the Crown to implement strategies that accommodate the needs of Māori, recognising Māori aspirations for health outcomes that are consistent with well-being and with being Māori. Though the focus has been on Māori needs, the collective benefits and outcomes will contribute to the wider New Zealand society.

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[1] Durie, M.H., (1994), '*Whaiora: Māori Health Development*', Oxford University Press, Auckland, p 32.

[2] Durie, M.H., (1994),p 34.

[3] Gilbert, J.; Jones, G.; Vitalis, T.; Walker, R.; Gilbertson, D., (1996) '*Introduction to Management in New Zealand*', Harcourt Brace & Company, Australia, p 8.

[4] Gilbert, J.; Jones, G.; Vitalis, T.; Walker, R.; Gilbertson, D., (1996), p 11.

[5] *Māori Health Service Provider Interview, (1997), Northland.*

[6] MacDonald, K. (1997), *Community Healthworkers in Auckland.* Research report for the degree of Master of Business Administration, Massey University, Albany.

[7] Crengle, S. (1998), *A case-study of the well child health programme provided by Te Whānau o Waipareira.* In Te Pumanawa Hauora (ed.), *Te Oru Rangahau Māori Research and Development Conference*, Massey University, pp 191-199.

[8] Workman, K. (1999), *A Māori Provider View of HFA and CFA / CYPFS Performance: A Draft Scoping Report to Te Puni Kōkiri.* Wellington. (Unpublished)

[9] *Māori Health Service Provider Interview*, (1997), Rotorua.

[10] *Māori Health Service Provider Interview,* (1997), Dunedin.

[11] *Māori Health Service Provider Interview,* (1997), Horowhenua-Kapiti.

[12] *Māori Health Service Provider Interview,* (1997), West Coast, South Island.

[13] Smith, V. M. (1996), *Contracting for social and welfare services: the changing relationship between government and the voluntary sector in New Zealand*, Victoria University, Wellington, p 54.

[14] Smith, V. M. (1996), p 16.

[15] Statistics New Zealand, (1999), *Measuring Māori Ethnicity in the New Zealand Census*, Statistics New Zealand, Wellington, p 68.

[16] Statistics New Zealand, (1999), p 68.

[17] Public Health Commission, (1995), *He Matariki: A strategic plan for Māori public health: The Public Health Commission's advice to the Minister of Health,* Wellington.

[18] Office of the Health and Disability Commissioner, (1996), *Code of Health and Disability Services Consumers Rights & Regulations,* Wellington, Right 7/4.

[19] World Health Organisation, (1991), *Global Strategy for Health for All by the Year 2000*, Geneva.

[20] Pomare, E.W.; Keefe-Ormsby, V.; Ormsby C., et. al. (1995), *Hauora: Māori Standards of Health, A study of the years 1970–1991,* Te Roopu Rangahau Hauora a Eru Pomare, Wellington, pp 23-24.

[21] Ministry of Health, (2000), *Māori Participation in the New Zealand Health Workforce: Draft Report,* Wellington. (Unpublished.)

[22] *Mainstream Māori Health Service Manager (1997), South Auckland.*

[23] The Ministry of Māori Development – Te Puni Kokiri, (1991), *Ka Awatea* Ministerial Planning Group, Wellington.

[24] *Mainstream Māori Health Service Manager (1997), South Auckland.*

REFERENCES

Adams, Peter, (1977) *Fatal Necessity – British Intervention in New Zealand 1830-1847*, Auckland University Press/Oxford University Press, Auckland.

Auditor General of Canada, (1996), '*Report of the Auditor General of Canada on the State of Accountability Practices from the Perspective of First Nations*, Canada.

Bagshawe. A (1997) *Public Health for Health.* Menzies School of Health Research Annual Report 1996-1997. Darwin, Australia.

Barwick, H (1992) *The Impact of Economic and Social Factors on Health.* A Report prepared for the Public Health Association of New Zealand, Department of Health, Wellington, New Zealand.

Boston, J, P Dalziel and S St John, (1999), *Redesigning the State in New Zealand.* Oxford University Press, Auckland.

Boston,J, Pallot, J, and Walsh, P. *Reshaping the State – New Zealand's Bureaucratic Revolution*, Oxford University Press, Auckland, 1991.

Burn, I (1996*) 'Contracting for Community Mental Health Care and the Effect of Other Changes in Government Legislation and Practice,' Public Sector*, (Edit 21), Oxford University Press, Auckland.

