KAUPAPA MAORI AND RESPONSIVENESS

MANAGEMENT RESPONSIVENESS TO MAORI HEALTH ISSUES IN THE REFORMED HEALTH SERVICE OF THE 1990's

A thesis presented in partial fulfilment of the requirements for the degree of

Master of Social Policy

Department of Social Policy and Social Work
Massey University
Aotearoa

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1995

HE TAONGA TE REO

1995

A CELEBRATION OF MAORI LANGUAGE

ABSTRACT

This thesis is about the responsiveness of the health system and health services to Maori needs. It examines the relationship of the Treaty of Waitangi to health and the commitment of organisations to biculturalism in health care provision. It focuses on the poor health status of Maori people and explores the issues of racialism, racism and exclusion as factors in the health and wellbeing of Maori people by drawing on literature, day to day observations and recordings as well as the responses of ten health service managers to the idea of biculturalism and the low status of Maori health.

It takes the position that Maori people have been and continue to be disadvantaged by monocultural attitudes, beliefs and practices in the health system and that managers have the power to change that. The time it was written in was a time of major restructuring in health and encompassed the change from Area Health Boards through the funder provider split to Regional Health Authorities as purchasers and Crown Health Enterprises as providers of services. Change was everywhere, yet the major inequality between Maori and non Maori health status in Aotearoa remained stable. The thesis begins and ends with the Treaty of Waitangi, thus the past becomes the present and the future, for as the Royal Commission on Social Policy notes:

> The Treaty is always speaking. It has relevance to all economic and social policies. Not only must the past be reviewed in the light of its principles, but the Treaty's promise must also be seen as fundamental to those principles, which underlie social well being in years to come. (Royal Commission on Social Policy. Vol. 2.3.-151.)

DEDICATION

This thesis is for the people of the Bay of Plenty

from

Mai Nga kuri a wharei ki Otamarakau

Ka kohi te toi, ka wahi te maramatanga.

If knowledge is gathered, enlightenment will follow.

ACKNOWLEDGEMENTS

Firstly I wish to acknowledge the support I have received from Maori friends and colleagues; especially those in Social Work, Manatu Maori, Te Mana Hauora and Te Puna Hauora. Others too, who were not formally included in the health service. Allowing Pakehas into your lives so that they may learn, is not easy, nor is it without risk. Thank you for staying alongside and for helping me learn where to go and where not to go.

Tena Koutou. Tena Koutou. Tena Koutou.

My supervisors too have been brave and consistent with their friendship, their time and their ideas as I struggled to maintain my pace and direction on the bicultural pathway and when some of what I wished to write did not fit easily within the constraints of an existing university discipline.

Tena Korua Celia Briar and Sarah Calvert.

Te kupenga hao parapara ka kitea

Te Matau aho hohonu

He mana he ihi

E kore e ara te hinga nui

Te kore e whakamatau

The net that skims the surface

gathers what is already seen

The hook line that fishes deep

Grasps the hidden strength and knowledge

But a great catch will not arise

Without a challenge of will and perserverance

This proverb symbolises for Te Tatau Pounamu joint venture Board the challenges that Iwi and the Crown face in attempt to improve the poor health status of Maori.

PREFACE

I am a Pakeha New Zealander. What this means, as Spoonley (1988:4.) has acknowledged, is that, my cultural values and behaviour have been primarily formed from the experience of being a member of the dominant group of New Zealand. The culture I have is my English protestant heritage plus additions from many other sources as I have lived my life here in this country. Michael King (1985) describes some of this process in his book, *Being Pakeha*:

> to be a citizen of Aotearoa in the 1980's and 1990's (my addition), even a Pakeha one, is to be inevitably affected by the enlarging Maori presence and the renaissance of Maori rituals and values . . . something my European ancestors have never experienced. For some, that effect may be limited to fear or rejection of those elements in New Zealand life. For most of us, they will penetrate our consciousness to some extent.

For myself, through the 1980's and earlier, Maori colleagues, friends and guides have provided opportunities for continuing to learn about their culture and mine and for speeding up a change in my beliefs, values and perceptions of the world. This has occurred to the extent, that for some, "the person they're looking for isn't there any more." (Ten Bears in the movie *Dances with Wolves*. 1991.)

I thank them for their patience in helping with the trials and enjoyments of those changes, for the enrichment and for the confidence to engage with others ethnicities about the way society should be structured and for the conviction that New Zealand can become a functioning bicultural society. (Spoonley.1988:67.) With their support I continue to learn and share my perception of a fairer society which supports the right of Maori to be different and where diversity is part of the richness of our development and in the hope that others of my background will become Pakeha.

Broadly, my area of work, interest and action is health. Specifically it is the improvement of Maori health. I work with a Maori health team. I support the kaupapa and my vision is a shared one with Maori people, that we should have as one long term

aim, the elimination of the current disparities between Maori and non Maori health. (Murchie, 1984:85)

As a person and a social worker, I have always felt that living and working and doing are not separate things and that one should try to change things not only, out there in society but in oneself, in the place where one works, and in ones everyday life. Accordingly, I have sought to have a close and competent relationship with myself and with Tangata Whenua.

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INTRODUCTION

> There has been a growing realisation in the health sector over recent years that Maori and non Maori people are not receiving equivalent benefit from our health services. While some changes have been made, our services remain essentially mono cultural and often fail to respond to the needs of Maori people. (Pomare and de Boer. 1988:7.)

This thesis is about responsiveness, the responsiveness of the Government's health system to Maori needs. It takes its title from the document called Kaupapa Maori and Responsiveness: An Introduction, developed and published by Manatu Maori in 1989/1991 to assist government agencies meet the Labour Government's Maori Affairs Policy statement that required all Government agencies to become fully responsive to Maori needs by 1994.

The three major factors considered by Manatu Maori as fundamental to Kaupapa Maori were the Treaty of Waitangi, the Government's Maori policy objectives as expressed in Te Urupare Rangapu and the impact of Government and its agencies on Maori. Simply stated, an agency would be responsive when its day to day business reflects the principles of the Treaty of Waitangi, it had achieved the Labour Government's principle objectives as outlined in Te Urupare Rangapu, and later the National Government's objective set out in Whaia te ora mo te iwi, and it had the ability to account clearly for the impact of its activities on Maori. Participation was the critical issue and Maori entitlement to participation (Manatu Maori 1989/199:8.) and to have an influence on the planning, policy formulation and service delivery of those agencies, related to their status as tangata whenua and as a partner to the Treaty of Waitangi. Thus all measures of responsiveness should be consistent with the Treaty.

The achievement of effective participation required that the planning, management and operations of agencies became accessible to Maori so that they could contribute meaningfully to these processes and influence their outcomes. The thesis is therefore

also about the history of the exclusion of Maori people from the mainstream of New Zealand society and from access to appropriate and effective health service.

It is also about my contribution to the struggle for regaining Maori health during twenty years of experience in social work practice, management and research in the health service in Tauranga Moana. Throughout this time I have come to believe that the results of colonisation, mono culturalism, racism and racialism are major causal factors in the relatively unchanging low status of Maori health that has been researched and known about for decades. The pages that follow are not only about substantiating observations but about developing strategies that contribute to a fairer society by achieving improvements in Maori health status for, as Ohia (1989.) notes, good intentions have no value without good outcomes.

At the beginning of my career in health services, I believed the notion that New Zealand was an egalitarian society, where all are equal, no one was poor except by their own doing and our race relations were a good example to the world; where in health everyone had equal access to the kind of service that was universally acceptable and would, since it was decreed by experts and professionals, produce health. I was unknowingly influenced by the values of the dominant culture and in particular by the dominance of the Western medical model in the health field. This is a field in which, as Davis (1981:142.) noted that:

> The ultimate flaw in the medical perspective is the inability to grasp, or, permit, concepts of health maintenance and promotion that lie outside the strictly biomedical or have their focus beyond the individual.

The intervening years in a conservative organisation, in a profession whose values purportedly arise from the issues of social justice, and whose practice is anchored in empowerment and reform, have provided ample opportunity to observe, examine, ponder and act on some of those early untruths as they increasingly failed to make sense of my world. This led to an increasing interest in the politics of health so that in particular, I have found it necessary to ask questions about health policies and a health

service that excludes the values and preferences of Tangata Whenua, and where constant change and new ideas and options were simply a reordering of the same mono cultural ideology. I have raised questions also about an organisation that had many Maori clients and almost no Maori staff, and which was being described by Maori as unresponsive to their needs. Statistics, as well as day to day observations in practice showed large discrepancies between Maori and non Maori health. Maori people were saying that in all aspects of health as we measure it, Maori have always been and still are, worse off than Pakeha.

This background has led me to an awareness of the discrepancy between what Tauiwi were saying and doing, what Maori were saying and requesting and that Maori were not having their health needs met under the terms of the Treaty of Waitangi. This awareness led me to the interest in investigating the nature of the obstacles to Maori participation in the development of the health system and the delivery of culturally appropriate and effective health services. The aspects which began to emerge as having possible significance in relation to the poor status of Maori health were the attitudes of Pakeha managers to the inclusion of Maori in policy and planning and the role played by constant change.

The motivation to record my interest into action by doing a formalised study arose as a result of the 1984 Labour Government's renewed emphasis on the Treaty of Waitangi, the role of Manatu Maori, in monitoring the changes for Maori people and my opportunity of a two week placement there working alongside the monitoring team in the social an cultural resources unit just as the measures of responsiveness were being developed late in 1989. As well, opportunities in that time to work alongside Maori people both in their world and mine, and academic study have all contributed to my active support of kaupapa Maori. It was the culmination of those things that further consolidated my learning and led to this study.

THE STRUCTURE OF THE THESIS

There are five main parts to this study. Because the face to face interviews with managers form central chapters they have tended to assume something of a focus. It is therefore important to note that the order of data collection and format of the document does not imply that one sort of information is more important than another. They were of equal importance in testing the implications of policy and management decisions on Maori health. Part one locates the ideas and the work of the research in the context of the Treaty of Waitangi, the influence of which is acknowledged in terms of the past, the present and future. The issues of the Treaty of Waitangi and the relationship between Maori and Pakeha that are inherent in it, are central to it and give it substance. It also discusses Maori health status and explores the circumstances that affect it. Some of the issues arising from researching Maori health are also included. The final pages of this section focus on the reform of the health system. At the time of the study, the health reforms were well advanced and I continued with it through the change from Area Health Boards to Crown Health Enterprises, Regional Health Authorities and the introduction of a managed health service. The process of change itself was found to have a particular impact on Maori participation and is highlighted.

Part two consists of three chapters which form the literature review. Each of the three chapters represents a particular perception for responsiveness: management, Maori and the literature of the "New Times" that were heralded with the health reforms. Part three contains the methodology and has a short introduction which leads to my discussion about choosing the research topic. In part three I also describe the central focus of the research, the selection of subjects, the process, some ethical issues that were considered, and the pilot study. Part four begins with a description and discussion of the interviews with managers and includes an outline of the other data that was collected and the ways in which it was collated and analysed.

I have devoted part five to the content of the interviews with the managers, set out their responses in the categories of the questionnaire and summarised the results. Part six is about the other data that was analysed as part of the ethno methodological method. Each of the chapters in this section represents aspects of day to day practice in a Crown Health Enterprise.

In part seven I have written about the themes that emerged as the study proceeded and focused on areas that present obstacles to Maori health development.
The final section is about the effects of biculturalism in health and about new and irreversible change in the ways of delivering health services and about my support for kaupapa Maori and tino rangatiratanga in health.

PART ONE:

THE CONTEXT OF THE RESEARCH

CHAPTER 1

DEFINITION OF CONCEPTS

In the preface and introduction to this thesis, I used the terms biculturalism, responsiveness and Tino Rangatiratanga. These terms all cluster around the central ideas and meaning of the thesis and are therefore important to discuss, however briefly, given that different readers have different ways of interpreting the world.

Biculturalism was used in the context of the belief that New Zealand could become a functioning bicultural society. However, there are different definitions and understandings of biculturalism, most of which range around the notion of social and cultural partnerships which in turn involve the understanding and sharing of values. Some include the accountability of institutions in meeting the needs of Maori. The definitions are important as they have different political implications as different priorities are placed on different aspects, for as Harre Hindmarsh (1993:483) noted:

> Policies and practices in the name of biculturalism have rarely addressed the dynamic of "power". Who decides? In whose interests? On what basis? The answers to these questions have rarely changed when followed to their ultimate conclusion. In the name of partnership, biculturalism has often continued to preserve the ultimate power of Pakeha as "senior" partner and to oppress the power of Maori, to treat them as the "junior" partner.

As Spoonley (1988:104) identified, there has always been a tension between those who support multiculturalism and those who see bicultural issues as of immediate importance and he suggests that any advocacy of multicultural policies in contemporary New Zealand should be questioned because the central issue is the unequal relationship between the dominant Pakeha group and Maori as tangata whenua. Multiculturalism is a soft option politically. It emphasises the plurality and diversity of cultures and often emphasises the need for "mutual tolerance" (Spoonley.1988:104)

Multiculturalism which invites State agencies to be aware of the variety and diversity of minority ethnic groups rather than inspect the institutions of society also diluted the focus on Maori as Tangata Whenua by regarding them as just another group in the population. The Midland Regional Health Authority (1993:2) announced this approach in a news release about its regional community health survey to help plan future health services in the area where Dr Sceats was quoted as saying that:

> The survey would look at the regional community as a whole and was not based on age or ethnic considerations. We are not looking at the needs of any particular group so no group is singled out or given an unbalanced say in the survey. This is a true random sample with everyone having an equal chance of being selected even if they live five kilometres up a mountain.

The Midland Regional Health Authority (1993:3) has in its Mission declared a commitment to promoting the wellbeing of Maori in accordance with the Treaty of Waitangi, a statement which implies biculturalism. Nevertheless its practices have illustrated that any such broad ranging definition of biculturalism encourages multiculturalism and allows for an escape from the conditions of the Treaty which is an agreement between the Crown and the Maori people. No other ethnic group has such an agreement, and in fact other groups have entered New Zealand under the auspices of one partner: the Crown.

The term 'bicultural' as Spoonley uses it was considered a disciplined and useful one as it has the potential to address the issue of power. When used in this study, it is this following meaning that is intended:

> There are different definitions of biculturalism, but central to most is the ambition of establishing Maori and Pakeha as groups of equal standing rather than one being subjugated by the dominance of the other. (Spoonley.1988:105.)

The terms of **partnership** and **participation** were two of the three principles recommended by the Royal Commission on Social Policy (1988: 47 - 69) as relevant to social policy and the Treaty of Waitangi. The word partnership was found to be often used in documents written for health organisations but also one that was imprecisely defined. The Bay of Plenty Area Health Board chose Partnerships in

Health as its slogan and whilst it made no initial definition as to what partnership meant it noted (1991:2) that:

> Partnerships take many forms. On some occasions we lead, on others we follow. At times we work closely with our partners, at others we act independently. Consultation with our communities and staff is an ongoing commitment of the Board and this is evidenced by the consultative networks that have been established. Such networks include: Te Whanau Poutirirangiora a Papa, the Regional Maori Health Authority which helps us develop a greater understanding of Maori perspectives and visions for a bicultural approach to service design and delivery.

The Penguin English Dictionary (1973:515) defines a partner as a sharer in an act or enterprise. Durie (1988:285) writes of partnerships and participation in relation to Maori health and (1994:3) of the partnership between Maori and the State, saying that:

> While the parameters of partnership range from devolution to mutual consultation, they have in common an acceptance of the Treaty of Waitangi as a basis for shared responsibility for Maori health and a joint commitment to the elimination of inequalities.

It is common acceptance of the Treaty of Waitangi that is the basis for the use of the word partnership in this study.

Participation, as Durie (1994:88) noted, refers to Maori involvement in a particular activity or sector. In the past Maori have in the main been excluded from participation in the health sector both, in the areas of professional practice and at policy and planning levels. Government has focused on this aspect of responsiveness to Maori health development in the documents Whaia te ora mo te Iwi (1992:21) which states an intention to address the issue of greater participation of Maori people at all levels of the health sector and this key feature is reiterated in the Maori policy Guidelines for 1995/96. Cautions about opportunities for genuine participation have been raised by Te Puni Kokiri (1993:66) who alerted Maori to the risks of the tokenist practice of appointing a Maori to a board or committee expecting that they will represent Maori. The ministry emphasised that:

> Effective Maori participation is not satisfied by the appointment of Maori individuals to boards or committees. New government structures should ensure that there are mechanisms in place so that representative Maori views can find full expression.

The other problem affecting Maori participation has been the Pakeha habit of inviting Maori to make comment on policies, plans and documents when they are already drafted or even in the final stage of development. This is not participation. Participation is required from the outset, through exploratory meetings, working parties and strategic planning hui. That is, from the beginning of a process, so that Maori can speak for themselves and contribute from their own perspective, for as Hohepa (1978:104) has noted:

> In the past, the request of Maori orators in a public forum often lose their significance and relevance when toned down in translation and filtered through a white mind.

Both concepts, partnership and participation are critical to the understanding of Maori development, for they continually raise the issues of tokenism and paternalism both of which are major contributors to monoculturalism and the continued enhancement of Pakeha dominance and the status quo. Tokenism and paternalism are always present in organisations of the Crown where Maori struggle to gain access to participation and partnerships that are more than nominal, slight or inadequate.

As well as the general examples given earlier in the definitions it is useful to highlight other practices which continue, as Sharp (1990:239) noted to submerge Maoridom. In health services there is the now regular "ordering" of Maori blessings by Pakeha are merely superficial facades to advertise to the world that Maori really are involved and do not lead to any changes in service structures or delivery. The use of one Maori on staff appointments panels without the necessary power of veto and the decoration of first line places of service contact with minimal Maori language or art a tokenistic change that does not lead to the recruitment of Maori front line staff who could genuinely improve Maori access to the health system.

Similarly, with paternalism where Pakeha continue to oppress Maori by speaking on their behalf and make decisions for them as though they were unintelligent, childlike

and incapable. The result of this was discussed by Williams (1990:251) who wrote that:

> We have neither power nor freedom, and the direction we are heading is being manipulated by those who own the capital and the technology, as well as those who wield political power. Maori are not interested in being "colour consultants". We are ready to make our own way in the world, but we want to take our equitable share of resources with us to do so.

Responsiveness was the term used by Manatu Maori in developing a set of guidelines and measurements to assist agencies in becoming fully responsive to Maori needs by 1994. Simply stated, a government agency will be responsive when its day to day business reflects the principles of the Treaty of Waitangi, it has achieved the principle objectives as outlined in Te Urapare Rangapu and it has the ability to account clearly for the impact of the organisation on Maori. Responsiveness entails establishing whether Maori interests are being responded to.

In its post election briefing to the Minister of Maori Affairs (1990:40) Manatu Maori noted that to date, Maori health had been viewed in a context which was influenced by economic, political, social and cultural environments that could either stifle or encourage the attainment of Maori health outcomes and the dominance of one set of assumptions over another equally valid set. It was with regard to correcting this situation that the focus was placed on accountability and measurements. Many have seen responsiveness as an imprecise measure, but its use in the study is quite specific. It incorporates management and agency behaviour that is innovative, timely, credible, feasible, defensible and relevant. It is innovative with regard to the movement away from a totally mono cultural approach and from the tokenism and paternalism inherent in that approach; timely in terms of the urgency of the evidence presented nationally and locally about Maori health, credible in terms of the acknowledgement of Tangata Whenua status, feasible in meeting Maori needs, relevant in relation to need and methods of delivery and defensible with regard to consistency with the Treaty of Waitangi.

In the study, responses that revealed attitudes or demonstrated knowledge and practice that matched in any of the categories were used as a measure and in particular Maori participation in the political process. Responsiveness implies some changes in the roles and relationships in the State Sector, the most significant being the introduction of the view of Maori into Government activity. Its central focus is the commitment to the Treaty of Waitangi and the principles of partnership and good faith. In the context of monitoring and evaluating responsiveness of Government agencies, the Treaty of Waitangi gives recognition to the relationship between the Crown and Maori, acknowledges the reciprocal obligations and duties and determines what has to be provided by agencies in the attainment of equity for Maori:

> Maori people have consistently measured the performance of Pakeha institutions against the Treaty and they will continue to do so. Thus all measures of responsiveness should be consistent with the Treaty. (Manatu Maori. 1989/1991:3.)

Tino Rangatiratanga is a concept that was always there for Maori. It did not begin with the Treaty. While the use of the actual word in the last one hundred and fifty years may be new, the concept which it represents in a Maori cultural and political context is not. Rangatiratanga is ancient and derived from tipuna. It was first formally acknowledged by Tauiwi in 1835 when as a result of missonary concern over the drunk, debauched and licentious conduct of Europeans who had settled in New Zealand, thirteen leading chiefs in the North petitioned the king of England to provide some form of control over British nationals in New Zealand and protection from the possibility of other foreign intervention. The resultant Declaration of Independence was signed at Waitangi in 1835 by a group of Northern and several prominent North Island chiefs. Two critical events pertaining to this are the meeting with James Busby in 1834 which as Walker (1990:88) noted:

> concluded with a ceremony hoisting the chosed (Maori) flag beside the Union Jack, an act signifying recognition of Maori sovereignty over New Zealand.