Clark, J (1997) *Welfare Restructuring in New Zealand: The changing relationship between the state and Auckland's voluntary health sector,* University of Auckland, Oxford University Press, Auckland.

Crengle, S (1998) *'A case-study of the well child health programme Te Whānau o Waipareira.'*, Te Oru Rangahau - Māori Research and Development Conference, Massey University, Palmerston North.

Cheyne,C, O'brien, M, Belgrave, M, (1997) *'Social Policy in Aotearoa New Zealand'* Oxford University Press, Auckland.

Core Services Committee, (1994), *'Core Services for 1995/96'*, National Advisory Committee on Core Health and Disability Support Services, Wellington.

Core Services Committee, (1993), *'The Best of Health 2'*, National Advisory Committee on Core Health Services, Wellington.

Department of Internal Affairs (1997) *'The Use of Discretionary Funding by Government to Fund Innovation and Initiative from the Community'*, A Literature Review., Wellington.

Department of Internal Affairs (December 1999) *Briefing to the Incoming Minister.* Wellington.

Durie, M H (1985) *'A Māori Perspective of Health.'* Journal of Social Sciences and Medicine, 5th edition, Wellington.

Durie, M.H (1991), *The Bicultural Continuum* - The Treaty of Waitangi in New Zealand Society, Study Guide 2, Te Putahi a Toi - School of Māori Studies, Massey University, Palmerston North.

Durie, M.H (1994), *'Kaupapa Hauora Māori: Policies for Māori Health, Te Ara Ahu Whakamua: Proceedings of the Māori Health Decade Hui'*, Te Puni Kokiri, Wellington.

Durie, M H, (1995), *Ngā Matatini Māori: Diverse Māori Realities*, Wānanga Pūrongo Kōrerorero, 14-17 February 1995, Ngāruawahia.

Durie, M.H (1995) '*Principles for the Development of Māori Policy*'. A paper presented at the Māori Policy Development AIC Conference, Wellington.

Durie, M.H (1996) *Characteristics of Māori Health Research*, Paper presented at Te Hui Whakapiripiri, Hongoeka Marae.

Durie, M.H (1998) *Whaiora: Māori Health Development (Second Edition)* Oxford, University Press, Auckland.

Durie, M.H (2000), '*Toi te kupu, Toi te mana, Toi te Whenua – Maori Development in a Global Society Conference*', Closing Speech, Massey University, Palmerston North.

Durie M.H, (2001), *Mauri Ora – The Dynamics of Māori Health*, Oxford University Press, Auckland.

Ernst and Young, (1995), *'Study on the Viability of the Not-for-Profit Sector in New Zealand'*, Wellington.

Fletcher, C (1992) '*Aboriginal Politics*', Melbourne University Press, Victoria.

Florence, J (1996) *'Culture of Partnership to Culture of Contract: Child and family support services contracting with the New Zealand Community Funding Agency'*. Massey University, Albany, Auckland.

Gilbert J, Jones G, Vitalis T, Walker R, Gilbertson D, (1996) '*Introduction to Management in New Zealand*', Harcourt Brace & Company, Australia.

Gillet G; Campbell A. (1993) *Ethical Issues in Defining Core Services - Discussion Papers.* National Advisory Committee on Health and Disability Services.

Health Funding Authority, (1998), *'Māori Health Gains Operating Groups Report to the HFA Board October 1998–2000'*, Wellington.

Hospital and Related Services Taskforce (1988), '*Unshackling the Hospitals.*' A report prepared for the Minister of Health and Finance, Wellington.

Huakina Development Trust, (1994) *Rapua te Oranga Hinengaro,* Pukekohe, Counties-Manukau.

Karetu, T, (1986), *66.101 Te Reo Māori*, Maori Language Department, University of Waikato, Hamilton.

Kingi, Te K R and Durie, M H, (2000) '*Hui Oranga: A Māori Measure of Mental Health Outcome.* ' A report prepared for the Ministry of Health, Te Putahi a Toi, School of Māori Studies, Massey University.

Kingi, Te K R and Durie, M H, (2000) '*Hui Oranga: A Māori Measure of Mental Health Outcome.* ' A report prepared for the Ministry of Health, Te Putahi a Toi, School of Māori Studies, Massey University.

Last, J.M (1998) *A Dictionary of Epidemiology*, (3rd Edit), London HMSO.

MacDonald, K and K Co (1997) '*Community Healthworkers in Auckland'*. Research report for the degree of Master of Business Administration, Massey University, Albany.