Further, Walker (1992:18) elucidated that the Maori translation associated the phrase "mana over land" with sovereignty and kingship and that the term Tino Rangatiratanga was thus translated to mean sovereignty. The continuing nature of

rangatiratanga was reflected in the consensus of Maori views presented to the Royal Commission on Social Policy (Vol 3:22) in 1988. It noted that rangatiratanga and mana are inextricably related, and rendered "rangatiratanga" as authority, and then "tino rangatiratanga" as full authority. It implies mana (power, authority, sovereignty) and the two are inseparable.

However, as noted in Te Whakamarama (1991:8.2) the notion of rangatiratanga has been subjected to so much discussion and definition by the Crown that its true meaning is often lost:

> In a welter of Pakeha legalese. In the current discussion about the notion of rangatiratanga, many people limit the korero to the Treaty. They then assume that the concept was both created by, and limited to the terms of article two. In fact of course, the authority of rangatira and the power they wielded, had existed for centuries. The Treaty acknowledged that fact: it did not, indeed it could not, create or restrict it.

In its simplest sense, Maori see rangatiratanga as independence, and that understanding is used in this study.

International issues are now of increasing importance and Te Puni Kokiri (1993: We Are Aotearoa) included in the section of their package called, Who are the World's **Indigenous Peoples**?, offer information that assists those who may still remain unaware of the social and cultural networks reactivated out of a shared sense of oppression and a renewed cultural identity that now constitute a political movement, an international movement that is called Indigenous. The package published to mark International Year for the World's Indigenous People 1993 observed that Indigenous peoples are descendants of the original inhabitants of many lands, strikingly varied in their cultures, religions and patterns of social and economic organisation.

Further, that despite their diversity they face similar problems with regard to the spread of colonialism and Christianity, the erosion of their culture, land and knowledge base. Growing awareness of unequal status, particularly since World War

2, has led Indigenous Peoples around the world to increase their levels of activism in a growing political and organisational competence in order to address critical issues of concern such as, land and resources, human rights, self government, self development, health education, cultural survival, intellectual property rights and social and economic conditions.

As part of this activism, Indigenous Peoples have been demanding justice from the international community for many years and have become active in the international diplomatic arena, seeking respect for the cultures and full participation in the decisions that affect them. The United Nations Working Group on Indigenous Populations reviews government policies which protect the human rights of indigenous peoples and makes recommendations on the prevention of discrimination and the rights of minorities.

The 1993 International Year for the World's Indigenous Peoples was proclaimed by the United nations general Assembly "to strengthen international co-operation for the solution of problems faced by indigenous communities in areas such as human rights, the environment, development, education and health."

At the request of Indigenous Peoples around the world United Nations General Assembly has declared the decade beginning December 1994 the Decade of Indigenous Peoples.

BEFORE THE TREATY OF WAITANGI

Prior to the coming of the Europeans, as Walker (1990:9) noted:

> The Maori have lived in isolation for a thousand years when the advance party of colonisation, the navigators, whalers, sealers and traders came upon them in the late eighteenth century.

They found a people and a society where personal, social, economic and political security was based on a close spiritual and material relationship between them and their land and as Oliver (1981:3) recorded:

> They valued the land not only as a source of food and raw materials but also because of its permanence and connection with their ancestors.

These early colonisers were welcomed by people of the land, the Tangata Whenua into a world of Maori values, beliefs, language, traditions, institutions, ways of living and interpreting the world. Maori was the dominant value system.

However in 1835 and 1840, two key events occurred that have Ruwhui (1994:508) observed have:

> Been earmarked as cornerstones that helped to establish this nation, and set in motion, conflicting processes between Tangata Whenua and Tauiwi in the struggle for sovereign rights in Aotearoa.

Those events were the Declaration of Independence and the Treaty of Waitangi. Both documents gave full recognition to the status of Tangata Whenua and the relationship with non indigenous "others". Hall (1992:256) described the development of race relations such as those between Tangata Whenua and Tauiwi in terms of belongingness and otherness and asserted that:

> Racism, of course operates by constructing impassable symbolic boundaries between racially constructed categories . . . along this frontier arises the discourses of the "other" - of imperalism, the colonised, orientalism, the exotic, the primitive and folklore.

The Declaration of Independence was signed in 1835 according to Busby, the King's representative at the time, to secure protection from the French who were also seeking to lay claim to Aotearoa, allow for the creation of a flag and to ensure the sovereign power of the hereditary chiefs. Ruwhiu (1994:509) emphasises that it was the first genuine attempt to create a single voice for Maori in the political terrain, when dealing with "dominant outsiders" and that it was established before the signing of the Treaty of Waitangi in 1840, evidence that acknowledges Maori sovereign rights over Aotearoa.

Jackson, S. (1989:570) addressed this issue when he stated with regard to some of the main events of colonisation:

> I think the main point to make is that we went to Waitangi from a position of strength . . . Our tipuna, from their writings of time, despised the behaviour and general decorum of those early colonisers. It is inconceivable that they would have just agreed to hand over power to them.

THE TREATY OF WAITANGI

The Treaty of Waitangi is an agreement between the Crown and the Maori people -a special contract between two nations. No other ethnic group has such an agreement. The signing of the Treaty by both Maori and Pakeha was seen as the recognition of equals and the basis of the relationship between two races, yet it has been traditionally understood and regarded very differently by the two parties. While it achieved for the British:

> The justification for claiming sovereignty over New Zealand, the clauses apparently protecting the interests of Maori carried little weight in the designing of legislation and procedures regarding Maori land and political participation. (Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare.1986:12.)

For the chiefs signing, what they thought they gave, and what the coloniser claimed were separated by an abyss that was to have cataclysmic consequences for the Maori people. Although some chiefs, notably those of Tainui and Tuwharetoa, were suspicious about the extensive efforts made in the collection of signatures for the Treaty in all parts of the country and refused to sign, the final total of over five hundred signatures allowed the coloniser to initiate process of undermining the structures of Maori society by the application of his own principle of majority rule and to begin to consolidate sovereignty and work towards the whole country being brought under the domination of the Crown.

Acquisition, control and ultimately the expropriation of land were the key factors in the consolidation of sovereignty and political domination for as Yensen (1989:67)

observes, a culture loses its viability and is no longer able to meet its people's needs when it's economic base is destroyed. Subsequently, policies aimed at redefining land ownership, converting a communal culture to an individualistic one, fostering new forms of leadership and educating Maori children out of their Maoriness were rooted in the colonising concept of "assimilation". Orange (1987:2) notes with regard to colonising attitudes and intentions, that in the years leading up to the Treaty, the British humanitarian movement was at the peak of its activities and the humanitarians shared a conviction that the trusteeship of native races should be complementary to the expanding British Empire. This was expressed in a concern to protect the native races from the worst effects of uncontrolled European contact-disease, loss of land, and depopulation. This "salvation", however:

> Was not intended to preserve traditional Maori society but ultimately to destroy it and to amalgamate Maori with the settler community. The Treaty laid the basis for this amalgamation.

Various legal and other means were employed to gain access to land that was in Maori ownership and to strip the land of its economic, social and political importance for the Maori. For example, the Royal Charter issued for Governor Hobson in 1840, gave the Governor power to survey the whole of New Zealand and divide it up into districts, towns and parishes with reserves set aside for such amenities as roads and schools. The Charter also made provision for grants of "waste land" which could be given to private persons or corporate bodies and since there was no "waste land" it could only be construed to mean Maori land. (Walker.1990:96) Land had to take on a new role, that of individuation and private property and it is the alienation that occurred in this process that has been so influential in ongoing relations between Maori and Pakeha. The loss of land stripped Maori of their cultural base and is considered by some Maori to be the ultimate weapon that colonisers have used against them:

> At the heart of our experience of Pakeha institutions has been the alienation of our lands. It was the primary driving motive for the development of "responsible" Government in Aotearoa. It was the "take" that brought us into armed conflict with the Pakeha and it remains a primary source of tension between us today. It is the taproot of our modern dependency.

> (Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare.1986:5)

Others such as educationalist Smith (1993:218) has argued that the most ultimate weapon in colonisation was in fact the way that the colonisers sought to colonise the minds of Tangata Whenua and thus legitimate further the retention of a society based in the exclusion of Maori. To illustrate her point she focused on the devastating impact that monocultural schooling has on Maori and the critical political reality that the dominant ideology has been internalised by many Maori.

Jackson, S. (1989:47) has also spoken out strongly about what he considers the violence that is perpetuated against Maori through the education system that:

> Actively discriminates against us and ensures that we fail in it. It is also geared to annihilate us psychologically and to colonise our minds.

For this level of alienation to take place, the substance of the Treaty had to be discarded and although some were suspicious, as Walker (1990:96.) notes, the chiefs were not to know that nation building in the period of European expansion was predicated on the destruction of the first nations. Maori views have been clearly and strongly stated since the document first appeared. This voice, whilst constant and unceasing, has often gone unheeded, particularly by those in power. Orange (1987:3) observed that as the structure of New Zealand's colonial society emerged rapidly after 1870, the Treaty dropped from settler consciousness and that successive Pakeha Governments, if they thought about the matter at all, simply assumed that full sovereignty had been acquired by the Crown in 1840, and that it was to be exercised by parliament without impediment. Much that these Governments and their agencies did penalised Maori, who, lacking power, economically, politically and socially after the land wars, held to the Treaty as the foundation stone of hope for the redress of wrongs. Although as Oliver (1991:8) stated, Pakeha could, and still do, forget the Treaty and explain it away when they were reminded of it, Maori could not because

as the Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare (1986:5) observed:

> In the Maori perspective of our history since 1840 the dominating theme is the interaction of our two cultures.

The Treaty of Waitangi is a document about equality and social justice. It is about what Sharp (1990:7.) called:

> distributive biculturalism, that is, the responsibility to protect Maori interest and where necessary, to redress grievances and the responsibility to ensure that Maori people enjoy all the rights and privileges of citizenship.

Maori resistance to the injustices of colonisation has always existed and Maori people have always participated in the debates and issues arising from the Treaty of Waitangi. As Ruwhiu observed:

> Be they social, political or economical those issues have remained a constant talking point during many post-Treaty hui held on marae around Aotearoa.

The resistance has been substantiated over time by various forms of protest that have included petitions, isolationism, political strategies and civil disruption. In the past three decades the encounters between Tangata Whenua and Tauiwi have been significantly dramatic, as recognition of the status of the Treaty of Waitangi has taken centre stage in New Zealand political, social and economic affairs.

From the 1970's, the demand that the Treaty be respected, even heeded and perhaps implemented have come to the fore as major disadvantages of Maori in health, education, housing, employment and access to services have become more apparent. Young Maori people especially, were politicised by their own disadvantages, by the example of the American Civil Rights Movement, by decolonisation and nation building in the Pacific and by the interest the United nations took in indigenous peoples.

Whilst some small changes have been made and there is a perceptible shift of opinion amongst some Pakeha, change is by no means universal or deep rooted and nothing

even fair and decent has any chance of survival and vitality unless the values and beliefs current in society give it support. As far as Maori were affected, as Oliver (1991:4) noted, those values and beliefs, in the powerful part of New Zealand society, have for the most part not been supportive of fairness and decency. The Bishop of Aotearoa gave meaning to the Maori experience of this in his speech at the commemoration of the signing of the Treaty of Waitangi in 1990, when in the presence of another British monarch, he said:

> That since the signing of the Treaty 150 years ago, the ideology of individualism, competition and inequality have prevailed. I want to remind our partners that you have marginalised us. You have not honoured the Treaty. Since 1840, the partner that has been marginalised is me . . . the language of this land is yours, the custom is yours and the media by which we tell the world who we are, are yours.
> (New Zealand Herald.1990.Feb 7)

THE TREATY OF WAITANGI AND HEALTH

In 1988, Durie (1988:283.) recognised that in the past most debate about the Treaty was centred on its application to property rights and its relevance to past grievances and noted that its other dimensions have been progressively identified, including its implications for contemporary issues and the maintenance of wellbeing. Williams (1995:1) also focused on this aspect when he noted that:

> The Waitangi Tribunal has said that the Treaty had at its heart, from a Maori point of view, a promise of development. Health services must necessarily have been an important part of that development guarantee. Ultimately it must have been expected that Maori would control those services in accordance with their own priorities - not just be passive recipients of the Crown's largesse.

Good health for Maori means more than good access to health services. It is seen as a taonga which enables people to participate in their whanau, hapu and iwi with a sense of belonging and wellbeing and to be able to live socially and economically productive lives. Good health is also connected with the past, the wisdom of the tipuna, the unique relationship Maori have with their environment and Maori generations yet to arrive.

For Maori people the Treaty articulates their status as Tangata Whenua, not their Tino Rangatiratanga which is not dependent on this document. The Treaty guarantees their rights with respect to land, water, forest, fisheries and other treasures and confirms the right to self determination. Implicit in the Treaty were concepts of equity, partnership and economic and cultural security all of which contributed importantly to the spirit of life and wellbeing. As Pomare and de Boer (1988:21.) suggest, poor standards of Maori health may therefore be regarded in part as non fulfilment of these Treaty concepts and obligations.

Each article of the Treaty has relevance for health in the realms of policy, planning and service delivery. Article one places responsibility on the Crown, to put legislation and public policies in place which enable all of the people to have access to culturally appropriate health services.

Article two gives Maori rights with respect to retaining those properties or taonga such as land, forests, rivers and language that they hold as important. It gives Maori the right to pursue tino rangatiratanga. It is vital that Maori are given the opportunity to be involved in shaping health legislation, health policies and to have the resources to develop their own service delivery systems.

The third article of the Treaty accords Maori, as individuals, the same rights and privileges as other citizens. This third article complements the second, requiring the Crown to ensure that Maori have the right not only to equal access to health services, but most importantly also to equal outcomes. Maori, as a minimum, have the right to expect to enjoy at least the same level of health as non Maori, consistent with the Government's response to Maori issues in the health sector. In brief, the Treaty made clear the Crown's protective role and the conferment of citizen rights but did not remove Maori control and management over Maori resources. Those provisions are

regarded as pivotal to the Treaty's implications for health care and health services in the 1990's.

During the 1980's the profile of the Treaty was raised in Government agencies and special groups. In 1985, the Board of Health's standing committee on Maori health recommended that the three articles of the Treaty of Waitangi be regarded as the foundation for good health in New Zealand. This was followed by a series of circular memorandum letters from the Department of Health setting out the view that the Treaty of Waitangi should be integrated into health services and that Maori people have a right to appropriate services - funded through our health system.

The Royal Commission on Social Policy discussed in detail, the contemporary implications of the Treaty and by the end of the 1980's, most major public institutions in New Zealand included in their philosophy or mission statement a recognition of the Treaty of Waitangi and some declaration of intellectual commitment to it. For example, the recognition of the Treaty of Waitangi in all its activities, forms a part of the corporate culture of the department of Health which states that we must aim to develop a timely indigenous health system based on the principles of high quality health. Further, of particular importance are the principles of bicultural partnership and management as enshrined in the Treaty of Waitangi. They are, partnerships and participation. Durie, (1988:284.) sees three major areas where these principles need to be applied. These are partnership and participation in understanding health and sickness, partnerships and participation in the development of health policy and partnerships and participation in the delivery of health services.

For Maori according to Manatu Maori (1989-91:18), the objectives of being involved in partnerships in managing health, relate to Maori having been deprived of the opportunities for involvement in the past and the need to ensure that there is a substantial change in the circumstances of Maori. In 1992, in response to Maori

unease at the lack of a Treaty clause in the Health and Disability Services Bill, the Government issued a statement "Whaia te ora mo te iwi" which recognises the Treaty of Waitangi as the founding document of New Zealand, and that Maori people have found the current system to be inflexible and unable or unwilling to meet their health needs. In it, the Crown acknowledges concerns articulated by Maori people. Demands for improvement include, greater participation of Maori at all levels of the health sector, resource allocation priorities that take account of Maori health needs and perspectives and the development of culturally appropriate practices and procedures as integral requirements of the purchase and provision of health services.

However, in spite of Government policies such as Te Urupare Rangapu (1988), focused on the health needs of Maori as well as the emphasis on biculturalism in "mission" and "vision" statements (Bay of Plenty Area Health Board. 1990), and the State Sector Act (1988), the ongoing problems of the implementation of the partnership inherent in the Treaty are still highlighted in the difference between the rhetoric and the action. This is aptly illustrated in the review of the Responsiveness of the State Services Commission (1991) by the following statement made by one of the respondents: My general impression is that the shift from theory to practice; of intention to implementation, is slow in coming. (Manatu Maori.1989.58.)

Some of these problems are related to unwillingness, fear or threat; others to lack of specificity and detail in policy, or that managers do not know, even if they are willing, how to get started. O'Reilly and Wood (1991:327) that from the Maori point of view it is felt, with some justification:

> that genuine power sharing may be difficult after a hundred and fifty years of Pakeha domination, institutional racism and failure to recognise Tino Rangatiratanga in article two of the Treaty.

Other practical problems revolve around who in Maoridom the individual manager should relate to. Pakeha people have a lack of understanding of, and therefore a difficulty with tribalism, which is the primary source of Maori social strength. The

Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (1988:6) discussed this aspect of Maori and Pakeha relationships and observed that tribal identity as a central part of the traditional social system was the very thing which enabled Maori people confidently to deal with each other. It also stiffened resistance to Pakeha ambition and has continued to be viewed as a barrier to the kind of "unity" that is seen as desirable by Pakeha planners.

Nevertheless, the Treaty's application encompasses all social and economic policies. It is a proactive document with implications for the future as well as the past. (Durie.1988:280.) Today the Treaty of Waitangi continues as a "living document" a focus for all New Zealanders to consider its ongoing role for our nation and in the partnership between our cultures; today and in the future as a focus for excellence, for as Durie noted for the 1990 commission: The principles of the Treaty are not diminished by time, rather it takes time to perfect them.

THE LABOUR GOVERNMENT'S TREATY POLITICS

New Zealand's recent past, since 1840, is structured by its colonial nature. The contemporary expression and structure of racialism, or cultural superiority, and institutional racism can be understood only in terms of the historical trajectory of a particular society and it is important to identify the specific nature of past relationships and issues in that society. In New Zealand, the critical event is the Treaty of Waitangi, which Spoonley (1988:7.) describes as a document designed both to gain British ownership of New Zealand and to protect the traditional interests of the Maori. It was this dual and contrary set of intentions of the colonist and Tangata Whenua, combined with the two versions, English and Maori, and the different interpretations made by both parties that led to conflict and the challenging of ideologies.

From the mid 1970's a story of continued conflict and oppression of Maori began to emerge in New Zealand the point of which was to condemn past and continuing injustice and lay claim to a different and better future. Sharp (1990:181) highlighted:

> The issues that equity covered were of two sorts. Firstly they were issues generated in Government's undertaking special policies aimed at helping the Maori to overcome their relative deprivation of the goods of life - in health and housing, in education for fulfilment and for employment in employment itself, in the status and income derived from employment, in power and influence in the state and in society, and in receiving proper respect from fellow citizens.

Secondly, they were issues generated in Maori attempts to retain, regain and expand their independence of Pakeha control for as Sharp (1990:181) appreciated:

> At the same time, Maori were vigorously pursuing their right to regain their tino rangatiratanga and thus independence of Pakeha control and by the 1980's the scene was set for some very fundamental arguments about the distribution of social goods and of human freedom - the central concerns of distributive justice in modern societies.

A critical point for addressing and processing these issues was the Waitangi Tribunal. The Waitangi Tribunal was created by the Treaty of Waitangi Act in October 1975 and as documented by Mikaere (1991:Foreword):

> The Act gave the Treaty of Waitangi a new prominence in the national consciousness, while in sixteen years the Tribunal has become one of the institutions which is shaping our society.

Sorreson's opinion that the work of the Tribunal was to provide the beginnings of a new and radical reinterpretation of New Zealand history is included by Sharp (1990:4) who noted that it was largely the republication of an older Maori history. Walker (1987:76) on the other hand described the tribunal as a partial solution and noted that the Government did not have either the integrity or political nerve to make it retrospective.

The 1984 Labour Government responded to the crisis facing the New Zealand economy, generally referred to now as the era of Rogernomics. Whilst the focus centred on the economy which was apparently in such dire striates there was, as has been noted by Kelsey (1993:233.) another crisis which needed to be addressed. It

was a crisis that had been gathering over the previous decade. That was, Maori grievances over the theft of land, suppression of culture, dishonouring the Treaty of Waitangi and denial of economic and political self determination had become the focus of high profile protests. Whether expressed as Mana Motuhake, Tino rangatiratanga or Maori autonomy/Sovereignty, the message was the same. The Treaty had recognised and the Crown had promised to protect, the political, economic and cultural self determination of Maori within their own land. The colonial State was being challenged to deliver on the promise published in its Maori Affairs policy statement, Te Urupare Rangapu: Partnership Response. Te Urupare Rangapu placed a specific obligation on all Government agencies to accept full and proper responsibilities for Maori people and communities, and for Maori values and issues.

In 1987, the Labour Government announced a progressive transfer of responsibilities for the management of Government programmes to iwi, and late in 1988 they recognised the urgent need to develop policies which strengthened the position of Maori people in today's society. In its Maori Affairs policy the Government acknowledged that all its major agencies such as Health, Education, Housing and Social Welfare with programmes designed for the general population, were not meeting the needs of Maori people, and declared an emphasis on responsive social policy and public sector reform. (Wetere.1988:4). It was also argued by Manatu Maori (1990:5) that:

> A further principle that is relevant here is the partnership that exists between the Crown and the Maori people under the Treaty of Waitangi, which for the first time is now being woven into Government policy.

The agency charged with reviewing and commenting on all government proposals, as well as monitoring and advising the government on the active responsiveness of state agencies to Maori issues, was Manatu Maori.

Four responsiveness reviews of state agencies were conducted by Manatu Maori before the Labour Government lost the General Election of 1990 and published in

1991. Those agencies were, the State Services Commission, the Department of the Prime Minister and Cabinet, Te Tira Ahu Iwi and Manatu Maori. All the reviews revealed a recognition of the need for responsiveness to Maori issues; they all however revealed that the understandings and perceptions were different. The information gathered from the Department of the Prime Minister and Cabinet (1991:9) showed a considerable intellectual understanding of the issues affecting Maori but the issues of responsiveness were minimised in an E.E.O context. In particular, E.E.O plans did not recognise (and may detract from) the tangata whenua status of Maori and there was the real danger that government agencies would lull themselves into a false sense of security by adopting the "E.E.O recipe" to Maori needs.

With regard to the State Services Commission the review team found that, again, there was considerable intellectual understanding but the strategic objectives set by the organisation itself were not achieved. This was described specifically by one respondent who stated that there is a large gap between what the State Service Commission says and what it actually does. (Manatu Maori.1991:58.) In both these organisations, what was and what was not done was found to be highly dependent on the attitudes and willingness of senior management.

From Te Tira Ahu Iwi came the findings that the issues of responsiveness were associated with the inability to transcend political obstacles. Firstly, in spite of the experiences of the past, Maori were too trusting and believed that what was lacking in officers of the agency was political analysis. There was also anger and disappointment at the poor alignment of other institutions in giving effect to the government's Maori Affairs policy. (Manatu Maori.1991:23.24.) The team reviewing the performance of Manatu Maori reached the following general and important conclusions. Firstly, that Manatu Maori was used by government as the one means of dealing with contradictions in the policy of "responsiveness", particularly differences

between the Crown and iwi interpretations of the Treaty of Waitangi and that it became increasingly difficult for the organisation to advance their iwi based perspective of the Treaty as Governments clarified their policies on it. Nevertheless, the Review Team agreed that the existence of the Ministry represented a much higher level of responsiveness than had existed before it was established but that it was constrained by the limits of the political system. (Manatu Maori.1991:vi.27.)

Nevertheless, the middle to late 1980's became an era of Government focus on the Treaty and public organisations did write their commitment to the Treaty into their policy documents. Apparent policy intentions were not matched by plans or action, however, in health there was considerable resistance by practitioners and planners to altering the status quo of the mono cultural system to include Maori opinions, values or preferences in planning or service delivery, that is, to make changes that come from a base of power. For example, the inability of managers and professional groups to include Maori on the grounds that they are "unqualified" reveals a fundamental belief that "ours is the only right and proper way to do things", a belief which conflicts sharply with their declared commitment to the Treaty and partnerships (Western Bay Crown Health Enterprise.1994.)

The unequal contract arrangements in joint ventures with iwi illustrate a similar approach. The contracts are written from an entirely monocultural perspective which requires Iwi to be accountable to the organisation but there is no reciprocal accountability requirement nor any mechanism that acknowledges redress to very poor health status or the strengthening of provider groups.

Similarly, with the recruitment of Maori staff. Managers in the organisation are reluctant to consult with the iwi mandated staff with regard to improving the staff mix to reflect both the population and usage patterns and are unable or unwilling to

correctly access Maori networks in the matter, or to acknowledge that the Pakeha means of advertising for staff does not effectively attract Maori responses.

On the surface of it, the Labour Government did take unprecedented steps to redress the injustices of the past, and the "principles" of the Treaty of Waitangi, along with other words like "partnership", "empowerment" and "equity" that entered the language of politicians and the media were felt by many to be signs of real progress. The Bay of Plenty Area Health Board (1990:6.) in its publication Partnerships in Health, listed amongst its key management goals that of cultivating communication channels, relationships and services with and for the tangata whenua of our region. However, Kelsey (1990:262.) sounded a note of caution in the statement, that behind the rhetoric Maori remained in essentially the same position as they had been since 1840. Arguably, they were worse off for as Kelsey (1990:268) suggested:

> The Rogernomics era left Pakeha workers insecure, unstable and economically vulnerable. Trade unions failed to defend the interests of their Pakeha or Maori members. Maori and the Treaty provided perfect scapegoats. Colonial racism, fostered by the "one people" mentality of the welfare state, left pakeha minds both susceptible and uncritical. The Treaty began to be deliberately excluded from local Government reform.

In health, the worsening situation for Maori was noted in the Report of the Royal Commission on Social Policy (1988:Vol 2.177.) where figures from a 1984 study of Maori health estimated that the dramatic differences in Maori and non Maori health could be explained by lack of equitable access to appropriate health services. In their submissions to the Commission, Maori women listed access as one of the main obstacles to Maori health improvement. With regard to poverty and access, Matheson (1991:28) expressed the opinion that the health reforms have led to the development of a large group of low-income people and their families who now experience difficulty in gaining access to health services and Reid (1991:27) focused on the fact that:

> The "level playing field" concept is a myth. Little or no recognition is given to the fact that we start "behind" the line and if it is acknowledged, the assistance is unrealistic, impractical or tokenism.

In terms of disease patterns, both mental health and the incidence of cancer illustrate the worsening state of the symptoms of poor Maori health. Pomare and de Boer (1988:115) reveal that in terms of admission rates to psychiatric care, the admission rate has fallen since 1970 except for Maori men, where it has risen by 19% and the incidence of cervical cancer in Maori women has increased by 14% while the non Maori rate has remained unchanged. The numbers of sudden deaths of infants reveals similar trends. For non Maori the figures are lowered and for Maori there is no improvement.

At the same time, there was beginning to be a large amount of unease amongst members of both Labour and National, and Kelsey (1990:263) noted that in 1989 the cost of its Treaty policies had become too high, especially those of the Waitangi Tribunal which dealt with new laws affecting the remnants of Maori land. The Tribunals jurisdiction was extended in 1985 and the amendment made a number of changes, especially in the assessing of retrospective claims that were likely to lead to an increase in the number, range and complexity of claims. During the amendment's slow passage, one that took twelve months from introduction to third reading, the changes met with strong opposition from National party M.P's which as Oliver (1991:12) notes remain a fair summary of Pakeha misgivings then and since. The pakeha public was divided about developments and emerged as hostile to Maori demands and as Sharp (1990:73) highlighted:

> The provision of a Maori majority on the Tribunal was seen as racist and it was argued that allowing claims as far back as 1840 would revive memories of bad times that were best forgotten.

Further, that the potential cost of settling claims would be exorbitant and as a result false hopes would be raised and provoke a Pakeha backlash. The social cost to Governments of the backlash as Kelsey (1990:267) noted could be counted in loss of support from powerful factions of voters and Labour therefore began downplaying the significance of the Treaty; it had become a serious liability for them.

THE NATIONAL GOVERNMENT'S TREATY POLITICS

National took full advantage of the growing "white backlash" and came forth with a campaign based on the predictable right wing themes of one law, one people, equal opportunity and respect for property rights. Continued tension over the Treaty led Government to play down the Waitangi day commemorations, to successfully minimise Maori fishing rights within the framework of the prevailing quota system and represent land issues as individual Maori versus Pakeha conflicts, thus the Pakeha public, fed largely on media sensationalism, became convinced that Maori had secured special and unfair privileges and had virtually taken back the country.

According to Kelsey (1993:236.) the most frequent targets of national conservatism were Maori. Management (September 1992:39.) noted that within the demographics of poverty, three groups stand out: Maori, women and the young. The 1986 census records that Maori male income was only 80 percent of that for non Maori and that almost half of Maori women were totally dependent on benefit income. Any conservative economic policies aimed at reducing government spending by cutting benefits would thus be a direct attack on Maori well being.

Te Whakamarama (1991:9.24.) supports this finding in analysing the effects of the Finance Bill/Social Security Amendment Act in an article headed, Denying the Treaty, Impoverishing Maori, in which the effects of the legislation on social issues, incomes, employment, and unemployment are cited. The article noted that the Finance Bill was part of the December 19 (1991) economic package announced by Government and quotes Easton who calculates that in purely financial terms:

> The effects of the benefit cuts outlined in the Bill impact most on Maori. The average Pakeha household will experience a 3.4% cut in its available income and the average Maori household a 5.3% cut. Maori people are thus 45% more penalised than Pakeha.

It concludes that Maori were not only the targets of welfare benefit cuts but that:

> The inevitable consequence of these economic indices is known social marginalisation and associated problems in health, educational achievement, and

> family stability. If monetarist changes would have negative effects on Pakeha poor, then, it would be devastating for Maori.

At the same time, National was not keen to make a statement on Treaty issues but needed to face the reality, especially with such powerful members as Sir Graham Latimer, Wira Gardiner, and Hiwi Tauroa as senior members. After much debate, in 1989 the party conference passed a resolution recognising the Treaty as the founding constitutional document of the country, yet in its first year of office the Treaty and Maori issues virtually disappeared off the agenda. This was reflected in the health reform documents, Your Health and the Public Health, Core Health Services and Providing Better Health Care for New Zealanders, where the Treaty was not mentioned and the focus was on improving access for all New Zealanders to a health care system that is effective, fair and affordable. (Upton.1991:3.) Thus rangatiratanga and redress, was limited to what the Government regarded as practical, justifiable and affordable. (Kelsey.1993:273)

Only later, in 1992, in response to Maori dismay about the lack of Treaty clause in the Health and Disability Services Bill, did Government release its statement about Maori health issues. This was a time of rapid and tumultuous change and at the same time as Maori were needing to address the issue of their exclusion from the agreement they had with the Crown, in the reform of the Government's structures, the life of Manatu Maori and the Iwi Transition Agency ceased and Te Puni Kokiri, the new Ministry of Maori Development was born. The new Ministry, established in 1992 had a clear mandate in increasing the effectiveness of public and private institutions for Maori. One of the statutory responsibilities of Te Puni Kokiri was to provide policy advice to Government and advice on the most appropriate interventions and strategies in the design and provision of health services for Maori. The vision of Te Puni Kokiri is that this will also assist in developing an environment of opportunity and choice for tangata whenua, consistent with the Treaty of Waitangi. (Te Puni Kokiri.1993:Foreword.)

CHAPTER 2

MAORI HEALTH STATUS

Maori people define health broadly and recognise the importance of the environment. Health for Maori is a holistic and social orientation which encompasses a range of social dimensions and also includes connections with Maori generations yet to arrive. In traditional Maori terms, health is an all embracing concept which emphasises the importance of the wairua, whanau, hinengaro and tinana aspects. The approach is an holistic one emphasising health promotion and prevention. It includes historical, cultural, spiritual, economic, social and political factors. The way in which Maori think about health is a difficult one for Pakeha to grasp as it has no comparable concept in Western terms where it is difficult to talk about health without speaking about illness.[1]

The difference between Maori and Western ways of thinking about health is critical for as Te Puni Kokiri (1993:1) noted, the achievement of equality of health status between Maori and non Maori relies to a large extent on accurate assessment of the health status of both populations and as the Core Health Services Committee (1993/94:9) pointed out, the gaps in our knowledge and understanding of the health needs of both Maori and non Maori are still large. The conventional Western model of health with its emphasis on physical illness and diagnostic categories has a narrow focus and the measures of health developed from them are limited. Mortality statistics and hospital admission data are still the principle sources of information on health status and although too little is known about the populations primary health care needs to know whether they are being met. In the case of Maori however, we

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[1] The cultural difference in ways of thinking served as a useful illustration. Maori thinking differs from Western styles in several respects, for example, the focus of Western thinking is in its analytical capacity where the whole is quickly dissected into component parts so that greater understanding may occur. By contrast, Maori thinking could be described as holistic and understanding occurs more synthesis into a wider contextual system. (Durie.1983:5)

can assume that they are not, for as Te Puni Kokiri observe, (1993:1) Maori continue to be hospitalised at a significantly greater rate than non Maori. The evidence of low Maori health status used in this study has been accessed from the traditional sources cited throughout. At the same time, an effort has been made pay particular attention to data produced by those mainstream organisations with a specifically Maori focus, such as Manatu Maori and Te Puni Kokiri.

Whilst focusing on health management and health policy in this study, it is important to briefly background the wider inequalities such as income, employment, education, housing land and alienation from culture, as the evidence links those factors strongly to health in its widest sense. Income is acknowledged as being one of the key socio-economic variables influencing health status and the Public Health Association (1993:v) noted that the health of a population is affected more by the degree of inequality of income distribution than by level of income per capita.

Maori are over represented amongst those on low income. Similarly the link between education and health is two way, that is, low level of education is associated with poorer health and poorer health can lead to low educational achievement. An example of this is where many Maori children have impaired hearing resulting from the inability to access health care for the treatment of the prevalent glue ear. Lack of access to care causes hearing impairment or deafness which in turn leads to learning difficulties. Lower rates of educational achievement are recorded for Maori. According to the 1986 census, 69% of Maori women had no school qualification compared to 46% of non Maori women and in 1990, only 62% of Maori students left school with a qualification compared with 85.5% of non Maori. A relationship between income, health and housing was publicised by the Public Health Association (1992:vi) whose findings revealed that:

> The unemployed have higher subjective and objectively assessed levels of physical and mental ill health. Housing has several types of direct impact on health which stems from: the condition of the dwelling; substandard housing has major effects on health and wellbeing.

In a chapter called "The State and Maori Housing", the Maori Women's Housing Research Project (1991:61) found that housing was a major area of concern for Maori people, and many Maori communities, particularly rural and isolated communities exhibit the effects of long term deprivation. Resource impoverishment was not confined to housing alone, but had repercussions on every other aspect of Maori society in terms of economic, social cultural and political wellbeing. High unemployment, low educational attainment and negative health statistics had a flow on effect and impacted on the ability to secure shelter.

Although as Shirley (1991:29) observes, New Zealand research on the physical and mental costs of unemployment is sparse, the extensive international literature on unemployment points to a significant association between unemployment and ill-health. Ill people also run a higher risk of becoming unemployed, a risk which increases with frequency and duration of illness.

There are major differences affecting life chances and wellbeing, in employment, income, housing and social class between Maori and non Maori in New Zealand. The Public Health Association (1992:52) found for example, that the Maori unemployment rate was both higher and rising more rapidly than non Maori. In 1990 the total Maori unemployment rate was 18.8% compared to 6.3% for non Maori and for Maori women it was even worse. Between June 1988 and March 1990 it doubled to 22.6%.

The Bay of Plenty Area Health Board Health Status review (1991:30) found that in 1990, unemployment benefits were being paid to ten to thirteen percent of its population. Twenty five percent of those were Maori. The review team set an income of $15,000.00 as a poverty line and found that in several rural communities between 68% and 70% of Maori earn below that.

Te Whakamarama (Issue 9:24) reported that:

> When all sources of income are taken into account, Maori households received over three times the amount that other households receive in the form of "other Government benefits". In fact, without including government transfers, Maori households received only 79.2% of the income of all households.

In addition since 1989, the Maori unemployment rate has risen more rapidly than the non Maori rate; in 1990 the total Maori unemployment rate was 18.8%, compared to 6.3% for non Maori, among Maori aged 15 - 25 years, 48% were unemployed and in the period of restructuring, 20% of the Maori working age population was made redundant. Some of the negative impacts of unemployment listed by Te Puni Kokiri (1993:40) include an increase in psychological and psychosomatic symptoms, a decrease in organised social activity, an increase in substance abuse and increase utilisation of health services.

Whilst it is observed that similar links exist between unemployment, poverty and mental health it was difficult to establish that for as Te Runanga o Raukawa (1991) found in their study of Barriers to Health care, that access to mental health services for Maori was not straightforward. For example, Maori people are twice as likely to be admitted to psychiatric hospitals following referral from non medical agencies such as law enforcement agencies, yet this small survey of Maori people found that if those interviewed had a mental health problem only 20% would think of going to the doctor.

The New Zealand Planning Council (1988:48) reported found the utilisation of health services varies with income, if age and sex are held constant. They state that:

> The poor and ethnic minorities tend to suffer more ill health than the rich (Social Monitoring Group, 1985) and thus have a greater need for health services. The use of health services may also vary because the way services are provided is not compatible with the needs of the poor and ethnic minorities, nor may they have easy access.

Health and health care are shaped by the larger social contexts in which they occur and in turn, these contexts are characterised by the enduring relations of economic, ethic, gender and political power so that accordingly, societies distribute illness among their members on the basis of general patterns of inequality. (Spoonley et al. 1990:49) Yet policy makers continue to ignore the discriminatory nature of the health system and when faced with evidence of poor health status, continue to blame the victim who fails to avail themselves of proper care.

Structuralist and anti racist studies in recent years, however, have revealed with new clarity, that the causes of poor health lie in the structures of society itself so that if class matters, so does cultural identity. In other words, as Spoonley, et al. (1990:149) noted:

> If working in a lower class job, being poorer and less educated already significantly increases the risk of death, the social consequences of being Maori adds further to that risk.

Pomare and de Boer also recorded major inequalities in health in their study of Maori standards of health in the years 1970 - 1984. For example, they found life expectancy at birth was seven years shorter for Maori males and 8.5 years shorter for Maori females when compared to the non Maori population. Maori death rates from diabetes, rheumatic and hypertensive heart disease were 4 - 5 times higher than the non Maori rates. More Maori suffered from respiratory disease, including asthma, chronic bronchitis and emphysema. As well, there was a high prevalence of ear disease in Maori children and hepatitis B infections and chronic carriage of the virus were extremely high in Maori people. Maori were three times likely to die because of an accident before the age of four, and eight times more likely to die as a toddler through a fall.

The Bay of Plenty Area Health Board Health Status Review (1993:71) reports the National diabetes mortality rates per 100,000 as 15 for Maori women and 7 for non

Maori. In the Bay of Plenty those figures rise to 39.5 for Maori women and lower than the national figure for non Maori.

The Maori Women's Welfare League research and report on Health and Maori Women (1984) reports similar findings. This research was one of the very few until recently where success in the field showed the value of investigative interviews being conducted by Maori for Maori and giving affirmation and credibility to culturally acknowledged practices. Chapter 6 sets out Te Puawaitanga - highlights of the information gleaned about the experience of ill-health and responses to current symptoms. Current symptoms of ill health were experienced by seven out of ten Rapuora women, the symptoms often corresponding to the chronic illnesses reported. Depression was the most common chronic illness of young women, with asthma bronchitis as the next most prevalent. Coughs and colds were the only symptoms more frequent than the stress ailments for young women. Middle years Maori women added high blood pressure to chronic depression and asthma as their chronic ailments. Mature Maori women showed expectedly high blood pressure (21%) and arthritis/rheumatism (16%) Their most common symptoms were aches and pains in the back, joints and limbs. Spoonley (1988:26-27.) notes that Maori women had the highest rate of lung cancer in the world and the report of the Ministerial Planning Group, Ka Awatea (1991.) quoted higher rates of cot death, respiratory diseases, heart disease and cancer of the cervix as major issues of inequality in Maori health status.

Whilst research shows that in all aspects of health as we measure it, Maori are worse off than Pakeha, recent measurements in the Bay of Plenty show that in addition when compared to Maori nationally, Bay of Plenty Maori are significantly worse off. (Bay of Plenty Area Health Board Health Status Review.1992:84.) This is an abysmal picture.