MacDonald, K, (1997), '*Community Healthworkers in Auckland*' - An accelerated tertiary training opportunities and bridging programmes will need to be created, and made appropriate, for Māori health workers with no formal qualifications. Research report for the degree of Master of Business Administration, Massey University, Albany.

Maclean. FS, (1964) *Challenge for Health – A History of Public Health in New Zealand.* RE Owen, Government Printer, Wellington.

Manaia, W.L, (1996) *'The Māori Provider Development Project Status Report'*, Māori Health Group - Te Kete Hauora, Ministry of Health, Wellington.

Manaia, W.L, (1996) *'A Māori Health Management Discussion Document'*, He Kamaka Oranga - Māori Health Management Service, Auckland Healthcare Services Limited, Auckland.

Massey University Te Putahi a Toi – School of Māori Studies, (1998), *Te Oru Rangahau - Māori Research and Development Conference*, Palmerston North.

Mathews.J (1996) *Menzies School of Health Research Annual Report 1994-1995.* Darwin, Australia.

McCarthy, P (1995) *'The Contract Crunch.'* Victoria University of Wellington, Wellington.

Ministry of Health, Health Services Directorate, (1992), *Policy Guidelines to Regional Health Authorities*, Ministry of Health , Wellington.

Ministry of Health & Te Puni Kokiri (1993), *Policy Guidelines for Māori Health 1993/94*, Wellington.

Ministry of Health, (1994), *Māori Health Policy Guidelines to the Regional Health Authorities 1994/95*, Wellington.

Ministry of Health (1994*) Te Ara Tohu - Strategic Management Plan for Māori Health 1994-1999,* Wellington.

Ministry of Health and Te Puni Kokiri (1995), *Policy Guidelines for Māori Health 1995/96*, Wellington.

Ministry of Health (1995*) Nga Matatini: Strategic Directions for Māori Health, A Discussion Document*, Wellington.

Ministry of Health,(1995), *Co-ordinated Care for Māori: Issues for Development*, Wellington.

Ministry of Health, Te Kete Hauora, Māori Health Group, (1996) *Māori Provider Development Project Status Report*, Wellington.

Ministry of Health (1996) *Māori Health Policy Guidelines for Regional Health Authorities - 1996/97,* Wellington.

Ministry of Health, Māori Health Group – Te Kete Hauora (1996) '*Māori Bureaucratic Hypothesis - Strategic Planning Meeting*, Portland Towers, Wellington.

Ministry of Health, (1996), *Our Health, Our Future – Ministry of Health Strategic Business Plan,* Wellington.

Ministry of Health, (1997) *Review of Regional Health Authority Strategies for Improving Māori Health Status*, The Performance Management Unit & The Māori Health Group - Te Kete Hauora, Wellington.

Ministry of Health, (1997) *Māori Provider Reference Committee Hui Report*, Tapu te Ranga Marae, Wellington.

Ministry of Health, (1999), *Briefing for Incoming Minister of Health - Facts about Health and Disability in New Zealand*, Wellington.

Ministry of Health, (2000), *Māori Participation in the New Zealand Health Workforce: Draft Report,* Wellington, Ministry of Health. (Unpublished.)

Ministry of Health, (2001), *He Korowai Oranga, The Māori Health Strategy*, Wellington.

The Ministry of Māori Development – Te Puni Kokiri (1991), Ministerial Planning Group, *Ka Awatea,* Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1993), *Ngā Ia O Te Oranga Hinengaro Māori - Trends in Māori mental health: A discussion document*, Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1994), *Mā te Māori e Puri te Maimoatanga Māori: Managed care for Māori,* Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1994), *Ngā Mahi Kakama Mātua Māori mō te Tiaki Hauora: Māori Primary Health Care Initiatives*, Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1995), *Mā te Māori e Puri te Maimoatanga Māori: Managed care for Māori – A discussion document*, Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1995), *Health Through The Marae,* Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1995), *Oranga Niho*, Wellington.

Ministry of Māori Development – Te Puni Kokiri, (1997), *Review of the Ministry of Health*, Monitoring and Evaluation Branch, Wellington.

Ministry of Māori Development - Te Puni Kōkiri (1999), '*Discussion Paper on the Review of the Māori Community Development Act 1962'*, Wellington.

Ministry of Māori Development, Te Puni Kokiri, (2001), *Strategic Business Plan*, www.tpk.govt.nz., Wellington.

National Party / New Zealand Party, *Government Coalition Agreement',* Wellington.

New Zealand Health Board, (1988), *Priorities for the New Zealand Health Services*, New Zealand Board of Health, Wellington.