Garlick, in an address to the International Congress of Health Managers 1990, saw Maori health as so bad that if health managers were sincere in their intention to improve it, they would find themselves doing only Maori health and the Aboriginal Australian writer Jimmy Durham (Te Whakamarama. Issue.9.24.) has said that:

> The socioeconomic status of colonised peoples ensures that they will always win, "The highest Infant Mortality (International) Medallion, the Cumulative Morbidity Cup, The Unemployment Stakes Shield, and the below the Poverty Line belt."

All the reports, but in varying degrees depending on whether the author was Maori or Pakeha, focused on the issue that Maori are unable to make effective use of New Zealand's mono cultural health services and that equitable access must take into account, cultural differences.

Both the New Zealand Planning Council (1988:48.) and The Public Health Association (1992:vi.) recognised that access to and utilisation of health services varied because of the way services were provided that was not compatible with the needs of Maori and noted that a number of Maori authors have focused on those additional contributing factors including access to culturally appropriate and safe health care. Pomare and de Boer (1988:17.) focused on the fact that there were strong challenges to Maori and non Maori alike in the actions needed to improve Maori health and as argued that the improvements will only occur through the concerted efforts of both peoples.

Any analysis of Maori health status raises the question of the ways in which data has been collected, of who defined Maori, for what purposes and who benefited. The short response is that in the past, Pakeha agencies have not only defined Maori health but also collected data made the interpretations and prescribed the cures. The question of data collection, analysis, and ownership is outlined in the next section.

RESEARCH AND MAORI HEALTH

In the introduction to He Kakano, A Handbook of Maori Health Data, (Te Puni Kokiri.1993:1.) it was first noted that the achievement of equality of health status between Maori and non Maori relies to a large extent on an accurate assessment of the health status of both populations. The conventional monocultural model of health with its emphasis on physical illness does not measure health accurately for Maori. For example, hospital admissions and mortality figures have not measured the earlier episodes of unwellness that if treated earlier could have prevented the need for major interventions. Another feature of data that has given an inaccurate picture is the classification of ethnicity. Some clerks that I spoke to informally said they looked at the patient's surname and made a judgement from that. Some simply looked at the patient and judged on that basis. Kilgour (1992:54) wrote of similar approaches amongst clerks, reporting that:

> Asking about ethnicity is embarrassing for some clerks. One said that if there was a bad response she would "flag it" and fill it in later by her own knowledge.

This situation demonstrates a common theme: where there is no specific protocol for self determining ethnicity each staff member may do it differently and be unaware of what other staff are doing or miss out Maori with Pakeha sounding names, leading to the risk of understating the true extent of health inequalities. In the past, hospital discharge data has provided much of the information in categories described as diagnostic related groups (The Committees Report. Core Services. 1993/94.) which described effect not cause and were therefore of little use to planners and practitioners whose concern was prevention and the promotion of health and well being. If Maori health development was to address future Maori needs then it must be driven by culturally accurate information and based on Maori needs rather than short term political agendas. (Te Puni Kokiri. 1993:67.)

These findings substantiate the earlier and often ignored experience gathered in Rapuora, a research project conducted by the Maori Women's Welfare League between 1975 and 1984. It argued that in the past, most research about Maori had been conducted by Pakeha researchers using methods that were inappropriate for Maori. Rapuora, as well as for its findings, was influential in returning credibility to Maori as researchers. A new methodology was conceived. It was as Murchie (1984:17) stated to be based on culturally acknowledged practices.

Later, Manatu Maori (1989:11) published a discussion paper, He Tikanga Whakaaro, about research ethics in the Maori community which noted that in the main, the dominant and aggressive researchers and academics in the Maori world were Pakeha, and their published works became standard texts through which Maori students of Maori more often than not had their history, their culture, their myth and their customary concepts fed back to them - often after some questionable processing. In the document Kaupapa Maori and Responsiveness (1991:24.) Manatu Maori reflected on the history of Maori values in organisations, saying that, for a long time, a lack of information to enable Maori to participate effectively, has virtually precluded the achievement of the goals inherent in the Treaty of Waitangi.

The validation and recognition of Maori methods of social research is now a critical issue for policy makers, planners and service providers in Aotearoa, as is the ownership of information and intellectual property. Maori have demanded that social science researchers recognise that there is a variety of ways to elicit information about peoples experiences and needs. In an article for the Social Sciences Researchers Newsletter (May.1993.), Roa, Ropiha and Wilkinson discuss this aspect and note that:

> We need to remove the myth of academic definition to widen the scope of research methodologies to include well practised and acceptable modes of research as perceived by Maori. Without a doubt, social research has failed Maori. It is time to change.

They sought support for changes that included Maori researchers in their own right, not just as a tokenistic enhancement to Pakeha organisations; challenging that it is no longer palatable for non Maori to define the needs and desires of Maori within their limited experience and knowledge of what Maori people need and desire, for, as they further note it is still the assumption of non Maori people that their culture, lifestyle and values are superior to Maori.

Smith (1986:143.) had earlier raised the issues of cultural superiority expressed in the dominant Pakeha definitions of research in Aotearoa and how the mono cultural concept of knowledge as a cultural concept was used to exclude the values and beliefs of the Tangata Whenua. She described the historically and culturally different ways in which knowledge was perceived by the two cultures; Pakeha believing that individuals have a right to knowledge and that pursuit of knowledge, and the acquisition skills that enables one to recognise it is an important cornerstone on which Pakeha education is based. In Maori society, on the other hand, knowledge never was universally available. It was valued highly, and certain types of knowledge was entrusted to only a few members of the whanau. Knowledge was considered tapu and there were sanctions that ensured that it was protected, used appropriately and transmitted with accuracy. (Smith.1986:146.)

Rolleston also (1989:8.) reported the unease that Maori felt not only about the inappropriateness of non Maori being involved with research into some of the more intimate realms of knowledge, but also of making traditional knowledge and information available anywhere that was not controlled by the appropriate tribal influence. He reported for example, that:

> People who worked with herbal medicines were, in general, either reluctant or refused to share their knowledge with others, particularly with people who were non Maori, and even those who belonged to other tribes. Many of them viewed their expertise as Taonga (treasures or gifts) that they were fortunate to inherit, to be able to use in their lifetime, and then to pass on to others.

There was concern too from the people whom Rolleston (1982:12.) consulted about research and knowledge, about the lack of action or effectiveness of research into Maori health. A comment from a respondent to Rolleston described the concern thus:

> we are the most researched people in the world and yet we seem to remain the sickest. If we are not getting any better, what is the point of the research.

The impression gained by many Maori people was that the benefits for them both from health research were not easily discerned. The Maori perception of lack of benefits from research was attributed to a variety of reasons ranging from too few Maori researchers, poor communication between researcher and the researched, the passive role of the researched in projects that involve them, dissatisfaction about the value of judgements made about Maori society when they were made on alien or unsympathetic terms and the use of Western criteria in the allocation of funding priorities.

Roa et al (1993:5) also raised the issue of funding criteria that disadvantaged Maori research and researchers and noted that funding bodies needed to examine their selection process and redefine it to include the range of skills and competencies valued by Maori so that Maori ill health was not further sustained as Roa et al (1993:3),suggest, by racism that assumes that non Maori culture is superior to Maori, by ethnocentricism that ensures that non Maori culture is the criterion which Maori culture is being measured against or by the disempowerment that occurred when decisions affecting Maori continued to be made by non Maori.

Each of these writers has highlighted the aspect of control over Maori health development that was perpetuated in Western methods of research. The research about Maori by Pakeha has led Maori to the recognition that the achievement of equality of health status between Maori and non Maori relies to a large extent on accurate assessment of and access to good quality information about Maori health status. This requires the full participation of Maori and Maori as researchers in the

process so that the issues of cultural safety and the ownership of intellectual property are acknowledged as rights. This can only be appropriately actioned by Maori accessing Maori networks for as Ruwhiu (1995:3) argued:

> Maori also had a history that still functions today and within its boundaries exist the rights to creating healthy responses that are not part of Te Tiriti o Waitangi obligations.

An exploration of the issue of the validation and recognition of Maori methods of research also raises the issue of intellectual property and the ownership of information. In health as Jackson (1995:1) noted, these ideas need addressing within cultural terms and must also be rid of the assumption that the Crown has the right to determine both Maori status and the perception of how that status should be understood. Jackson (1995:2) argues that whilst the pain and effort of trying to "biculturalise" existing processes must be recognised, these ideas need to be debated in the belief that health information is an issue of rangatiratanga and therefore equally belongs to the world debate that is centred around the colonisation of other Indigenous Nations and the development of a United Nations Declaration of Indigenous Rights.

Thus in the 1990's research and the concept of both health and information as taonga has become an important area of challenge to the ideology of the dominant group, for Maori are saying that it is time for us to speak for ourselves, or as Rangihau (1975:232) explained:

> I am constantly reminded of the number of Pakeha people who know better than I do what is good for me. It is about time we were allowed to think for ourselves and to say which things we were allowed to think for ourselves and to say which things we want and why we want them. And to say that we do things for our reasons and not for reasons set down by Pakeha experts.

REFORM OF THE HEALTH SYSTEM

Restructuring of the health system is a process which has been undertaken from time to time for over a century. Almost all the restructuring has been prompted by the rising economic costs of providing health service, and in recent times the cost in combination with questions about effectiveness have led to major restructuring. As Davis (1981:9.) pointed out, New Zealand is following international trends in this respect.

> Economic pressures on State funding and the limited impact of medical services together have created a climate of opinion in which cuts and controls are being imposed on the health sector in most advanced industrial societies.

In New Zealand, by the 1970's, moves were being made to curb the increasing proportion of public hospital treatment. The problem facing health planners and policy makers was how to limit the increasing cost and at the same time move health care to a more holistic and wellness centred focus. A special Advisory Committee on Health Services Organisation was set up to advise the Minister of Health on ways to integrate the health services more appropriately. The aim was to provide strategic planning for the health of entire regions by bringing together professionals and lay people representing all interests of the community. Historically, in New Zealand, lay people have had very little input into the development of health services. These have traditionally been dominated by medically oriented health professionals. Maori have had even less input and as noted, the indifference of health professionals to many issues that concern women's and Maori health, were examples cited repeatedly. (Report of the Hospitals and related Services Taskforce.1988:11.) The new bodies which were to achieve this aim were Area Health Boards, and legislation enabling their formation was passed in 1983.

The new boards came into being unevenly until 1989 when their formation became mandatory along with their charter which stated their objectives. These objectives were firstly, to promote, conserve and protect the public health, to provide health

services within the region and to ensure effective coordination of the planning, provision and evaluation of health services between public, private and voluntary sectors. In addition they were to establish and maintain appropriate balance in the provision of and use of resources between health protection, education and treatment services. (Bay of Plenty Area Health Board.1990:6.) At this point, with regard to Maori health, the health system stood at the crossroads.

A strong commitment to the Treaty of Waitangi and true partnership had been expressed by Government through the establishment of Manatu Maori, the new Ministry of Maori Affairs. The Ministry was to provide a Maori perspective in policy making and reaffirm the principle objectives set out in the discussion document He Tiroanga Rangapu, and later the policy statement Te Urupare Rangapu. Those objectives were to honour the principles of the Treaty of Waitangi through the exercise of its powers of government in a way that would actively protect and promote the development of government services that were accessible, meaningful, useful and effective for Maori.

It was also envisaged that the Boards would eliminate the gaps which existed between the educational, personal, social, economic and cultural wellbeing of Maori people and that of the general population, providing opportunities for Maori to develop economic activities as a sound base for realising their aspirations in order to promote self sufficiency and eliminate attitudes of dependence. They were expected to deal justly and expeditiously with breaches of the Treaty of Waitangi and the grievances between the crown and the Maori people which arise out of them. They also had a role in providing for the Maori language and culture to receive an equitable allocation of resources and fair opportunity to develop having regard to the contribution being made by Maori language and culture toward the development of a unique New Zealand identity also to promote decision making in the machinery of Government, in areas of importance to Maori communities, and to provide opportunities for Maori

people to actively participate, in policy formulation and service delivery as well as encourage Maori participation in the political process. (Wetere,Hon.K.1988:3.)

In addition, the agencies of government such as the State Services Commission and the Department of Health declared something of their support for the inclusion of Treaty issues as part of their responsiveness to Maori needs. In health, a series of Circular Memoranda such as The Undiscover'd Country: Customs of the Cultural and Ethnic Groups of New Zealand Concerning Death and Dying (1986/60) Treaty of Waitangi and Maori Health Services (1986:70.), Traditional Healers and Kai Ahwina in Health Services. (1987/9) and The Creation of Area Health Boards: Treaty of Waitangi (1987:82.) were issued by the Director General of Health. The purpose of those memoranda was to assist Hospital Boards in understanding the principles of the Treaty of Waitangi and how they could be integrated into the Health Services by developing a bicultural health system in Aotearoa.

This was to be achieved by regarding Maori tribal authorities as the proper trustees for Maori people, by making resources available to Maori people for development of their own health programmes. Whilst it was assumed then that improvements in Maori health were likely to come about mainly through whanau, hapu and iwi developments. This tendency to Iwi focus did not take into account the needs of urban Maori or the new social formations in Maoridom later described by Durie (1994:2) as diverse Maori realities. Those circulars also recommended the involvement of a greater number of Maori people in the delivery of health services and that training programmes must reflect the bicultural nature of New Zealand society. There was to be less direction from Wellington, as the role of the central agency was to influence rather than direct or control, thus leaving more chance for regions to meet the unique and different needs of their particular populations.

The circular memorandum relating to the formation of Area Health Boards specified that proposals to become Area Health Boards should clearly document how Maori people had participated in the process of consultation and planning. The series of four booklets published by the State Services Commission were aimed at assisting staff in organisations to take action that was consistent with the Treaty of Waitangi. They were prepared by the responsiveness unit of the Commission and covered, Partnerships Dialogue, A Maori Consultation Process, He Korero Rangapu which aimed to introduce Tauiwi to the processes of Maori consultation. Readers were asked to bear in mind that major issues were not well charted and understanding of those issues was not deeply bedded within our society and because of this Tipene O'Regan of Aoraki Consultant Services offered this advice about consultation:

> Reading will help and there's a huge range available . . . Discussion will help particularly if its informed. Most of all, though, an open and professional attitude towards working effectively on our nation's most important interface will help ensure it is a creative interface and not a corrosive one.
> (State Services Commission.1989:7.)

To assist in the consultation process, contacts for consultation, a directory of Maori Organisations. Nga Ropu Kai Korero a Iwi, He Whakamohio, gave maps showing tribal areas, a complete list of iwi, contact information and the Pan Tribal Organisations with guidance about how to use them and the set of four was completed with the addition of Towards Responsiveness. Objective setting and Evaluation. Me Penapena Nga Whainga atu me nga hua e Kitea ana, and Personnel Response, A Practical Approach; Me Penapena Au Kaimahi Maori Hei Whakatinana, both of which set out in measurable plan form, some practical ways of making the required responses and actions.

The combination of the Labour Government's statement of partnership with Maori, the encouragements of major and powerful state agencies such as the Health Department and the State Services Commission, and the formation of the Area Health Boards, evoked a measure of hope amongst Maori for the improvement of Maori health, for as Pomare and de Boer (1988:7.) noted, additional impetus was needed for,

although some changes have been made, our services remain essentially mono cultural and often fail to respond to Maori people. However, the Area Health Boards Act, when it came, totally omitted things Maori. There was no Maori word, no mention of Maori people, no mention of Maori health status, nor any provision for their representation. Thus in reality, the Area Health Boards Act became, for all the hope it had engendered, simply another piece of mono cultural legislation and the same level of exclusion of Maori people and Maori viewpoints that is their historical experience was evident. While Pakeha, could get on with the business of preparing the new structures and building the new health system, Maori were again forced to deploy their skills and energy to renegotiate their position as Tangata Whenua before they could claim the resources needed to focus on the poor status of Maori health.

In the Bay of Plenty, Maori organisations such as the Tauranga Moana District Council and the Tauranga Moana Trust Board petitioned Government to object to the fact that no mention was made of the Treaty of Waitangi, and to seek its inclusion. (Wiremu Ohia.Conversation.1984.) No change was made as a response to these concerns, nor did any of the amendments to the act mention the Treaty or Maori, until May 1988, when under the conditions imposed by the State Sector Act, with its "good employer" provision, Area Health Boards were charged with operating a personnel policy that included recognition of the aims and aspirations of the Maori people and the employment requirements of the Maori people as employees of Area Health Boards. The irony of this was that it came at a time when health budgets were beginning to shrink dramatically and when most institutions had policies restricting the replacement of staff in place.

The Area Health Board legislation was another bitter blow to Maori people and to those Pakeha health professionals for whom the previous few years of perceived reform in relation to the Treaty of Waitangi, had been encouraging and driven health

services to contemplate new forms of policies, practices and service delivery more open to Maori.

A MANAGED HEALTH SERVICE

The change to Area Health Boards had as one of its objectives, the limiting of spending on health, but there was also another change signalled, which would further disadvantage Maori. That was the new emphasis on a managed health service. Boston et al, (1991:9.) noted that this was variously referred to as corporate management, the new managerialism, and the managerialist revolution, the essence of which lies in:

> The assumption that there is something called "management" which is a generic, purely instrumental activity, embodying a set of principles that can be applied to a public business, as well as in private business.

The Report of the Hospital and Related Services Taskforce (1988:18.) laid a great deal of emphasis on poor management structures and practices in health services and made strong recommendations for change. Many of the problems identified were attributed as the outward signs of a management structure which was over centralised, bureaucratic, inflexible and confused. In the report, Triumvirate management, which comprised the three executives, a doctor, a nurse and an administrator representing the three major work groups in hospital, and was how the New Zealand hospital system was run, came in for some particular criticism. It was criticised on the grounds of, firstly, the few groups it represented, and that it stifled leadership, diluted accountability, made for poor management relationships at lower levels of the organisation and was generally inefficient and ineffective in terms of staffing, management information, cost consciousness, lack of productivity and monitoring.

The new style general managers to be appointed to the new structures were to provide leadership in the broadest sense, meaning that given the criticism that health services

were poorly managed, a whole management culture would have to be turned around before the health services would have managers who were able to perform in the changed environment. To this end, a Top Management Course was set up by the Health Department in 1988 and 1989 to prepare selected people for the transitional role. There were at the time few Maori in management. The fact that none were selected into the course is at once a reflection of the inequality inherent in the education system, the inequality of the status of the two major cultures that make up Aotearoa and the unwillingness of Pakeha selectors to comprehend the issue of cultural superiority and redress. The selection of only Pakeha students reflected the beliefs of the organisers that only Western models or opinions were valid and that comprehension of the State's or their own commitment to the terms of the Treaty of Waitangi in health reforms that were consistent with Maori values was again easy to ignore. The exclusion from this significant change at a time when partnerships and the Treaty of Waitangi were being promoted did nothing to allay fears that the predictions of the Royal Commission on Social Policy would become reality. In the new system, the white English speaking male, of higher educational attainment, who is a friend of the establishment still gets to make the running. (Royal Commission on Social Policy.1988:Vol.4 50/51.)

In this environment, according to Powell (1992:39) the cult of management has expanded, given impetus by the current Government's health restructuring. He notes that the management cult believes that it holds the central role in health service and that it is managing a commercial enterprise which just happens to be providing health care. One aspect of this development was an attempt by management to develop among the health workforce a "corporate culture" which maintains that attitudes of management at the top of the pyramid, should be adopted by health workers.

This significant change in bureaucratic culture could, in spite of its mono cultural limits, be seen as something of a revolution towards the production of a new

corporate culture which was characterised by what Yeatman (1990:13.) calls the adoption of the discourse of management, that is, capture of the language of social reform; justice, fairness, decency, and equity; and at the same time doing more with less, focusing on the outcomes and results and managing change better. With these emphases on results oriented management, the public health system tended to be reduced to effective efficiency and economic management of human and financial resources. This direction was signposted by Short (1992:9) who observed that the appointment of a commission and replacement of the Auckland board, together with mounting criticism of some boards' performance and management, sounded a death knell soon to become a reality. Health care was regarded as an industry in some quarters, best run on commercial lines with a market place philosophy.

This was a technical management approach, rather than a health professional approach to public management and administration and public service that was couched within the broader policy framework dominated by economic, rather than cultural or social considerations. It was clear in the assumption that Government activities should be measured in terms of their effective resource management (doing more with less) and that, where it is clear that for some reason such effective resource management was not possible, usually because was too dollar costly, the Government would attempt to reduce this service or drop it altogether. The downgrading or closure of small provincial or community hospitals such as Taumaranui or Waihi were examples where Government defined that local people would be better off travelling to a central city location such as Waikato Hospital, where expert care was to be offered, even if families did not wish to, or could not afford to, travel the required distance to access it.

The shift to management has meant that managers were not necessarily selected for their knowledge of the management of social services but were more often selected for their private sector commercial experience. There was an increasing value placed

on high degrees of technical and interpretative skills and seniority was replaced by merit as a means of promotion. Merit is a principle which emphasises competitive performance and judges merit on examinations, credentials and work experience. At the same time, merit established a new elite and its culture within the public sector, amongst a group whom Yeatman (1990:12.) noted were:

> Those with higher education credentials who can speak and manipulate the rationalised discourse of this new class. The dominant agenda of administrative reform means that merit is judged against managerialist criteria and that the preferred education of aspirants is an M.B.A.

The new management was oriented by a rational scientific approach to delivering health services. They valued and were oriented by a rational approach to tasks within the public service and valued and sought out all relevant knowledge and knowledge producers. As part of this movement, most public hospitals in New Zealand had employed information system experts and installed the technology to support them. In this respect, as Yeatman observes, (1990:29.) the newly managed system is quite open to new ideas, and to some extent they may be open to dialogue with those who are concerned with partnerships and participation in developing management strategies involving redistribution and social justice in a way which refers to the life and needs of a community. They do not however, go so far as to take into account collective responses to collective needs. In New Zealand, the combined force of financial accountability and the individualistically driven, conservative market forces ideology, increased insecurity, tension and distrust for Maori who valued the collectivity.

Copeland, (1988:49) writing of management in both the public and private sector raised the issue of management responsibility for substantial change when he noted that biculturalism and cultural diversity was the new reality in the workforce, yet few employers or managers were prepared to face it. He asserted that many managers grew up having little contact with other cultures and that they were actually "culturally deprived". Further, he noted (1988) that:

> Most traditional models of human behaviour and management methods, as well as many of the recommendations in recent best sellers such as In Search of Excellence, are based on implicit assumptions of a homogeneous white male workforce.

It was thus important to develop management practices and models that combined technical and substantive orientations and in New Zealand that should have involved the participation of Maori and the development of genuinely bicultural models. Western, mono cultural models of management are traditionally based on competitiveness and high levels of individualism. Managers trained in this system tend to prefer to work alone, to have career goals as their first priorities, belong to small mobile nuclear families and to be confident in their ability to tap into exclusive networks and resources. For Maori, the values will often be the reverse of those that inform parts of their daily lives.

The different behaviours and value preferences that arise out of individualism and communalism have always been a source of tension between Maori and Pakeha. The Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare (1986:6) argued that:

> Since the 1850's when Maori and Pakeha first began to shape up to each other in cultural terms right down to the present, tribalism has been the focus of Pakeha hostility. It was early identified as the primary source of Maori social strength, the thing which stiffened the resistance to settler ambition.

The report further commented that these tensions transfer to all aspects of institutional arrangements where the centralised and impersonal state of the dominant individualistic culture replaced the kinship solidarity of traditional Maori politics and strangers ignorant of and threatened by their communal values compromised traditional law and custom.

A parallel tension has existed within management as to the ideologies that underpinned particular models of practice. Both the literature and the rhetoric of management focused on the team approach which implied the development of

collective rather than individualistic practices and flattened rather than hierarchial structures. Chapters were headed with titles such as "Participation is In," (Crawford.1991:122.) Vision statements included items that gave priority to a culture of teamwork, openness and trust, (Western Bay Health.1993:2.) at a time when individual contracts and individual accountability for performance had become essential ingredients of the new technical orientation to work.

Garlick, (1990.) signposting the changes that managers needed to make in themselves in order to enhance their performance, spoke of the importance of a new "mind set", or the "right premise", for health management. He gave an additional impetus to the ideas of management in New Zealand and highlighted the active dimensions of power sharing, giving, sharing, gaining and losing as critical priorities for end results that were specifically inclusive of Maori and would, if pursued willingly, lead to cultural reconciliation, collegiality rather than hierarchy and decentralisation of care. He also focused on the importance of managers who were able to blend and include the knowledge, skills and behaviours inherent in both the technical and the cultural orientation to their tasks.

Yeatman (1990:30.) has noted that is was important to recognise that public servants who are oriented to the substance of public policies and public values can develop what she described as a combined technical and substantive orientation to their work. Further she suggests:

> that if at the moment the tension between technical and substantive aspects of a rationalised public service is poorly articulated, and is pushed to the wings by the dominance of the technocratic orientation, this will not always be the case . . . Even the most technocratic of professional managers may be forced to become more literate in substantive public service requirements.

PART TWO:

A REVIEW OF LITERATURE

CHAPTER 3

A REVIEW OF LITERATURE

An extensive review of literature is not always considered an essential part of thesis writing. It is however an important part of Kaupapa Maori and Responsiveness for the Maori way of more synthesised thinking which constantly acknowledges the past, the present and the future, is to some extent now part of my way of thinking, and it is essential in understanding Maori health, for as the saying goes; "how can we know where we're going if we don't know where we've been."

Section one of the literature review traces some of the literature of "good intentions". The opportunity has clearly been presented for the monocultural system to be changed, for things to be done in new and creative ways, or at least to question why its expensive system had failed to produce health for large numbers of New Zealanders.

Section two, "hears" the voices of Maori people experiencing, critiquing and monitoring a system which has failed them and focuses on the reality that we, the dominant people have ignored them and continued to reinterpret Maori opinions and to underpin health policies and planning with individualistic, medical model, blame the victim attitudes. Hohepa expressed a Maori distress response when he wrote in relation to this great Pakeha propensity for reinterpretation that;

> The vocal requests of Maori orators in a public forum often lose their significance and relevance when toned down in translation and then filtered through a white mind. (King.1978:104.)

It also seeks to highlight that social structural theories and practices which involve the monitoring of performance and change, suggest an intimate connection between

social justice and health, and are not either theories or practices that sit easily with those that benefit from the status quo.

Section three attempts to raise awareness of both the new complexities and the sameness of the past and present and of the difficulties of achieving improved Maori health status against the obstacles of power elites and white backlash and of the difficulties before Maori, of staying in the "positive" spirit of Ka Awatea. I hoped it would be useful to risk the extra length to make the points again by selecting out monitored evidence which had identified the problems again and again, and which also focuses on our failure either to act on the evidence, or to monitor the health impacts of our management practice or performance. Sadly, I was left with the words of Jules Older (1978:11.) at the forefront of my mind. He wrote a social condition of conspiracy called hysterical blindness which he saw in New Zealand as a defence against the invasions of unpleasant reality. He called it the Kiwi Conspiracy, and added:

> but there are also conspiracies of silence in which no one ever meets, and there are no evil deeds. In fact there are no deeds at all, unless silence is defined as a deed.

TAHI. MANAGEMENT

A review of literature undertaken in 1991, found no currently available studies which measured management attitudes, understandings, or responsiveness to biculturalism in health services delivery. A similar scarcity was also revealed in the monitoring of management responsiveness to biculturalism in service planning, mission, goal and objective setting, although Manatu Maori (1989/1991.) was then in the process of reviewing the four major agencies. Those results have been discussed in the earlier section on the Labour Government's Treaty politics.

At the same time there was an abundance of Government directive, agency aims and professional opinion regarding the desirability of developing bicultural services, all of which provided clear directions and methods for achieving that state of responsiveness.

In November 1988, the Labour Government reaffirmed seven principle objectives in its Policy Statement released by the Minister of Maori Affairs and outlined its intention to address m ajor Maori concerns regarding honouring the principles of the Treaty of Waitangi, eliminating gaps in social, economic and cultural wellbeing of Maori, providing opportunities for Maori to develop economic activities, deal fairly and justly with breaches of the Treaty, provide for Maori language and culture to receive an equitable allocation of resources, promote decision making in the machinery of Government, in areas of importance to Maori communities and encourage Maori participation in the political process. (Partnership Response.1988:3.) In the following year, the Department of Health also issued a general statement which declared that:

> The Government believes that all its agencies must accept full and proper responsibility for Maori people and communities, and for Maori values and issues, and that its agencies must rouse themselves and respond in a definite and positive way to the needs, concerns and aspirations of the Maori people.
> (Department of Health.1989/2.)

The Mission Statement issued by the department in the previous year had included in the Kaupapa the intention to ensure that the principles of the Treaty of Waitangi "permeate all our activities". There was however, little or no practical guidance about how that was to be achieved. A Management Journal article (March:1990.), Pearson detailed strategies to facilitate biculturalism in the workplace, and noted that the breaking down of the barriers that prevent Maori from advancing within the state sector was the aim of the State Services Commission 1989 publication, "Me Penapena Au Kaimahi Maori: Personnel Response: A Practical Approach." The booklet gave a range of strategies to make State Sector agencies more responsive, and emphasised that the advice was also relevant to private sector companies, that is to all New

Zealand. He went on to say that by improving its awareness of Maori aims and aspirations, an organisation would be able to respond more sensitively to the needs of its Maori clients and customers and would also gain access to a wider range of skills, knowledge, experience and culture, and to the development of culturally appropriate management plans and practices. He also noted that monitoring procedures should be built in to the action plan to allow for annual reporting and review.

Between 1986 and 1989, when the Director General of Health released the series of discussion papers and circular memoranda (referred to in the section Reform of the Health System) designed to assist health care personnel in the development of responsive bicultural organisations that would replace the monocultural structures that prevailed. These papers were all of an advisory or guideline nature and as such they were effective only to the extent that managers and their organisations were willing. However, they usually included the Treaty of Waitangi in philosophical statements of intent. The response at Tauranga Hospital was that the Treaty was recognised philosophically and Maori were invited to participate at management level in an advisory rather than voting capacity. Full partnership and voting rights were being strongly and it seems successfully negotiated when a new manager arrived and the practice of having Maori representation was discontinued. Maori were turned away from one meeting and no longer invited to meetings at management level. Maori representation at top level management has not yet been regained.

Other agencies made similar responses. For example, also in 1986, The Department of Social Welfare prepared and circulated to its staff, a discussion paper called, "How could Social Welfare become Bicultural Quickly." The paper focused on planned changes in the structure, mission, goals and service delivery which acknowledged that Maori and Pakeha applied different measurements to service and in some critical situations these were irreconcilable which it noted highlighted the necessity to have the standards which determine whether practices were ethical, effective, efficient and

reality based and accordingly, culturally based. (Department of Social Welfare.1986.3/4.)

The discussion document was an immediate response to the publication released by the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare which pointed in a very direct way to the causes of Maori dispossession, poverty, oppression and dependency. It had also highlighted the disparity between the large proportion of Maori people who needed service from the department and the low numbers of Maori staff, and of culturally competent Pakeha staff. This publication called, "Puao-Te-Ata-Tu" called strongly for change, change which would require a conscious effort to make our institutions more culturally inclusive in their character rather than tokenistic ones that began and ended at "the counter", for as it went on (p.27) to say:

> The change must permeate to the recruitment and qualifications which shape the authority structures themselves . . . Affirmative action programmes aimed at reducing the monocultural bias in our institutions are an essential ingredient of change. The first stage of a more culturally inclusive New Zealand is the recognition of biculturalism. This involves both the place and the status of Maoritanga in our institutional arrangements.

In 1990, the year of New Zealand's special recognition of a unique Nationhood that had begun with the Treaty of Waitangi, the Ministerial Advisory Committee on Maori Health found five compelling documents that stated why health agencies should develop specific policies for Maori health. They were, The Treaty of Waitangi, The Area Health Boards Act, The New Zealand Health Charter, The New Zealand Health Goals Maori Development and the Royal Commission on Social Policy. This further substantiated not only the need for responsiveness to the issue of low Maori Health status but supported actions that matched the intentions.

The Royal Commission on Social Policy (1988:Vol 3.p.808) developed a section about the issues of assessment and monitoring and noted that the trend to make Government departments more accountable to their clients would undoubtedly have

an impact on the research and monitoring activities. At the same time they also recorded that a number of major departments, including education, health and justice did not refer to their responsibilities for monitoring in their submissions to the Royal Commission.

Most organisations did however include groups of staff who were responsible for statistical collections, but it was invariably the case that the prime orientation of these was to provide management indicators for administrative purposes such as budgeting, recruitment, deployment, or capital works and their use for monitoring and assessment of the social impacts of their policies and programmes is usually a very secondary consideration. This was demonstrated by reluctance to keep records that illustrated variations in high or low usage between Maori and non Maori. Maori and non Maori statistical figures were difficult to obtain. Some small change to this method of accounting was found to have begun at the Bay of Plenty Area Health Boards Western District, but there was no meaningful relationship between them and staff numbers that reflected a realistic mix of the population, usage patterns or participation in prioritising and allocation of financial resources.

The Commission highlighted two broad categories that need to be considered in assessment and monitoring activities. Those which relate to the social context in which the assessment and monitoring occurred. Issues such as accountability, cultural appropriateness, freedom of information and the politics of evaluation, and those which related to the way in which the assessment and monitoring was undertaken, such as the cultural appropriateness, training and expertise of the researchers, management commitment, methodologies for evaluation, data content and quality, and the time frames within which the work was undertaken. The Commissions Report (Vol.3:p.821) noted that the growing response of Maori people to their experience of being the "subjects" of social research was negative and that there was strong criticism that much of Maori research serves only to reinforce

existing negative stereotypes - low socio economic status, high crime rates, low educational attainment levels and so on.

The Royal Commissions attention was also drawn to the keen interest Maori people have in developing and sharing ways of tracing their geneologies, (submission 2739) and the skilled research that occurs by Maori for Maori in terms of the data required for presentation to the Waitangi Tribunal. According to the report (vol 2. p.841), the Maori critique of Pakeha social research has direct implications for the way Government social policy should be monitored, with more insistence that the Treaty be an integral part of the development, more Maori participation in that development and in monitoring the social impacts of policies.

In this section the small amount of literature that could be regarded as tracing or revealing management responsiveness to the improvement of Maori health showed more ability to write about developments than to action them. There was an air of confusion, uncertainty and timidity of approach about such things as responsiveness, measuring and monitoring and of debate about the need to do so.

Editors such as Novitz and Willmot (1992) have assisted in explaining the confusion by publishing *New Zealand in Crisis*, a useful handbook which does set out a debate about topics as important as Sovereignty: Te Tino Rangatiratanga, Nationhood, Government, The Economy, Welfare, Education and Justice in sections where Maori and Pakeha views are presented side by side. This exchange of views had the potential to create understanding out of confusion, crisis and change and to contribute to management theory and practice for as the editor noted:

> In order to adopt adequate policies, our policy makers and their critics have to be open to evidence: they have to be willing to have their reasons, predictions and arguments tested against the best available research. And they have to be willing, and they need to be praised for being willing, to abandon their chosen policies in the light of evidence and reason.

RUA. MAORI

This second part of the literature review, in contrast to the paucity of management information on the subject, looks at a considerable body of currently available publications which have monitored the responsiveness of the state sector and its management, to the issues of the Treaty of Waitangi, mono culturalism and Maori development. The authors were all Maori, so that this section reflected the opinions and experiences of Maori people challenging the infrastructure challenging the bureaucratic system to be transformed to include biculturalism (Walker.1987:23.) We have been monitored consistently by Maori people since the signing of the Treaty of Waitangi, but as Ihimaera and Long (1982:2.) state:

> It was not until the early 1960's and via written English that Maori literature began to unfurl in views of the people, until then, participants in the largest underground movement known to New Zealand. Since the what has happened has been a cultural revolution . . . that focused on inequality, injustice, underachievement and over representation in negative health and welfare statistics, and the monocultural European methodology that excluded them from the national mainstream. Hence the necessity for a bicultural bureaucracy and particularly the innate rights of Maoris to be able to have control over their destiny in Aotearoa.

Race Against Time, published for the Human Rights Commission by the then Race Relations Conciliator, Hiwi Tauroa (1982:45-46.) supports this view in reviewing the myth of the egalitarian society that non Maori New Zealanders believed so steadfastly in and pointed instead to the reality of institutionalised discrimination through employment, education and justice. The publication made strong recommendations for change that included a framework for monitoring saying:

> We must move from merely speaking about acceptance and cultural understanding and put into practice some worthwhile changes to traditional institutional behaviours that are concurrent with the active promotion of a bicultural and then a multicultural society.

Walker, (1987:228.) too, points to the limits of Pakeha experience which have become obstacles to full participation in change, noting the most Pakeha New Zealanders are monocultural in outlook, it follows, then that they have to learn to become bicultural first.

Ihimaera has remained a consistent publicist of the Maori point of view both as a writer and editor. Of special importance is the continuation of the tradition begun with Into the World of Light (1982) that has now produced the Te Ao Marama series. The Kaupapa of Te Ao Marama, Contemporary Maori Writing. Volume 1. Te Whakahuatanga O Te Ao. Reflections of Reality. (1992:14) noted that whilst there had been a proliferation of other anthologies in the decade this was the first Maori to appear since 1982 and:

> Given that Maori writing is regarded as the pokumanawa of contemporary New Zealand literature the absence of Maori anthologies is telling. It remains as difficult ever for Maori writing to be published in Aotearoa.

Volume two of the series Te Ao Marama, Regaining Aotearoa: Maori Writers Speak Out (1993:15) explains that:

> He Whakaatanga o Te Ao is the non-fiction volume of Te Ao Marama. It presents the "reality of the world" as Maori writers of non-fiction have seen it since 1980. It is also, if you listen, Mokomoko's song.

Volume three returns to the theme of Contemporary Maori Writing and acknowledges a second generation of Maori writers who have burst beyond the traditional cultural constraints on form and content as the title, Te Puwaitanga o Te Korero. The Flowering, illustrates. This is explained further in the Kaupapa (1935:15) which states

> The concepts of centre and margin are challenging ones for any minority culture. English post colonial and post modern methodologies have defined the centre in majority terms as that which is mainstream. Maori literature like many indigenous literatures, is, by this definition, not the centre. From our perspective Maori literature is the centre - for if you are Maori and looking out, you do so from your own centre. This is the subversive viewpoint we have taken. We wish to look at things our way, from the inside out, not from the outside in.

The final volume to date in this series of Te Ao Marama, Volume four (1994) is Contemporary Maori Writing for Children and has the title Te Ara O Te Hau. The Path of the Wind. Nga mihi is to the tamariki with the following message:

> This is the legacy of your matua, and we pass it on to you with all our aroha, love and affection. This is who we are, who you are, where you have come from and what we are now. You are tamariki of a proud heritage, and this is part of it - a special part - written and composed just for you.

Magazines have a special place in this review of Maori literature because they are part of the process that Ihimaera (1982:2) described as unfurling the views of the people, into the world of light. Here, Broadsheet, the New Zealand feminist magazine, which although not a Maori magazine, made real attempts to include Maori women in a more comprehensive way than any other publication at that time, and published the article written by Awatere on Maori sovereignty as a series between June 1982 and February 1983.

Other more recent contributions about Maori health are the Maori magazine Mana which provides a regular forum for presenting a wide range of information by Maori for Maori. Mana receives regular comments from readers as well as making regular comment about events as the following extract from Volume 2 (1993:1) reveal:

> From the moment we first talked about publishing a glossy Maori magazine, we heard two reactions. "Beauty. About time too. That's choice or words to that effect.", or "You mugs. That's a sure way to do your dough."

Sales have reflected the enthusiasms of the first comment and mana sold out straight away in shops around the country. The staff are aware that they could still do their dough and that they have some way to go in making the country aware the magazine exists for as Fox noted (1993;1), we have progress to make with a few retailers who won't stock a publication that's Maori. Another serious note is struck in the editorial in volume 6 (1994:1) where the editor began:

> Tena ano tatou katoa.
>
> I'm not too sure that Jim Bolger and the rest of the political establishment had any right to be making a fuss over the passing of Whina Cooper.
>
> There's no doubt she deserved a fuss. Her life was as rich in achievement as was in years. Whina was gutsy, wise though sometimes wrong headed, a theatrical and fearless fighter, a charmer, ogre, hard-case character and genuing rangatira such as we'll never see again.
>
> But the politicians had a cheek applauding in public someone whose work they have opposed and whose dreams they are destroying day by day.

The Metro magazine also has a regular contribution from Ranginui Walker presenting a different point of view on current cultural, social and political issues. His column, Te Karanga provides a well researched analysis of major events that is useful beyond the "issue of the week". For example, from the last section of the February (1993:124) issue which had a cover story entitled Commonsense on Race by Laidlaw, he observed that:

> Another Waitangi Day is upon us . . . . . The present Government wants to be shot of Treaty claims before the turn of the century. If Government has its way, the Treaty is on the way out.

Together, these publications form an interconnected series about Maori Development and Maori health in the past, the present and the future.

The Report of the Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare, (1986) provided a potentially influential state supported critique of the state which "laid it on the line" after it had travelled around the country giving Maori people the opportunity to reveal the reality of the responsiveness of management and services in all areas, to Maori needs, from the recipients point of view. It concluded that the institutions by which New Zealand society governed itself, distributed its resources, and produced wealth, (health) did not serve Maori people but they did clearly serve the great bulk of Pakeha people. The effects of institutional racism were seen to be illustrated in our social statistics.