New Zealand Employment Service,(1990), *New Zealand Employment Service Annual Report,* Wellington.

Office of the Auditor General of Canada, (1996), '*Report of the Auditor General of Canada on the State of Accountability Practices from the Perspective of First Nations,* Toronto, Canada.

Office of the Health and Disability Commissioner, (1996), *Code of Health and Disability Services Consumers Rights & Regulations,* Wellington.

Orange, C, (1987), *The Treaty of Waitangi*, Bridget Williams Books Limited, Wellington.

O'Regan, T (1988) *Maori development and devolution*, In Martin and Harper (eds.) *Accountability and Devolution: Proceedings of the 1988 Conference of the New Zealand Institute of Public Administration*, GP Books, Wellington.

Osborne, D. and Gaebler, T, (1992), *Reinventing Government – How the Entrepreneurial Spirit is Transforming the Public Sector*, Addison Wesley.

Parata H, & Durie M.H, (1993), *Māori Health Review*, Ministry of Health, Wellington.

Penner, K, (1992*) Their own place: The case for a distinct order of Indian First Nation Government in Canada.* In Long and Boldt (eds.), *'Governments in Conflict: Provinces and Indian Nations in Canada'*, University of Toronto Press, Toronto, Canada.

Peters, Winston, (1991) *Ka Awatea – An evaluation report for the Minister of Māori Affairs,* Wellington.

Pickup, D, (1995) *He Kamaka Oranga Scholarship Award Speech*, Auckland Healthcare Services Limited, Auckland.

Pomare, E.W., Keefe-Ormsby. V, Ormsby C, et al. (1995), *Hauora: Māori Standards of Health, A study of the years 1970–1991,* Te Ropu Rangahau Hauora a Eru Pomare, Wellington.

Public Health Commission, (1995), *He Matariki: A strategic plan for Māori public health: The Public Health Commission's advice to the Minister of Health, W*ellington.

Ropiha D, (1993), *Tipu Ora: Programme evaluation: Final report,* Department of Health, Wellington.

Schick, A (1995) '*The Spirit of Reform',* Report prepared for The State Services Commission and the Treasury, Wellington.

Seedhouse, D (1993) *Ethical Issues in Defining Core Services - Discussion Papers.* National Advisory Committee on Core Health and Disability Services, Wellington.

Smith, V M (1996) '*Contracting for social services: the changing relationship between government and the voluntary sector in New Zealand'.* Victoria University of Wellington, Wellington.

Statistics New Zealand, (1999), '*Māori Now*', Wellington.

Statistics New Zealand, (1999), *Measuring Māori Ethnicity in the New Zealand Census* - Summary, Statistics New Zealand, Wellington.

Steering Group to Oversee Health and Disability Changes to the Minister of Health and Associate Minister of Health, (1997) *Implementing the Coalition Agreement on Health – The report of the Steering Group to Oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health,* Wellington.

Townsend P; Davidson N. (1982) *Inequalities in Health,* Hammondsworth, Middlesex: Penguin.

United States General Accounting Office, (1999), *Indian Self-Determination Contracting: Shortfalls and Alternatives for Funding Contract Support Costs,* Testimony before the Committee on Resources, House of Representatives, Washington DC

University of Auckland, (1998), *Nurse Training Module Guidelines*, Faculty of Medical and Health Sciences, Auckland.

University of Canterbury , (1996), *Cultural Safety Guidelines for Nurse Training*, Faculty of Medicine, Christchurch.

Voyle, J and D Simmons (1999) *'Community development through partnership: Promoting health in an urban indigenous community of New Zealand'*, Social Science and Medicine Journal 49.

Waitangi Tribunal, (1998) *'Te Whānau o Waipareira Report'*, GP Publications, Wellington.

Walker, R (1996) *'The Walker Papers - Science, Intellectual Property and Cultural Safety'*, Oxford University Press, Auckland.

Weiner, JP and Ferris, (1990) DM. GP *Budget Holding in the UK: Lessons from America*, Kings Fund Institute: London.

Woodward A; Kawachi I, (1998) *Why should we reduce Health Inequalities?*, A paper prepared for the National Health Committee, Wellington School of Medicine, Wellington.

Workman, K, (1999), *A Māori Provider View of HFA and CFA / CYPFS Performance: A Draft Scoping Report to Te Puni Kōkiri.* Wellington. (Unpublished paper)

World Economic Forum & Lausanne's Institute for Management, Geneva (1995), *'The World Competitiveness Report'*. An annual report based on data about economic performance of OECD countries. A 129 item questionnaire to 16,500 business executives, public officials and opinion leaders world-wide.