Pomare and de Boer, (1988:17.) introduced its findings by commenting that:

> Serious social, economic and cultural inequalities still exist between Maori and non Maori people and are important reasons for the disproportionately high levels of sickness reported within. Some of these difficulties are the result of the difficulties associated with mono culturalism.

Rapuora, (1984:85-89.) revealed the same dismal state of Maori health and noted that New Zealand was going through difficult times and Maori people in particular were poorly placed to withstand the buffeting. Having monitored "us" through a major research project, the report made some recommendations These included:

> We should have as a long term aim, the elimination of current disparities between Maori and non Maori so that all New Zealanders have life expectancies

> that do not differ between ethnic groups . . . That 1985 to 1995 be made a decade of health with some measurable goals . . . Maori are poorly represented in the Health professions. More doctors, nurses and health professionals would lessen Maori difference about seeking treatment and increase respect for Maori values in sickness and death.

The Treaty of Waitangi was very much to the forefront of Maori thinking and Government had a commitment to it. The signing of the Treaty by both Maori and Pakeha was seen as the recognition of a partnership between the two races. Poor standards of Maori health were therefore regarded by Maori as part of the non fulfilment of those Treaty obligations. The Department of Health had made a commitment to the development of a bicultural health system and workforce, and there had been strong calls for more effective involvement of Maori in health planning which was seen as a critical factor if the health needs of Maori were to be met.

Whilst Ihimaera sets a scene for what Pakeha might describe as health promotion, prevention of illness, community development and the development of self esteem, others such as Rolleston (1989) and Pomare and de Boer offer their contribution in a complimentary way, highlighting more specifically the present health status of Maori. For example, Rolleston (1989:43.) noted that Maori people were all concerned about the inferior status and social position of their people. He recorded that the blame had been laid on Maori shoulders:

> Lack of ambition, low aspirations, inability to adapt to changing social circumstances, and reliance on what some have termed, an out-moded cultural value system, have been some of the reasons put forward.

However, such explanations came largely, from people with little or no comprehension of Maori society and such judgmental criticism was being rejected by Maori and Pakeha alike. More recently explanations have tended to emphasise the limitations of governmental policies that have aimed at the assimilation of Maori into European and Pakeha cultural thinking.

Rolleston (1989:43.) went on to report that:

> From Maori people, who have been able to retain strong links to a rich cultural heritage, the cry has come, "enough is enough". They have become more strident in their demands to have their aspirations, values and structures incorporated into social and political processes in this country.

The demands derive from the terms of the Treaty of Waitangi, which showed clearly that Maori culture has as much right as Pakeha to official recognition and protection.

TORU. "NEW TIMES"

Earlier in this review, reference was made to the significance of the time frame in which the work was done. (Royal Commission on Social Policy. Vol.3.819) The Commission referred to several aspects with regard to timeframes; one which was cited was a description about social science research which addresses the issue of timeliness and described the speed with which demands for information occur and noted that, our existing knowledge base needs updating in the light of rapid change, as well as the practical difficulties in preparing timely data in such conditions and the need to find new ways of reflecting the changes in society. In particular it was noted that measurement in an increasingly deregulated environment was resource demanding. (p839) This section which includes both Maori and Pakeha authors acknowledges that as a special issue for, these were changing times. They were times where reports written one day may have been out of date the next, and where what seemed real one day may not have seemed so in the near future and where people were often overtaken by events outside their control. One such example in health has been the dismantling of the Area Health Board membership on budget night 1991. The public, accustomed to access to a member who might reasonably be expected to represent their interests suddenly did not know who to approach, and saw the small amount of influence they had in the development of health systems and services discontinued with no plan for a replacement forum.

Nevertheless, for Maori the issues of the Treaty and poor health remained constant, but required new responses in new circumstances. The growth of Maori nationalism and the increased demands by Maori for the right to decide about and control their own destiny in the 1970's and 1980's led to forms of service delivery such as targeted services, and policy directed at Maori. The New Zealand Health Goals and Targets (1989:4.) noted that targets specify the amount of change and the time by which the change is to be achieved. Six criteria were set for the selection of goals and targets, one of which was that, the achievement of goals and targets should reduce social and ethnic inequalities in health status. Departments, as Spoonley et. al., (1990:92.) noted were to be culturally sensitive and to be guided by the needs of the community they served but the partnership model, based on recognition of the Treaty of Waitangi and the need to share resources and power, have left many unimpressed with the rhetoric of reform.

There was now a need to go beyond those approaches and devise systems that would lead to more accurate use of resources. Circumstances had changed, and the social and political effects were substantial. To mark the different nature of them, a group of social scientists coined the phrase "new times". They described a "two nations cleavage," that is a cleavage between a core workforce skilled and well paid, and marginalised groups of workers whose locality or industry can no longer provide jobs. (Norris 1991-1992:129) in an article about change, wrote similarly of ideas that had been overtaken by the passage to a postmodern, "New Times" outlook. He called the article "Old Themes for New Times" and wrote of similar phenomena highlighting facts like:

> Unemployment, urban deprivation, the run down public services, and the emergence of a two tier public health system.

Other writers about postmodernism such as Giroux (1993) and Hall (1992) have also raised the issues of "new times" and the need for new understandings of the more sophisticated postmodern and New Right responses to the old issues of racism,

exclusion, marginalisation, dispossession and dominance. Identity politics, that is, personal and political identity and representation that reflects difference has according to Giroux (1993:5) replaced communism as the most serious domestic threat to the New World Order and contributed to the New Right's powerful strategy for abstracting cultural difference from the achievement of social justice. It does this, not by centring on the racial superiority of whites or the promotion of Anglo-European culture as synonymous with civilisation, but by focusing on cultural uniformity which Giroux (1993:5) noted was parading under the politics of a nationalism and patriotism which removes difference.

Hall (1992:252) also noted a shift in the responses of the disposed where he observed:

> The existence of a cultural politics that was designed to challenge, resist and where possible transform the dominant regimes of representation . . . which involved access to the rights to representation and a shift from a struggle over the relations of representation to the politics of representation.

In New Zealand, Walker (1987:228.) also notes the two nation cleavage, writing that there are basically only two cultures in the world, the culture of, indigenous peoples and the culture of metropolitan societies. They equally describe the history of dispossession and poverty; the gap between the rich and the poor and link these conditions to the shared experiences and responses of the world's indigenous peoples.

This dichotomy of cultures as described by Walker is an important prerequisite to the understanding of the substance of the unity of the world's indigenous peoples with regard to their recovery from the experience of colonisation. Indigenous cultures around the world are diverse and varied but they share the experience of dispossession and oppression. Their interaction at international, national and local level has become critical in the actioning of postmodern representation, political practice and the politics of difference are as Hall (1992:252) observed, designed to challenge, resist and, where possible, to transform the dominant regimes of

representation and they pose a serious threat to dominant configurations of power and control.

Maori in New Zealand are pursuing a course that includes the new politics of identity and representation. At the same time, the development of new government strategies for privatising health and social services had major implications in terms of access to a range of goods and services and was especially critical where the quality of services depended on the ability to pay. Additionally, there was, as competition for scarce resources in the open market increased, the creation of a new racism by various right wing groups, which altered the way in which many understood racism and ethnicity. As Spoonley noted, they:

> Emphatically reject the ambition to develop a bicultural or multicultural society, and oppose changes to "traditional" beliefs about gender and sexual relations. Typically, they encompassed notions about . . . the inherent superiority of British customs and institutions and of the necessity of preserving these advantages by maintaining "racial purity."

While the New Right contained disparate groups, all were critical of social engineering and the "privileged" status of Maori generally and had become increasingly hostile during the late 1980's to anything Maori. A new set of postmodern arguments appeared. Racism was something that Maori practised against Pakeha. Pakeha were the "new" disadvantaged and institutional racism was used by the New Right to refer to Maori privilege and Pakeha disadvantage. Giroux (1993:5) noted that in America the trend was also apparent as politicians were asking, "Who speaks for the Euro-Americans? Is it not time to take America back?" Thus, gaining support from this turnaround, by 1989, the State had manipulated the issues of Maori nationalism by neutralising land claims, coopting Maori people as advisors only rather than decision makers, and retaining control over budgetary items. (Spoonley et al 1990:96.)

Researched for the "new times" heralded by the health reforms, Ka Awatea, the report to the Minister of Maori Affairs (1991) has remained one of the most up to date

monitoring documents on the performance of Pakeha management in the development of health systems and services. In the letter of transmittal, the researchers voiced the hope:

> That the ideas they portrayed in Ka Awatea would lead to the lifting of some of the difficulties which weigh upon us as a people. We begin our report by describing the current position of Maori in society. Our description portrays a people in crisis, beset by major disparities in almost every area measured. (1991:2.)

As well as describing the position of Maori in society, the report formulates key strategies to achieve Government responsibility which includes an assessment of current policy and delivery systems in the Maori Affairs area, on the premise that policies that continue to disadvantage Maori also deprive all New Zealand and that development cannot occur with the current unacceptable socio economic imbalances between Maori and non Maori. The report sets out clear strategies for change that are partnerships between the state, the private sector and the people. Programmes and services were to have the characteristics of being well structured and cost effective, completely transparent, totally accountable, highly focused, proactive and effectively monitored.

As the health reforms were occurring, Maori continued to monitor what the "new times" were to mean for Maori and at the Bay of Plenty Area Health Board, (1992:22-23.) Te Mana Hauora, the administrative arm of the recognised Maori health authority for the area from Mai Nga Kuri a wharei ki Otamarakau, called Te Whanau Poutirirangiora a Papa conducted a responsiveness review of the Boards Corporate Office. The review remains, as an internal document, unpublished. The review was about the efforts being made in the Bay of Plenty to improve Maori health. As Te Mana Hauora noted, it was accordingly, about:

> New relationships and new behaviour, and about inexperience and often, the need to try again; about a new mind set and about courage, goodwill and tenacity, and about a commitment to reversing the disparity between Maori and non Maori health. It is about the future, "a way forward", about reformed and improved health services, about getting it right together and about wellness in Aotearoa.
> (Bay of Plenty Area Health Board.1992:5.)

The results of this review were encouraging, and slow but consistent progress in Maori participation in policy making was recorded. Gains were traced in access to information, resources and a consolidation of positive attitudes to Maori in the organisation.

On the other hand, there was a note in the conclusions that, the shift from theory to practice, intention to action was a difficult process. As it was recorded in the review report:

> this is reflected particularly in the absence of spontaneous initiatives and the sometimes slow attention to Maori priorities.(1992:15.)

The recommendations included the need to continue the bicultural education and training of non Maori staff, the sustaining and increasing to Maori staff levels, that a cultural safety policy be put in place, the refinement of the system by which monthly totals of spending by the Corporate Office, Districts, Service categories and programmes, to show the totals of spending directed to Maori health. Additionally, it was recommended that the present Maori structures be supported and developed and that a Responsiveness Action Plan be formulated as part of the corporate office strategic plan and similarly at each of the districts. This plan was to include monitoring arrangements (1992:23.)

Later and similarly, Te Puni Kokiri the Ministry of Maori Development which replaced Manatu Maori in 1992, published a series of documents which gave advice based on the past and the present, which was designed to inform Maori and assist them in understanding and acting in the tumultuous changes of the health reforms. In April 1993, the Ministry published the document called Kete Matatiki Hauora. A Health Reforms Resource Kit, which not only offered advice for those Maori wishing to get into the business of health, but also a history of Maori health development generally which traces Maori difficulties with Pakeha organisations from first contact with Europeans and the Treaty of Waitangi, through to the learnings considered

useful in improving Maori health in the new climate of the health reforms. Historically, the handbook noted (Te Puni Kokiri 1993:31) as far back as 1900, the separation of the administration of Maori health development, through the Maori Councils Act 1900, from that of other New Zealanders recognised:

> The need to employ different processes to achieve the same health goal in different populations. However this process was also short lived.

Six years later, the Department of Native Affairs which had previously subsided health services to Maori, handed over this responsibility to the Department of Public Health where Maori needs and priorities were in competition with those of Pakeha. In 1909, frustrated by the lack of government responsiveness and achievement in Maori health, the first coordinators of Maori health development, Dr Maui Pomare and Te Rangihiora, resigned.

The report presented warnings to Maori regarding the lessons of the past that were cautions for the present and the future. Six lessons were highlighted beginning with the risks to Maori that were inherent in restructuring. Risks such as the appointment of only one token Maori on boards and committees, the expectation of Maori that they play full, positive and active roles in policy and the delivery of services, that development be driven by long term Maori agendas rather than short term Pakeha political expedients, that Maori energies be spent in the development of fresh approaches with iwi acting in concert rather than Pakeha driven competition. (Te Puni Kokiri.1993:60-68.)

Despite the fact that health has been regarded as a priority area in social spending and Maori health a priority in the funding of health services, Maori have remained disenchanted by the new organisational arrangements of the health reforms. For example, the Midlands Regional Health Authority (1994:13.) in a document called, "We are Listening" listed Maori Health as one of its ten priorities and stated that together with Maori, they would identify what health services would best meet those

needs and make sure the services they bought for Maori were working for Maori. At the same time, Maori were saying that the regional Health Authority was not listening to them and they were reported in the Bay of Plenty Times (1994:2.) as not being listened to, and protested accordingly by stating in response:

> Bay of Plenty Maori say the Midland Regional Health Authority, with whom they have formed a partnership to advise on the needs of Maori health, is not listening to them. For example, in their document Midland says they will with Maori, identify what Maori health needs. We have already done that and given our findings to them. They are ignoring us. Further, the spokesperson said the "We are Listening" document was published without consultation with the iwi group.

The continued discrepancy between the health status of Maori and non Maori has raised questions about the dislocation between the policies and the services that Maori have received and ultimately about the ability of managers to plan and deliver them. It has raised again for Maori, the issues of management, who are in the main non Maori, understandings of and responsibility for, meeting the need by both planning and delivering effective culturally appropriate services.

From 1989 until 1991, the responsibility for monitoring the outcomes of central Government and its organisations was the broad responsibility of Manatu Maori. However, Manatu Maori was also caught in the rapid institutional changes of Government reforms and had in its short life only part facilitated communication and information in this respect. This viewpoint was supported by the authors of Ka Awatea (1991:54.) it would appear that:

> It has been largely ineffective in assessing the principle cause for the differentials and has had little influence in obtaining changes which result in better primary health care and more equitable access to health services. An important adjunct to its strengthened policy function in vote Maori Affairs remains the need to monitor the health portfolio.

PART THREE:

THE METHODOLOGY

CHAPTER 4

CHOOSING THE RESEARCH TOPIC

This chapter describes how the research topic was chosen. It discusses the methods used and some of the reasons for choosing them. It provides a background in the literature that is available, in monitoring Kaupapa Maori and Responsiveness. Lastly, it describes the process of the research, the selection of the subjects, the material gleaned in the interviews and the analysis of that information.

This research was strongly influenced by the events of my life and to the extent that those events can with hindsight, be traced as a pathway, I believe that the research topic "chose" me. By this I mean, as Noonan (1993:57) described, that I am a generation too early to have planned my life. Things have happened to me. I have been lucky. In the early seventies having married and raised a family, I sought to return to a career in nursing and found that Tauranga Hospital did not undertake any refresher courses for nurses. Soon after, I was offered a new direction, a position in Social Work. What Comfort (1987:15) would have described as my third "career trajectory" has now spanned twenty plus years and led to a new way of looking at the history of New Zealand and the world, that can be described as a continuum. A continuum that has been shaped by family and friends and by Maori and Pakeha and by being part of a particular context in the history of Aotearoa.

Within social work education and training I had the opportunity to explore the theoretical and ideological notions that helped make sense of my life, the lives of others, and the context in which we experience those events. As well, I had the opportunity as a senior social worker to recruit Maori staff and to start the development of a social work service that could deliver culturally appropriate care, to see and feel some of the deeply ingrained obstacles to the success of bicultural

development. In the decade of 1980's in Aotearoa, it was not possible to practice as an agent of change without questioning the discrepancy between understanding, intentions, energy outputs and the outcomes of planned change.

These were the years of recognising, as Brake and Bailey (1980:19.) highlighted:

> that the notion of the individualism of social work practice and decision making needs to be resolved by more collective action. That is extremely difficult to work radically without involving the team, and other welfare state workers.

Later in 1990 I was chosen as a policy consultant to Te Puna Hauora Maori health unit providing services designed by Maori for Maori, where I returned in 1991 as a team member to fully support their kaupapa, following a secondment to another Maori unit, Te Mana Hauora, at the Corporate Office of the Bay of Plenty Area Health Board. These most recent opportunities gave me critical experience in social policy analysis, formulation and planning that was underpinned by a demonstrated commitment to the Treaty of Waitangi and which had a major influenced the topic for this study. With hindsight, I have been able to see my life and my work as a series of connected events that came closest to the paradigm called radical social work practice. Galper, (1980:12-13.) in describing radical social work practice, comments that:

> Radical social workers, to the extent that they practice radical social work, are not liberals whose practice of social work is radical. Rather, radical social workers are radicals who are social workers and who bring greater consistency to their lives by integrating their political commitments with their work - as they try to integrate their politics with other aspects of their lives . . . Radical practice will call on people to grow, to risk, to change, and to work hard. It is not defined by its commitment to dead-end adventures, one shot acts of conscience, militant postures and the like.

It is important to have noted that the research was planned, and that the interviews were conducted in the last stages of the life of the Area Health Boards. The data was analysed and the results compiled in the midst of the funder provider split which involved a change over from those Boards to Crown Health Enterprises and Regional Health Authorities. That is, whilst the research was about the changes needed to deliver culturally appropriate services to Maori, it was itself caught up in the tumult of the significant instability and change in the health system. For example, in the

period from the end of the era of Hospital Boards in 1989, to the beginning of the Regional Health Authorities and Crown Health Enterprises in 1993, Tauranga Hospital had nine different managers. This was in some sense a benefit to the research as it raised the issue of the effect of constant change in organisations as well as the endurance of attitudes of resistance to real ideological and structural change and the continued disadvantage of Maori in sharp relief.

Further impetus was provided by the increasing international profile of indigenous peoples seeking to assist each other to regain sovereignty, health and power. For example in the Hawaiian publication News of the Kingdom (vol one 1993:1) it is emphasised that Polynesian Pacific developments are a supportive network working towards a new dawn for Indigenous peoples and that the question of independence is no longer debatable.

In line with these ideas of regaining independence and responsibility for themselves amongst Indigenous peoples, Arrien (1992:4) identifies four, rather than the three worlds that form must conventional global parameters. She comments that we live in an age that is calling for "new World order" and suggests that our current world actually consists of four worlds. The industrialised first world, such as the United States, second world socialist nations, the developing nations of what we call the third world like Brazil or Thailand and the fourth world. The fourth world is described as:

> The name given to indigenous peoples descended from a country's aboriginal population and who today are completely or partly deprived of the right to their own territory and riches. The differences between these worlds can be stated very simply: the first, the second and the third worlds believe that "the land belongs to the people", the fourth believes that "the people belong to the land."

Arrien goes on to discuss the interface of these belief systems and states, that the interface between them is where the vital relationships are established that are necessary for survival in a world of increasing inter dependence.

Ritchie, (1992.7.) too, refers to the fourth world and to fourth world cultures as those which have struggled to release themselves from colonial domination are forced by circumstances to seek to assert their identity while submerged in some wider culture, usually industrialised, technological, and resource hungry. In his view, minority people in fourth world situations have developed the following three intertwined political objectives, that reflect their similar circumstances:

> To capture or repossess resources upon which to base some measure of economic self determination. To penetrate the bastions of power and become politically audible and visible and to secure the means of continuing cultural distinctiveness or identity.

Alongside these factors were some of the issues of science and of being a researcher. It is clear that all research supports a particular point of view. For as Bryson (1987:88) wrote:

> The fact that we do research at all is itself based on a particular view of the world and involves the implicit belief that this is the right and proper and "natural" way to understand something.

She went further to note that the choice of a method and the prior choice of a subject also necessarily support a particular point of view and involve a power dimension, therefore, she argues (p88) that at the most fundamental level all research is thus a political act.

My focus on measuring and monitoring the fate of Pakeha initiatives to improve Maori health reflects an active interest in the issues of the Treaty of Waitangi. The issues of equity, and equality of access in health; in where money was being spent; how services were being prioritised and delivered; the results of these arrangements on Maori health status and what obstacles there were to be more effective distribution of resources. In other words, as Wilkes and Shirley (1984:10.) note, who decides and on what basis will influence both priorities and outcomes. They consider value free science to be an unsophisticated position. Yet, many scientists claim no particular point of view, that is, they acknowledge no inequities between the two major cultures in New Zealand and make the "we are one people" claim. Further, they claim

objectivity, a value free stance or that their practice is what Bryson (1976:96.) describes as "context free" and will rarely discuss the political nature of this stance.