World Health Organisation, (1991). *Global Strategy for Health for All by the Year 2000*, Geneva.

APPENDIX A:

THESIS RESEARCH RESPONDENTS AND INTERVIEWEES

POLICY AND PURCHASING AGENCIES

1. The Ministry of Māori Development - Te Puni Kokiri.
2. Ministry of Health Māori Staff.
3. The Māori Provider Reference Committee.
4. Northern Regional Health Authority Māori Staff.
5. Midlands Regional Health Authority Māori Staff.
6. Central Regional Health Authority Māori Staff.
7. Southern Regional Health Authority Māori Staff.
8. Tainui Māori Co-Purchasing Organisation.
9. Ngati Whatua Māori Co-Purchasing Organisation (Tihiora).
10. Taitokerau Māori Co-Purchasing Organisation.
11. A Ministry of Health Māori Manager.
12. A Ministry of Health Māori Senior Policy Adviser.
13. A Ministry of Health Māori Senior Policy Analyst.
14. A Regional Health Authority General Manager of Māori Health, Auckland.
15. A Regional Health Authority Manager of Māori Health, Auckland.
16. A Regional Health Authority Manager of Māori Health, Wellington.
17. A Regional Health Authority Manager of Māori Health, Hamilton.
18. A Regional Health Authority Policy Analyst, Dunedin.

MAINSTREAM SERVICES

1. A Mainstream Māori Health Management Service, Green Lane Auckland.
2. A Mainstream Māori Health Service, Grafton, Auckland.
3. A Mainstream Māori Health Service, Papatoetoe, South Auckland.
4. A Mainstream Māori Mental Health Service, Wanganui.

5. A Mainstream Māori Health General Manager, South Auckland.
6. A Mainstream Māori Strategic Projects Manager, South Auckland.
7. A Mainstream Māori Mental Health Service Manager, West Auckland.
8. A Mainstream Māori Mental Health Service Manager , Tauranga.
9. A Mainstream Māori Mental Health Service Manager , Palmerston North.
10. A Mainstream Māori Community Health Service Manager, Wanganui.
11. A Mainstream Māori Health Service Manager, Rotorua.
12. A Mainstream Māori Health Adviser, Dunedin.

MĀORI HEALTH SERVICE PROVIDERS

1. Māori Health Trust, Hokianga, Northland
2. Iwi Health Service Provider, Kawakawa, Northland.
3. Urban Māori Authority Health Service Provider, Henderson, Auckland.
4. Marae based Māori Medical Health Service, Orakei, Auckland.
5. Marae based Maori Health Service, Mangere, Auckland.
6. Marae based Māori Health Service, Papakura, Auckland.
7. Māori Community Mental Health Service, Otahuhu, Auckland.
8. Multi-Contract Māori Health Service Provider, South Auckland.
9. Māori Mental Health Residential Service Care, South Auckland.
10. Marae based
11. Māori Mental Health Management Service, Hamilton.
12. Māori Medical Health Centre, Waikato.
13. Māori Child Health Service, Rotorua.
14. Māori Mental Health Service, Tauranga.
15. Iwi Health Authority, Wanganui.
16. Māori Community Health Service, Masterton.
17. Māori Community Health Service, Otaki, Kapiti Coast.
18. Māori Health Education and Promotion Service, Christchurch.
19. Maori Disability Resource Service, Christchurch.
20. Māori Mental Health Residential Care Service, Dunedin.

21. Māori Community Health Service, Dunedin.
22. Māori Mobile Dental Health Service, Dunedin.
23. Maori Women's Welfare League Health Education Service, West Coast.
24. Urban Māori Authority Mental Health Service, Invercargill.

APPENDIX B:

Policy Agency Interview Questionnaire.

1. In general, what is your occupation and what do you do within that role?

2. In general, what does your organisation do?

3. What Maori health issues have arisen from within your organisation?

4. What Maori health issues have developed for your organisation since the 1991 health reforms?

5. What changes have occurred within your organisation to address Maori health needs?

6. In retrospect, do you think the National Governments health policies have been good for Maori health?

7. How was your organisation affected by the 1999 election?
    a. What will the Labour Governments policies do for your service?
    b. Which Governments health policies do you prefer – National or Labour?

8. Do you think privatisation strategies in the health sector have been good for Maori health?

9. What other Maori health issues do you consider relevant to this research topic?

10. In regard to strategies for addressing Maori health since the 1991 health reforms, what do you think has worked well, what has not worked well, and what lessons have we learnt?