Bell and Newby (1978:10.) go further to say that normative methodology often appears to be "context free" or as they describe it, carried out by non people in non places. It is also clear that much health research is of a conservative nature. That is, it supports the system, often not by being directly exploitative but by ignoring the study of the processes of exploration. Little promotes any restructuring or redistribution. A symptom of this conservatism is seen in the choice of topics; in the way most research studies "down" to the poor, the deviant, the sick, ethnic groups, trade unionists. Thus, when data is collected it tends to be from relatively powerless sources and leads to the prevailing practice of locating a problem in a target group or blaming the victim, rather than society or its structures.

One of the reasons for this in the health sector, as Davis (1981:12-13.) reports, is that the medical profession has come to dominate our thinking in the entire health arena and a very important aspect of the medical model of practice is the individualisation of health problems. A tendency to "blame the victim" is a very widespread manifestation of this dominance and individualisation. In other words, as Spoonley et al note, what management see that target groups really then need, is not more doctors, hospitals or appropriate treatment centres but more willpower. (1990.150.)

"Studying up" is a phrase coined by Laura Nader (1974:289.). It describes a different approach that we use when we discuss questions related to social and political power. She notes that we tend to seek a different sort of information, relying on documents, statistics and policy analysis, since direct access to the powerful is difficult to obtain and may carry retributive risks. Bryson (1979:18.) too, suggests that powerful people can protect themselves from the intrusion of social scientists. In New Zealand, the Maori health profile has been obtained by researching down and as Murchie (1984:5.)

records, Maori people, along with other relatively powerless groups have been observed, dissected and frozen in sometimes unflattering and unpalatable figures. The project was not only a criticism of outmoded and unuseful ways of collecting data but to validate a model that was culturally appropriate and that would lead to action designed to improve Maori health status. Seven years later, the report Ka Awatea (1991) was highly critical of the lack of responsiveness of health services to adequately meet the needs of Maori, despite ample information showing the difference in health status between Maori and non Maori.[2]. That report cautions (1991:9.) that policies which continue to disadvantage Maori also deprive all New Zealand. Even the conservative statement of Government health policy (Upton.1991:63.) acknowledged that our system has been described as monolithic and monocultural.

Three main factors coalesced and provided the final impetus for this study. They were firstly that I worked alongside Maori and supported their vision for improved Maori health status where it was impossible not to have observed on a daily basis the mismatch between the evidence of poor health status, the struggles experienced by Maori health professionals to gain the right to participate in what Perrucci and Pilisuk (1979:xviii.) note as, the formation of those policy decisions that will affect their daily existence.

In working with a Maori health team and committing to their Kaupapa, the racism and exclusion of Maori health as a priority became insupportable for me as a person and a social worker, for as Friere (1972:26.) noted, solidarity requires that one enter into the situation of those with whom one is identifying; it is a radical posture. Coupled with this was a perceived lack of understanding or willingness from managers of health organisations to include Maori expertise in policy and planning or to try to do things substantially differently, and the opportunity to spend time working with the Manatu

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[2] ????????

Maori team developing the package called Kaupapa Maori and Responsiveness (1990) which was about the introduction of measurement and monitoring strategies for the success of health outcomes.

It was the issue of responsiveness in the face of growing evidence of unresponsiveness that encouraged the idea of "studying up"; of eliciting some of the subtle and not so subtle obstacles to the achievement of Maori aspirations; of not ignoring the continued process of exclusion and exploitation. The responsibility for improved Maori health, in the reformed and managed health service where as Boston et al noted, (1991:9.) the familiar slogans included "Let the Managers Manage" and "Managing for Results" clearly lay with management. Just as the evidence of unequal health status for Maori people, and the intentions of the reformed managed health service were well documented, so was the evidence of risk to those intrepid researchers who have dared to ask those questions which bring the present system into question. Choosing topics which had the expressed aims of helping the less well off in society may be considered contentious, radical, impossible or a career risk, for as Robbins and Anthony (1980;288.) comment, the dominant medical system has the power to sanction or eliminate competing systems. There was also the strong possibility that the information gained, just as in the past, will be ignored. Nevertheless, we live in times of change and there was conflict and challenge and discussion and the potential for progress. This was what I believed should be promoted, for in the end I agreed with Gouldner (1970:49.) that "soul searching" is better than "soul selling".

THE SELECTION OF SUBJECTS AND PROCESS

The decision to "research up" to management did in itself select the subjects, as management were being targeted to provide the data for this aspect of the study. The

group available in a medium sized health facility such as I worked in, was small and easily identifiable. They form a particular sample which Kidder (1981:427.) calls purposive samples. The basic assumption behind proposive sampling is that with good judgement or an appropriate strategy one can hand pick those to be included in a sample and thus develop samples that are satisfactory in relation to ones needs. Whilst I was not able to choose the sample in quite that way because of the low numbers of managers in the organisation, it was deemed a satisfactory purposive sample because they were all managing towards shared organisational goals.

The intention was to invite managers from both Western Health District, which included Tauranga Hospital and the corporate office of the Bay of Plenty Area Health Board to participate in the study. This included a range of people in senior management or influential advisory roles which encompassed the main range of services delivered by the Western Health District. Researching up to management, rather than down to the poor or the powerless, did create some difficulties in sampling as the numbers of mangers was already small and the restructuring of the health reforms caused further changes of management staff and reductions in personnel who might have influenced decisions with regard to the improvement of Maori health status.

The sample were chosen by me because of the management positions they held and their availability. The total number was ten. Four were women. There were no Maori in senior management positions in the organisation where the study was actioned. An additional sample of three managers were chosen to participate in a pilot study to pretest the questionnaire. That was as Kidder (1981:162.) suggests, a means of catching and solving unforeseen problems in the administration of the questionnaire and the interview such the phrasing and sequence of the questions or its length. It could have indicated the need for additional questions or the elimination of others.

THE RESEARCH PROCESS

The dominant position of the research - policy relationship in health in New Zealand and at Tauranga Hospital has been that of western scientific medicine, which sees research as providing objective, factual information and distrusts that which is subjectively felt or part of the researchers daily experience. Paul (1994:1.) in a recent quest editorial for the Otago Bioethics Report wrote that:

> Many ethics committees explicitly take a view of ethics that excludes scientific issues. Consequently, poor or useless studies pass such review even though they can reasonable be considered to be unethical.

The difficulties which qualitative researchers and insiders doing qualitative research with respect to questions of objectivity may, as Finch (1991:197.) suggested, be regarded as having been settled some time ago by many social scientists, but they remain live issues in policy related research.

Partly this was seen as a function of what has been called the dominant tradition in research which remained strong, and partly as a result of the undertaking of research where there was a clear and direct engagement with the social and cultural worlds. In health research it was the dominant medical tradition which remained strong, and has been challenged by research which highlighted questions of values and culture and where in advocating change, those values have had to be made explicit.

The choice of a research framework was significantly influenced by Spoonley (1987:281) who noted that in some situations, rigorous hypothesis testing and statistical techniques are inappropriate and that flexibility and insight are most likely to be provided by the domain of methods referred to as ethnographic research. The ethnographic method allows for a range of approaches that was suited to the variety of research aspects such as I intended to use. That is the examination of documents, the recording of events such as strategic planning meetings, consultations as well as interviewing some managers through the use of a semi structured questionnaire.

Stanley and Wise (1983:40.) discussed some of these difficulties within a concept they called theory from experience that led to the inclusion of theory, experience and research. They suggest that:

> the researcher's own experiences are an integral part of research and should therefore be described as such. The kind of person we are, and how we experience the research, all have a crucial impact on what we see, what we do, and how we interpret and construct what is going on.

These difficulties needed to be addressed in the study as my day to day work with a Maori health team provided a myriad of seemingly small relatively informal events that were relevant to the research. The difficulty lay not with the paucity of information but with its amount, so decisions had to be made about what would and would not be used; not necessarily because of perceived preference but rather that the frequency which new and potentially useful data became available was a daily occurrence, for as Davis (1981:59.) noted:

> The prevailing system was almost entirely attuned to the mainly urban white population, it was not surprising that the health care system continued to respond rather inadequately to the requirements of ethnic diversity.

The amount of data available and the consequent need to make decisions about the extent and limits of what was used was an early problem of the research. Access to both formal meetings and chance conversations inherent in my position as an insider, and which would not have been available to an outsider were at once an advantage and a disadvantage. There was constant information, yet too much to use so these aspects needed to be explored.

However, given that I worked with a Maori team in a Pakeha organisation, the perception of advantage and disadvantage failed to describe day to day practice where the realities were of access to dual information. Complex information from two worlds created a different "normality". After some exploration, it seemed more relevant not to make a judgement on those possibilities, rather, to raise them for the consciousness of the reader, for as Rolleston has noted (1989-1990:1.) using the

analogy of a windows, one labelled Pakeha perspective and another labelled Maori perspective that:

> From each of these windows the view of Maori health is quite different, although there is no change to what is actually there. There are a host of reasons for the differences. The most important difference is that appropriate education and acculturation is needed before it is possible to see through any of the windows.

The factors that I considered might be for me as the researcher significant were, the length of my tenure in the organisation, my attempts to become bicultural, and my widely known stance about injustice and unresponsiveness in the health system to the long held knowledge of poor Maori health status and the fact that I was doing evaluative research which as Kidder (1981:83) observed: is applied research and therefore has an explicit social and political component for clients, staff and the agency, because it produces findings that are applicable, practical and immediately useful.

Additionally, there was the consideration that as an "insider" in a Maori team, I was open to similar levels of exclusion, racialism and racism and reverse racism described in the study as Maori are. I have raised this for readers because I had from time to time been asked, what kind of problem it posed, whether it lessened my conviction or whether I had felt caught between two cultures. My reply was that as Spoonley (1987:13.) notes that racism has been part of New Zealand society since Pakeha colonisation, dealing with it by developing behaviour and strategies that resist racism was for me, part of the process of becoming a Pakeha New Zealander.

Further, I have highlighted an excerpt from what Sivanandan (1990:16.) has said, that describes some of all our struggles in his own conclusions, saying that:

> At the end of the twentieth century, when all our boundaries are breaking down, we should be looking not to roots in some place but to resources within ourselves for our understanding of our place in society, our place in a particular country, our place in culture. The heart is where the battle is.

I chose a questionnaire guided interview as the focus for the data collecting process. Because I believed that open ended yet, set format questions were sufficiently flexible

to allow for enlargement of the respondents ideas and allay any fears held about the topic. As well it provided a framework in which researcher and respondents were guided and remained focused on the central issue of responsiveness in both though and action.

The response to the letter of request to participate in the study that was sent out would also begin to test one of the central ideas of the research, that was, that managers would resist "researching up". Thus the starting point was considered to be the beginning of the subjects "self report", which was an important consideration in monitoring responsiveness. I was aware that the nature of the study would have been substantially different if managers refused the invitation to be interviewed.

The questionnaire as a guide was also considered to have other benefits; I believed that it would yield a better sample of the attitudes and actions of the people being studied, for as Kidder (1981:146.) wrote:

> It (the questionnaire) is more appropriate for revealing information that is complex, and social responsiveness is a complex issue as it involves peoples knowledge, attitudes, beliefs, feelings, motivations, anticipations or past behaviour.

Moser and Kalton (1981:45.), note that nine out of ten social surveys use a questionnaire, and Briar (1991:8.) concluded that problems arose in any attempt to keep a purely quantitative or qualitative set of methods and concluded that most researchers use a combination.

ETHICAL CONSIDERATIONS IN THIS RESEARCH

The combination of reading a number of writers (including: Kidder 1981; Bryson 1979; Finch 1984; Rolleston; 1988-1989 Manatu Maori; 1991) and doing this research has raised my awareness about ethical issues. Equally it has raised my

awareness of another important area of values and beliefs that have remained monocultural and which were impossible to ignore in the study. Accordingly, a brief outline of the history of the exclusion of Maori values from the development of ethics in New Zealand was considered appropriate as an illustration of areas of practice that are deeply affective for Maori and which remain part of the issues of unresponsiveness.

The development of ethics, their philosophical underpinnings and codes of ethics is contained in the development of the Western Scientific tradition which went back as far as the Greeks. Lowenberg and Dolgoff (1989:9.) noted that:

> Several thousand years ago, Hippocrates demanded that Greek physicians pledged themselves to a high level of professional conduct. The Hippocratic Oath became a guide for the correct conduct of medical doctors in the ancient world as well as modern times and the first of the modern codes was prepared in England in 1803.

In New Zealand, ethics and ethical practice have developed from those of the early colonist doctors who brought with them, the culture, customs, traditions and ideology of 19th century Britain which as Bedggood (1981:24.) observes became strongly embedded in the New Zealand way of life. The beliefs and values arising from this background are those that have continued to inform majority standards. Majority standards are largely, then, monocultural in origin, drawn from a narrow sector of Pakeha society, usually the more conservative, ethnocentric and powerful middle class whose background and precedents are English.

Historically, medical ethics based in the Hippocratic Oath have been the most influential in the formation of ethical codes and in sustaining the dominant value system in health where as an as Davis (1981:12.) commented:

> A more fundamental issue in the social funding of medicine is the way in which a single occupational group, the medical profession has come to dominate our thinking about the entire health arena.

But the subject of contemporary ethics goes far beyond mere custom or habit. It begs the question of consensus, of whose custom or habit, for Madison (1980:9.) writes,

ethics lead us directly to the question of values, then there is the question of whose values, preferences or assumptions about what is valuable and good are to be considered and given dominant weight.

In New Zealand, the major traditions in research have been bound into the monocultural system and the ethical considerations that have been developed are also part of the dominant culture and have disadvantaged Maori people. For Maori, ethics was a central part of their culture which had its own mechanisms to ensure what Pakeha (Oxford Dictionary:1969:415.) have called the science of morals, moral principles and rules of conduct. Ancient Maori society was essentially tribal, with each iwi being a nation unto itself, with its own distinctive leadership system, particular economy, and particular types of information, were highly prized and tightly regulated. Secrecy and imposed sanctions were the norm, and the observation of tapu formed a practical basis for the protection of such knowledge. As Manatu Maori (1991:7.) discussed:

> Each skill had its own secrets, strategic or mnemonic and these secrets were closely guarded. To betray them and break the ethical commitment made to continuing or protecting the tradition for the iwi's benefit usually resulted in punishment. The acolyte or adept was always accountable to a higher authority, such as the chiefs, or a broader, more collective authority such as the whanau, hapu and iwi.

In an attempt to regulate the relations between professionals and clients, and to protect clients from exploitation, all modern professions and organisations have developed codes of ethics and ethics committees.

Whilst social research is frequently conducted in order to promote positive social change, researchers also have a duty to protect the lives of research subjects from undue disruption and intrusion. To this end Thiroux (1986:25) established a set of principles of ethics which included, the value of life, justice and fairness, individual freedom, goodness and rightness and truth telling or honesty. The Massey University Human Ethics Committee has laid down the following principles in social research;

confidentiality, informed consent, the minimising of harm, truthfulness, and social sensitivity to the subjects involved, especially those of a different race, gender, social class and age from the researcher and where there are power imbalances. Those principles were followed in this study.

THE ETHICS COMMITTEE

My submission to the ethics committee of the Bay of Plenty Area Health Board was correctly presented through the organisations protocols for research. That was, through the Western Health District, where the requirements were that all the research information, documents and application forms were presented through the General Manager to the Chairperson of the regional committee.

The General Manager Western District supported the application through to the regional ethics committee and the reply from the Bay of Plenty Area Health Board gave their consent to proceed (1992:1), saying:

> This is to confirm that you do not require the approval of the Board's Ethics Committee for your research study. Your research clearly does not involve access to patients or their records and it appears to be based on a sound methodology.

ETHICAL ISSUES: THE MASSEY UNIVERSITY GUIDELINES

Confidentiality

Except where managers may have told others of their participation, I am the only person with the knowledge of those who eventually participated. Only I have heard the taped interviews or seen the transcripts of them. Names, not even false ones, were not used and the titles of management positions were deleted to assure confidentiality.

This was the main ethical issue in the study because of the small numbers of managers in the sample, in a wellknown organisation.

Informed Consent

Informed consent relates to the stance of the researcher and also tests their openness and communication skills. This aspect was actioned by speaking with each of the Managers in the sample to explain the project before sending a letter and seeking their consent to be interviewed and I checked that they were happy to participate.

The Minimising of Harm

As Kidder (1981:3) pointed out:

> Evaluation research differs from the other forms of research we have discussed not its methods but in its purposes, its use, and its relationships to social and political institutions . . . it is carried out for practical reasons - to produce findings that are applicable, practical, immediately useful.

Whilst the practices involved in confidentiality and informed consent serve to minimise harm, when making evaluations that have implications for social policy and public welfare researchers must pay particular attention to questions of protection of respondents and the minimising of harm.

Kidder (1981:373) listed some of the questionable practices that may be encountered by participants which included lack of informed consent, coercion, dishonesty about the true nature of the research, leading the participants to commit acts or that diminish their self respect and causing physical or mental stress.

Truthfulness

There was no necessity for deception of any kind in this study. My intention to influence social policy was always openly stated. No participant queried that information that I wanted from them and they have all been kept in touch with the

progress of the study. In presenting the thesis, my intention is to be true to their statements and to either their emphasis.

Social Sensitivity

The phrase, social sensitivity, may be applied to the notion of cultural awareness, tolerance, acknowledgement, acceptance, and validation of differences.

The people I interviewed were all by cultural background and social class, similar to my own. That was, none declared any indigenous status and we shared a work background of professional qualifications such as nursing, social work, occupational therapy and management. My experience differed however in my opportunities and efforts to become bicultural and my strong stance on the subject of Maori health was known, as was my intention to promote change in the organisation. To my knowledge, those more recent differences did not significantly affect the rapport that I had with the respondents.

THE PILOT STUDY

A pilot study was conducted, as discussed earlier, largely to test the questionnaire for ease of handling, the comfort of the flow and the adequacy of the questions in eliciting information for as Kidder (1981:62) suggests:

> This is a means of catching and solving unforeseen problems in the administration of the questionnaire. It may also indicate the need for additional questions or the elimination of others.

The questions were structured to lead from relatively well publicised issues, such as the poor state of Maori health, through the more complex issues of beliefs, the relationship of those to actions and ideas that raised the concepts of power, racism, racialism and the separation, or otherwise of the personal and the political. The final

question was developed as an appropriately comfortable one about research, and was designed to relieve interview anxiety should it occur.

The findings were that the content of the questionnaire was effective in eliciting responses comfortably and that the method of questionnaire guidance was felt to be a reassurance mechanism for respondents as well as serving to keep the interviewer "on track." One of the acknowledged risks for me as the interviewer was that of becoming sidetracked from the task in a topic that held a high priority and that had been pursued passionately over time. The amount of time requested of participants had been assessed accurately and the only adjustment to the questions was that the final one was widened to include specific reference to New Zealand research and or, local studies and findings.

The interviews were with the consent of the participants, to be taped. This proved to be a fruitful learning experience and was found to be effective and a useful alert for me about such things as the most effective placement of the recorder so that my voice did not dominate the responses of the interviewees. Care was also taken to safeguard the process so that the study was not compromised because people were not willing or able to give accurate information. The response from those asked to take part in the pilot study was willing and enthusiastic and I thanked each of them for their participation and gave them some feedback from the results.

APPROACHING THE MANAGERS

The managers whom I sought to interview were initially contacted by telephone and given a brief outline of the nature, style and purpose of the study and invited to participate. All were willing to be interviewed. A letter was then sent to each participant further outlining the research objective, establishing that the ethical

requirements of the agency had been met. That letter also explained the proposed style and structure of the interview and requested a time.

The time lag between the request for an interview and the response was used as part of the measure of willingness or resistance to the issue of "researching up". A ten working day period was set as the limit of waiting time, at which point, if there had been no reply I phoned to ask specifically to ask that a time be set. Three calls at four day intervals was the responsiveness criteria. The criteria was not tested to the limits as one respondent replied immediately to the letter of request and the remaining at the first telephone call. All respondents were brisk and helpful in offering time. Each checked that the interview time was correct as set out in the letter. At this point, it was helpful to be able to say that it was accurate and had been tested in a small pilot study as all of the managers presented themselves as busy people in the midst of major changes in the structure and the funding of health services.

No obstacles to the interview appointments were encountered. A request was made to each respondent that they allow the interview to be taped and the transcript was available to them to be checked and corrected if they wished. The decision to tape the interviews if possible was made to allow for the complexity of the information that might be received, to maintain accuracy in the transcripts and to restrict the distraction of notetaking and have the capacity to receive free flowing opinions if they were offered. One respondent was uncomfortable with that method of data collecting and chose not to "go on tape", and the responses to this interview were recorded manually on the questionnaire.