11. In your opinion, what is effective health service delivery to Maori people?

12. How is the future looking for your organisation?
    a. Where do you see yourself going from here?
    b. What do you perceive as future problems for Maori health?

13. What changes in the health sector would assist you in addressing Maori health?

APPENDIX C:

Purchasing Agency Interview Questionnaire

1. In general, what is your occupation and what do you do within that role?

2. In general, what does your organisation do?

3. What Maori health issues have arisen from within the history of your organisation?

4. What changes have occurred within your organisation to address Maori health?

5. In retrospect, do you think the National Governments health policies have been good for Maori health?

6. How will your service be affected by the 1999 election?
    a. What will the Labour Governments health policies do for your service?
    b. Which Governments health policies do you prefer – National or Labour?

7. Do you think privatisation strategies in the health sector have been good for Maori health?

8. What other Maori health issues do you consider relevant to this research topic?

9. In regard to strategies for addressing Maori health since the 1991 health reforms, what do you think has worked well, what has not worked well, and what lessons have we learnt?

10. In your opinion, what is effective health service delivery to Maori people?

11. How is the future looking for your organisation?
    a. Where do you see yourself going from here?
    b. What do you perceive as future problems for Maori health?
    c. What changes in the health sector would assist you in addressing Maori health?

APPENDIX D:

Provision Level Interview Questionnaire

1) What is the history of your organisation?
   a) How long has it been in existence?
   b) How difficult has it been over the last 10 years?
   c) What Maori health issues have arisen from within the history of your service?

2) What health service/s does it deliver?
   a) How old is the/each service?
   b) What changes have the/each service undergone?
   c) How well (not how much) are the services funded?

3) If your service existed before 1991 - How was it affected by the 1991 health reforms?
   a) What changes occurred?
   b) Were they good for the service?
   c) What Maori health issues arose for your service from the reforms?
   d) What suggestions do you have?
   e) In retrospect do you think the National Governments health policies have been good for Maori health?
   f) Do you think privatisation strategies in the health sector have been good for Maori health?

4) How will your service be affected by the 1999 election?
   a) What will the Labour Governments health policies do for your service?
   b) Which Governments health policies do you prefer – National or Labour?

5) What Maori health issues do you consider relevant to this research topic?

6) What did you do to maintain a Maoritanga kaupapa within your service?

7) In regard to strategies for addressing Maori health since the 1991 health reforms, what do you think has worked well, what has not worked well, and what lessons have we learnt?

8) What do you believe is effective health service delivery to Maori people?

9) How is the future looking for your service?
   a) Where do you see yourself going from here?
   b) What do you perceive as future problems for Maori health?
   c) What changes in the health sector would assist you in the delivery of your service?

APPENDIX E:

CONFERENCES AND SEMINARS WHERE PRESENTATIONS ON THIS RESEARCH WERE MADE FOR DISCUSSION AND FEEDBACK.

Ministry of Health, Māori Provider Reference Committee Hui, (1997), Tapu Te Ranga Marae, Wellington.

Hui Whakapiripiri, Māori Health Researchers Hui, (1997) Whaiora Marae, Otara, Auckland.

Te Putahi a Toi – School of Māori Studies, (1998), PhD Students Seminar, Massey University, Palmerston North.

Tuteao Marae Hui, (1998), Tuteao Marae, Te Teko, Eastern Bay of Plenty.

Kahotea Marae Hui, (1998) Kahotea Marae, Otorohanga, King Country.

Te Putahi a Toi – School of Māori Studies, (1998), Te Oru Rangahau - Māori Development Conference, Massey University, Palmerston North.

Indigenous Peoples Health Conference, (1998), Cairns, Queensland, Australia.

Te Putahi a Toi – School of Māori Studies, (2000), PhD Students Seminar, Massey University, Palmerston North.

Healthlink 2000 Conference, (2000), Toronto, Canada.

Kahotea Marae Hui, (2000) Kahotea Marae, Otorohanga, King Country.

Applied Behavioural Science, (2001) Māori Health Seminar – Alcohol and Drug Studies Post-Graduate Programme, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Auckland College of Education, (2001) Māori Seminar, Te Puna Wananga – Maori Department, Auckland College of Education, Auckland.

Applied Behavioural Science, (2001) Māori Health Seminar – Mental Health Development Post-Graduate Programme, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Māori and Pacific Island Health, (2001) Māori Health Seminar, Māori Mental Health Development Post-Graduate Programme, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Applied Behavioural Science, (2001) Māori Health Seminar – The Management of Opioid Dependency Post-Graduate Studies, Faculty of Medical and Health Sciences, University of Auckland, Auckland.

Health Research Council of New Zealand, (2001) Hui Whakapiripiri, Māori Health Researchers Hui, Ohinemotu Marae, Rotorua.

APPENDIX F:

THE MĀORI PROVIDER REFERENCE COMMITTEE HUI – 5th MARCH, 1997.

The need to conduct this research was identified at this hui. Issues regarding methodology, process and implementation were discussed and incorporated during the compilation of this study. Most of the attendants made contributions to this research at this hui or were directly involved at different stages.

FIRST NAME	SURNAME	PROVIDER	ADDRESS 2
Takatu	Ahomiro	Te Tatau Pounamu JV Board	Te Puke
Mark	Barrett	Te Puni Kokiri	Wellington
Aroha	Biel	Poutiri/Te Puna Hauora Western Bay	Tauranga
Sheila	Cameron	NZCHS	Wellington
Joan	Chettleburgh	NZ Council of Healthcare Standards	Palmerston North
Catherine	Cooney	Lakeland Health	Rotorua
Barbara	Donaldson	NZ Council on Healthcare Standards	Wellington
Cilla	Douglas	Te Puna Oranga	Christchurch
Raewyn	Dowman	NZ Council on Healthcare Standards	Wellington
Sue	Ellis	Ministry of Health	Wellington
Joel	George	Wairarapa Health	Masterton
Jan	Grant	Orakei Medical Centre	Orakei
Barbara	Greer	Ratou MWWL	Hokitika
Ernest	Gripp	Raumano Trust	Patea

Queenie	Gripp	Te Whare Punanga Korero	New Plymouth
Marion	Hakaraia	Te Whanau o Waipereira	Henderson
Ariki	Hamilton	Otautahi Māori Regional Diabetes Society	Christchurch
Connie	Hasson	Te Whakahauora-a-rohe, Healthcare Otago	Dunedin
Kath	Hemi	Te Rapuora o Te Waiharakeke	Blenheim
Erima	Henare	Ngati-Hine Health Trust	Kawakawa
Makere	Herbert	Poutiri/Te Ika Whenua Hauora	Rotorua
Shelley	Hiha	Māori Disabilities & Resource Centre	Miramar
Rangimarama	Hiroti	Te Maramatanga ki Otautahi	Christchurch
Te Maari	Joe	Māori Women's Welfare League	Napier
Riripeti	Joyce	Te Hiiri Hauora Health Services	Papakura
Miriama	Kahu	Te Tai o Marokura Health Services	Kaikoura
Moana	Kennedy	Te Ihonga Hauora	Wellington
Phyllis	King	Putea o Pua	Otahuhu
H. (Joe)	Kingi	Te Rapuora o Te Waiharakeke	Blenheim
Pauline	Kingi	NZ Council on Healthcare Standards	Auckland
Te Wera	Kotua	Puangi Hau	Wellington South
Sharon	Lambert	Wai Health	Henderson
Catherine	Logan	NZ Council Healthcare Standards	Auckland 5
Miriama	Manuirirangi	Te Ara Tuhono JV	New Plymouth
Carol	Marino	Pirangi Hau	Wellington South

Lyvia	Marsden	Awataha Health Clinic	Northcote
Christine	Matangi	The Ngati Hine Health Trust	Kawakawa
Christine	Maxwell	Te Roopu Tautoko ki te Tonga	Moray Place
Toni	McCallion	Queen Elizabeth Hospital	Rotorua
Wiremu	McCrae	Hine Kou Tou Ariki Trust	Napier
Paul	Murchie	Te Oranganui-Hinengaro Hauora	Whanganui 5001
Rewa	Paku	Putea o Pua	Otahuhu
Molly	Pardoe	Te Tahuhu Hau Ora o te Tairawhiti	Gisborne
Jacob	Paul	Te Ara Hou & Te Aturama	Manurewa
Regina	Peretini	Ministry of Health	Wellington
Allan	Pivac	Te Roopu Whakapiringa	Whangarei
Tuari	Potiki	Te Aroha o te Hau Angi Angi	Hamner
Joy	Ripia	Te Tahuhu Hau Ora o te Tairawhiti	Gisborne
Pam	Ritai	Te Whare Punanga Korero	New Plymouth
June	Robinson	Māori Womens Welfare League - Rata	Hokitiki
Lavinia	Robinson	Māori Community Health Worker	Timaru
Anawarihi	Rudd	Te Runanga o Raukawa	Otaki
Metarina	Schenkel	Māori Disabilities & Resource Centre	High Street
Rosemary	Simpson	Te Ohu Whakatapu: Women's Affairs	Wellington
Phyllis	Tangitu	Lakeland Health	Rotorua
Wayne	Taylor	Ngati Koata Trust	Nelson
Aroha	Te Hiini-Bell	Poutiri/Te Puna Hauora Western Bay	Tauranga
Jean	Te Huia	Kahungunu Health Services	Hastings

Deborah	TeKawa	Te Puni Kokiri	Wellington
Linda	Thompson	Te Oranganu Iwi Health Authority	Wanganui
Carmen	Timu-Parata	Ati Awa ki Whakarongotai Inc.	Waikanae
Muriwai	Tukariri-Popata	Te Hiku O Te Ika	Kaitaia
Benita	Wakefield	Roopu Awhi Ora Rehua Marae	
Alayna	Watene	Te Taiwhenua o Heretaunga	Hastings
John	Whaanga	He Kakano Oranga	Wellington
Ngaire	Whata	Poutiri/Korowai Aroha	Rotorua
D	Woodward	Kia Mataara Society Inc.	Te Kao

APPENDIX G:
THE MĀORI PROVIDER REFERENCE COMMITTEE (MPRC)

The following is the list of members to the Māori Provider Reference Committee. The proposal for this research was first developed in discussion with this committee. On-going participation and involvement with members of the MPRC was maintained throughout the duration of this study.

NO	NAME	NAME & LOCATION	SERVICE TYPE
1	**Christine Matangi**	***Ngati Hine Health*** Whangarei (09) 404-1551	Whanau & Well Child Health Care
2	**Jacob Paul**	***Te Ara Hou***, Manurewa (09) 267-9522	Residential Services for Males
3	**Thomas Maniapoto**	***Raukura Hauora o Tainui*** Hamilton, Huntly & South Auckland (09) 270-5860	GP services & Nursing, A&D services, Cervical Screening, Health Promotion & Education, Hapu Promotion etc.
4	**Te Miringa Huriwai**	***Hokianga Health Trust*** Hokianga, Northland (09) 405-7709	Dental Care, Home Help, Attendant Care & Elderly Health Services
5	**Olivia Marsden**	***Awataha Marae*** Northcote, Auckland (09) 489-3049	GP Services and Nursing
6	**Sharon Lambert**	***Waipareira Health*** Henderson, Auckland (09) 836-6683	Maternity, Well Child, Whanau based Services, Mobile Dental, A&D and Cervical Screening.

7	**Ngaire Whata**	***Korowai Aroha Health Centre***, Rotorua (07) 348-8454	Community Support & Kaumatua Care
8	**Aroha Biel**	***Te Puna Hauora***, Tauranga (07) 577-8563	Integrated Māori Health Services (CHE based)
9	**Marama Oti**	***Te Ara Tuhono*** New Plymouth (06) 757-5526	Joint Venture Board Midlands Health
10	**Jo Barnaby**	***Te Puna Hauora o Mataatua*** Whakatane (07) 571-8975	Community Support & Kaumatua Care
11	**Linda Thompson**	***Te Oranganui Iwi Health Authority***, Wanganui (06) 345-5352	G Ps, DSS, Mental Health, Health Promotion & Maternity Services
12	**Alayna Watene**	***Te Taiwhenua o Heretaunga*** Hastings (06) 878-3833	Primary, Mental Health, DSS and Health Promotion
13	**Carol Marino**	***He Puangi Hau*** Wellington (04) 389-6836	Alcohol and Drug Rehabilitation Services
14	**Wayne Taylor**	***Ngati Koata Trust*** Nelson (03) 546-8018	Alcohol and Drugs Services / Disability Support Services
15	**Metarina Schenkel**	***Māori Disability Resources*** Christchurch (03) 365-6886	Disability Support Services
16	**Bonita Wakefield**	***Rehua Marae*** Christchurch	Asthma Education and Health Promotion

		Ph (03) 355-7780	
17	**June Robinson**	***Māori Women's Welfare League***, West Coast (03) 755 – 8737	Asthma Education
18	**Kris Maxwell**	***Te Roopu Tautoko ki te Tonga***, Dunedin (03) 477-4670	Sexual Health and Health Promotion
19	**Witana Murray**	***Uenuku ki Murihiku Urban Māori Authority*** c/o Apartment 6, 145 Esk Street, Invercargill (03) 214 – 0097	Health Consultancy Services