The interviews took between thirty minutes and one and a half hours, and were conducted within a two week period in November - December 1992. No more than two interviews were undertaken in any one day, as it was anticipated that they would

be quite tiring, and potentially stressful for me and the participant and if unduly pressured I might have inadvertently altered the process.

PART FOUR:

COLLECTING THE DATA

CHAPTER 5

THE INTERVIEWS

The interviews began in November 1992 and during the next two weeks I interviewed ten managers. At the time of the interviews the Bay of Plenty Area Health Board had effected the funder provider split so that all of those interviewed were employed in the service provision sector. The purpose of the interviews was to contribute to a base of information, which when supplemented with the analysis of other items, would allow me to draw some conclusions and make recommendations if that seemed appropriate.

All the questions reflected a desire not only to understand something of the characteristics, beliefs and stance of the managers, but also the amount of knowledge and concern held about the low status of Maori health and how that was translated into action. In order to accommodate the possibility of varying levels of learning the questions were in a sequence that could elicit information at a quite basic level but were sufficiently open ended so that any potential for advanced or sophisticated knowledge and practice was not lost and I introduced each question with a brief explanation about its background. At the same time it was recognised that the subject was a controversial one and there was the temptation to soften my approach as I also carried a large responsibility with regard to the potential damage my questions could do to the progress in the development of Maori health services by antagonising managers or exposing low commitment. At the same time, as Lambert (1994:58.) notes, the most direct way to discover the standpoint of a particular group of people, is to ask them, and in the asking there was for me, the hope of encouraging the managers to develop some of their ideas, for as McCracken writes:

> The long interview is one of the most powerful methods in the qualitative armoury. For certain descriptive and analytic purposes, no instrument of enquiry is more revealing. The method can take us into the mental world of the individual, to glimpse the categories and logic by which he or she sees the world.

ARCHIVAL RESEARCH AND PARTICIPANT OBSERVATION

In addition to looking at the attitudes and beliefs of managers, I also considered it important to look at a broader range of data than would be provided by the interviews alone. A range of data that tested and measured the impact of responsiveness ideas in day to day practice and planning and that would also enable me to trace the connection between intention and action.

With regard to the practice of science, Kidder (1981:13) noted that:

> One reason to learn research methods and practice science is to be able to predict correctly how people or nations will behave. Another is to understand how the social world works by discovering casual connections.

In order to rediscover some causal connections I examined and measured for responsiveness, an internal newsletter, a strategic management meeting and several examples of consultation with Maori in the organisation. These are described in detail in the next section.

DATA ANALYSIS

The analysis of this section of data began as each manager responded to the request for an interview and continued as they talked to me and I transcribed the information. Alongside the interview process I was also collecting the other data. The interviews were transcribed by me within one month after they were recorded. The transcripts were offered to all the participants for checking and correction if they wished. Only one participant did so and was satisfied with the accuracy.

During the transcribing some themes emerged, and I became aware of just how much and sometimes how little information speech carries in the tone of voice, emphasis, the language of management, the language of health professionals, and some

politically correct responses. Following the transcriptions the data was sorted in sections matching the questions and the measurement criteria and followed at the end of each section by a summary of the results. The same process was used to analyse and order the results of the other data collected and similarly any central themes that emerged were noted and recorded.

The issue of confidentiality posed a particular challenge, for even as no names were used, in a small organisation where management numbers are few and highly recognisable there was the risk of recognition. Therefore continued attempts were made to protect the exact identity of the managers. Where some researchers used first names and report on individual interviews, giving some quite personal details about each respondent when they have used the ethno methodological approach, I have not and although I did consider giving them false names as many researchers do but that option seemed clumsy and I did not proceed with it. The process of protecting privacy was to some extent assisted by the passage of time, and the fact that fifty percent of the managers interviewed have left the organisation.

The data from the sections called Archival Research and Participant Observation was collected at specific times, for example the internal newsletters which were published fortnightly were examined within a given period to correspond with the time frame of the research and the meetings, consultations and policy formulation were also chosen as examples within the research timeframe. In analysis the criteria for measuring responsiveness throughout this study were used and these correspond to the focus of the questions in the interviews.

PART FIVE:

MANAGERS PERCEPTIONS OF RESPONSIVENESS

CHAPTER 6

RESPONSIVENESS ISSUES IN THE HEALTH SERVICE

Each of the managers was asked for their opinion, understandings and actions on various issues concerning Maori health. This section describes the results of the interviews and other data. The information was grouped into the six responsiveness parameters of the questionnaire, Maori health status, biculturalism, bicultural action, goals and training, language, vision and research responsiveness.

MAORI HEALTH STATUS

Do you think the low status of Maori health is a concern for our organisation?

All of the participants knew that Maori health status was worse than non Maori and all stated that they believed it to be a concern for the organisation. All gave relaxed yet very definite yes responses and several added emphasis to their replies with comments such as "most definitely", and a "grave concern". The reasons for the definite responses fell consistently into two categories of concern. The first was what could be called the corporate approach, that is, the concern related to the fact that health was the "business" of the organisation that must be seen to be a success.

As one manager stated it:

> Yes, because its a significant part of the population. Health resources obviously aren't getting through to Maori. We aren't achieving our corporate goal unless we actually improve the health status of Maori people.

The other centred more on service delivery and a multicultural approach; a response born out of, as one respondent put it, a wider concern for the health of every individual within our district and a variation on this response was:

> Yes, the reason for it being a concern is because our organisation should be concerned with the health of every individual in our district.

All of the responses were congruent with the opinions of Pomare and de Boer (1988:17.), who noted that their report issued,

> A strong challenge to Maori and Pakeha alike, for substantial improvements in Maori standards of health will only occur through the concerted efforts of both peoples.

Is it a concern for you as a manager of health services?

When the emphasis of the question was shifted from a concern for the organisation, to a concern for each manager in their section, the replies were less clear, slower, and made with less conviction that the one before which allowed for some projection into structural, rather than practice responsibilities. Approximately half of the sample declared themselves as having low influence on the decisions affecting Maori health status. The following replies illustrated this attitude:

> I don't feel I have a lot of influence on those sort of decision making opportunities.

> O.K. Very careful on role. I don't actually have a front line job, but it is a concern to the executives too.

At the same time none declared examples where they had tried to act on their concern by advocating for Maori health or developing specific programmes that had and not been successful.

The remainder of the sample, gave answers that identified practice problems in addressing the issue. For example, this reply:

> From a management perspective, there are a lot of cultural issues that I'm not familiar with, that need to be handled delicately.

This self identified gap in knowledge raises the issue of competency to identify training issues at the least, at most the competency to manage diversity, for as Copeland (1989:49.) observes:

> The big challenge of the 1980's is not the retraining of workers but the retraining of managers. Diversity is emerging as one of the most serious issues in the workplace today, yet most employers are not prepared to deal with it.

BICULTURALISM

Could you please describe what biculturalism means for you?

This request elicited a wide range of replies, some which indicated previous thought about the concept, but few of the managers were able to describe what it meant for them even within a broad spectrum of ideas which included the notions as partnership, equality, redress, sharing or cultural reconciliation. Only one of the group made reference to the Treaty of Waitangi, recognising it as a fundamental way of doing business. More than half gave replies that indicated that they had not thought much about it, or considered the term as having no meaning for them. For example:

> In the areas I've been involved in, no bicultural aspect needed. The roles I've been performing are there for people.

This example quoted raised the question of the still strong belief that many New Zealanders have that we are all one people and that within that somewhat homogeneous group called New Zealanders, we are all the same and have equal opportunities. Tauroa (1982:29) noted this phenomena saying that:

> Because Pakeha New Zealanders have been reared on the notion of egalitarianism and the myth of their ideal race relations they are particularly sensitive to suggestions that this is a racist society and accordingly respond with opposition and the argument that we are "one people".

It is an enduring belief amongst many Pakeha New Zealanders as was highlighted by Bedggood (1980:8) who sought to explain why that dominant myth of equality still

prevails. The next example relates more clearly to power and the resistance to the sharing of resources.

> I don't like the word sharing because it means I've got something and you can take part of it. I think it should be a without prejudice thing.

Attitudes such as these reinforce the need for legislation that supports and establishes in Pakeha terms, the status and place of tangata whenua for as Kelsey (1989:10) noted,

> history has taught us that liberation is brought about by the struggle of the oppressed, not the benevolence of the oppressor.

A more thoughtful and informed reply was given by one manager who said:

> Partnership. A system of equality. Equality of information, power, participation in planning. Inclusion. Its something that permeates your mind set.

Do you know something about the Bay of Plenty Tangata Whenua Health Accord?

Knowledge of this much publicised partnership document which was considered by Maori and the Bay of Plenty Area Health Board, to be an important philosophical and practical agreement then and which had gained national recognition, was low. Only one respondent had a clear and accurate knowledge of the background, purpose, functions and potential of the agreement Three had heard of it, and could be said to know something about it, but they did not locate themselves in an environment that included it. More than half of the sample had either no knowledge or insufficient to be counted. The ten replies cited were important because they revealed some major knowledge gaps and represented the central issues which had left health organisations unprepared for the 1990's.

This was how the response to the question was related by each manager:

> Yes, I've seen it in the Bay Board Bulletin (monthly newsletter) and knew about it but not the detail.

> Yes. It came from the Maori people. It's a statement of how they want partnership to proceed.

> No, I don't. To be quite frank the needs never arisen actually, no one's actually mentioned that we should do things differently.
>
> I don't need an Accord on the wall to remind me that Maori health needs looking after.
>
> Both sides commitment to the Treaty.
>
> Very little.
>
> No, not really.
>
> I'm only aware of it.
>
> Yes, I know something of it. I tended to see it more as being the boards, rather than our own as a provider unit.

There was little doubt that those in the sample had some way to go to locate themselves substantially in Aotearoa in the 1990's.

The low awareness and knowledge of the Accord posed something of a puzzle as the Bay of Plenty Area Health Board had raised the profile of both the Treaty of Waitangi and its partnerships with tangata whenua consistently from 1989 to 1991, all but two of those interviewed were part of that era and I thought that this had resulted in some shift in management attitudes.

In part, the low level of knowledge may have been due to the fact that the health reforms were producing change at such a fast pace that it was not possible to keep up with information, or that in times of rapid change Maori as Te Puni Kokiri (1993:65) observed are negatively affected, excluded and must renegotiate their position as tangata whenua in the new structures.

Kelsey (1993:45.) has raised the question of whether the past decade saw a major shift in Pakeha thinking and suggested that:

> If we wish to play a meaningful role in the next decade, we must be prepared to rethink our role from scratch. This means a disciplined and systematic analysis of all aspects of the Treaty debate as we move into the 1990's, identification of the major barriers to the exercise of tino rangatiratanga, and the most effective and realistic programme to break those down.

BICULTURAL ACTION

What action does the move towards biculturalism in health services require of you in your management and planning?

For most of the managers, this aspect of responsiveness proved to be quite difficult and there were several comments about it being the hardest to answer so far. Only two were able to give an action oriented answer and those centred on strategic plans which included Maori health but the priorities were defined by Pakeha or were couched in negative terms. An example was found in the Statement of Intent (Western Bay Health 1993/94:4.) which under the section headed Population Demographics, notes that the demographic trends had the following implications:

> Substantial additional resources to improve the health status of Maori, in particular, young Maori. Maori are susceptible to illness induced by smoking, alcohol abuse, obesity and motor vehicle accidents. Young Maori women place high demands on antenatal and post/neo natal care service.

Maori health was not listed as one of the Core Services. At the same time, they said that they saw that a beginning was important and that measuring progress would trace where things were and were not, although they did not address the issue of recruitment. The remainder of the responses indicated strongly, how difficult it was to move from the intention to the action, and especially in situations where people believed that all was well and there was no need to change.

Some replies included the ideas of change, such as getting away from conventional thinking yet were unable to do so. Others stated the obvious like "you actually have to have a strategic plan of how you're going to implement your planned process", or as one was, a confused arrangement of words spoken with confidence:

> People like myself who actually understand how to put it in place, the point I've got is that I would hope significantly that my team practice those things by definition anyway, so what would we have to change anyway?

None of the managers had a plan that had been formulated in consultation with Maori. Some responses failed to address the question at all and for several reasons. Those respondents did not answer the question, firstly because they had not seriously thought about including clauses that would address the issue of Maori health in their own unit or departmental plans, and saw the organisation as being responsible entirely for such things as the inclusion of Maori in strategic planning and plans. Most wished to be part of the formulation of such overall plans but were uncertain about where to start with their own.

In your day to day delivery of services?

One manager acknowledged a difficulty in having contact with Maori customers as few used the service. The discussion around this aspect of service provision was one of the few wide ranging and thoughtful ones that I encountered in the interviews. It led comfortably from a recognition that the way the service was organised may have been an obstacle to Maori people observing that:

> In fact it may well be that our system is just incompatible as it stands at the moment, with any sort of achievement at all. I say that perhaps from a personal sense because we've tried very hard to practice in a sensitive way biculturally, to encourage contact and there's been no awareness in fact of a need for a service such as ours.

This respondent was able to identify some of the features of health services which make them uncomfortable for Maori and which Maori authors such as Ramsden (1990:7) publicise:

> Major difficulties for Maori are affordability and accessibility to an appropriate health service, one which validates the cultural context in which Maori people operate in relation to their health. Such awareness should lead to adjustment of health service delivery in order to provide a safe environment in which Maori people can approach, negotiate and recei ve service from health professionals. (if Maori so choose)

The section led several respondents to reflect on the discrepancy between what they said they believed and what they actually did. Most however, did not demonstrate a connection between the response they first gave to concerns about Maori health and

the difficulty they had in answering those ideas in the action of day to day practice.

At the same time there was a recognition by several that, as one stated:

> Attitudes need changing in our organisation. You can't have a bicultural approach until you're aware of the differences and you actually respect and respond to them.

One noted that it would be helpful to seek more Maori staff.

GOALS AND TRAINING

Do you have a bicultural training programme at any level in place? If so, please describe it.

This section sought information about any bicultural training that was in place either as a specific topic or that was included as a component of other more general subjects. One manager responded in the affirmative and described a situation where a Maori staff member was running a small series of in-service training about cultural issues in care. Several were able to say that guidance had been sought from Te Puna Hauora, the Maori Health Unit, for assistance in the development of a bicultural direction in planning and training. I monitored the result of this consultation for one year, from December 1992 to December 1993 and no action had been taken. Two managers related to courses that had been run as far back in the past as 1983 and which were credited as leaving a lasting awareness. However even though those courses were recognised as being at introductory level no requests had been made for more advanced ones. One respondent referred to the courses that had been run by E.E.O, which highlighted the difficulties of minority groups, that were seen as useful.

Do you ask for a bicultural objective in personal development plans?

The responses in this section fell broadly into three categories. Firstly, one where there was no bicultural objective and no intention of developing one, then a small number who had included one in the past but let it drop and some who were going to formulate plans for such an inclusion but had not begun and were uncertain about where to start. There were no time frames on future development.

One manager was able to say that the social work section of service had bicultural objectives in their personal development plans in place as part of their professional requirement, but they had not been generalised for other staff. Most answers were brief and the question did not generate any discussion.

Most answers were brief and the question did not generate any discussion. This seemed to be because for some it had been an intention for an embarrassingly long period, that whilst some managers may have had good intentions they were unable to find ways of justifying cultural change. There was also the issue of measuring outcomes. They did not know how to set a criteria and measure bicultural action particularly in relation to their own and staff progress and thus held to a sincere belief that one cannot measure cultural development. One manager expressed it in this way:

> The problem with that is that you cannot include something that you can't measure. It must be specific whether you can actually do that. If you can't, its very difficult to judge someone's performance in which their career prospects, their salary performance is judged, where the whole thing is based on it. There's got to be a more equitable way.

Some complex clusters of planning difficulty were raised especially the measurement of the social and cultural concepts. This revealed the tension that is known to concepts. This revealed the tension that is known to be present when old models of practice such as scientific management, rational goal models or open systems models fail to answer the problems of rapid change and value transitions. Quinn et al. (1990:3) takes an evolutionary approach to the development of new management

models and notes that even when old models become less useful, they are not simply swept away. Parts of them still survive and remain useful while other new ideas and values are added. This provides an integrative perspective and helps managers to operate in frameworks that foster the inclusion of social and cultural factors as well as the process of lifelong learning. Fletcher (1986:18) says that in his view it is indisputable that the most critical area for managers in dealing with change is learning and this includes both quality and range.

LANGUAGE

Do you use any Maori words in your signs, notices or letters?

This question was based on the reality that Maori is an official language of New Zealand and that the functions of the Maori Language Commission (1987:vol 76.4.) included that of, generally to promote the Maori language, and, in particular, its use as a living language and as an ordinary means of communication. Usage was deemed to indicate something of the organisations understanding of that as well as the respect that for another culture was generated in a service seeking to make itself more user friendly for as Ropiha (1994:7) observes about getting messages to Maori:

> The creation of messages needs to utilise the images, language and protocol of Maori to ensure that the meaning of the message gets through to the receiver, Maori people.

The responses revealed a very low usage of Maori words, even those basic greetings and words that were commonly included in conversations and media reports. Two respondents were able claim efforts to change from one language to two, using effective consultation and participation with Maori. This related specifically to signage. One area had included translations to Maori on internal signs to important facilities and another had taken a step further to include both internal and external

signs. In both instances English was on top of the sign with Maori below, one having the lettering the same size and one with the Maori print very much smaller.

Several relied on what others had done in the past and had no made any attempt to extend the usage. None used Maori in correspondence and none in newsletters or notices. One of the sample said that they had done a Maori language course at the Polytech, but noted that they had never been comfortable using other languages, indicating that one of New Zealand's official languages was still regarded by some as an "other language".

Another reply, made very enthusiastically, was:

> Certainly, when I greet people who greet me (in Maori), when I spoke to the Maori Resource Unit (called Te Puna Hauora), I've said Kia Ora and certainly when I spoke to Maori staff I did.

Whilst the status of Maori language is no longer and issue in Aotearoa, its role is. The Maori language is seen as something for Maori people alone, and not related to Pakeha New Zealand yet it is known that one of the ways in which the health service has failed Maori people is the exclusion of their language and as Spoonley (1988:58) notes the biculturalism became part of the New Zealand public service philosophies there was an accompanying concern about the need for bilingualism in the State Services.

Workman (1994:6) focuses on the importance of Maori language in the public service stating that:

> So much of what we do as Maori and with Maori depends on our ability to communicate clearly within the framework of another culture. Most Maori public servants learn to work within the non-Maori paradigms every time, but for Maori clients and consumers, messages from public officials are often percieved as negative and alienating, or simply not understood.

Do you use any posters, pictures or other decorations that include Maori language or images?

Similar responses were made with regard to posters, pictures and other decorations that included Maori language or images, and that might have recognised the existence of Tangata Whenua or made the organisation more welcoming to Maori. The amount of material was slightly higher but the effort minimal and most managers had simply carried on with things that had been provided by past staff, that happened to be left behind.

The respondents who had such images in their environment reported a lot of variance about quantity and position, for example, just one poster behind the door to several posters at the entrance. None indicated an understanding of the idea of inclusion through signs and symbols or that biculturalism required more than front row decorations or that the idea should proceed beyond the front desk.

VISION

How do you think we should continue our commitment to biculturalism in the new Crown Health Enterprise?

The substance of this section was devoted to eliciting how managers felt that the relationship between themselves and Te Iwi Maori, described in the Bay of Plenty Tangata Whenua Health Accord was best anchored and further developed. It proved to be a difficult area of thought. One manager unhesitatingly gave the opinion that the Accord was important and should be "rolled over" to the next stage of the reforms but had no plan to market the idea to other managers either individually or to the

management group as a whole. No strategic action or perceived commitment was observed to be attached to the belief.

A different trend in the responses in this section was their length. Whereas in some sections the responses were very brief and to the point, in this section the managers did respond to the question about vision in a confident and relaxed way that may be representative of the ideas people might have about the nature of creativity and visioning. Of the remainder, several of the managers who did not respond specifically to the question of an ongoing relationship with Te Iwi Maori did focus on the needs of a population. For example this relatively positive response was given although with no accompanying plan for action:

> I think from a purely commercial point of view, notwithstanding moral requirements that we have as a nation, O.K, it would be very stupid for this hospital, this Crown Health Enterprise to neglect the needs and wants of a large target population.

Another with some positive ideas but also no action plan noted that:

> Clearly the initial Accord should be the relationship with the Regional Health Authority but we as a provider unit need to be abreast of the so called market place, so to be able to liaise with a group like that would, I would suggest, be facilitative for us in keeping ahead of the requirements of our service. I see a relationship particularly on sharing of information would be relevant.

Others, however, in their vision for the future relationship with tangata whenua thought that Maori needs would have to take a lower priority than other unspecified issues. The following uninterrupted verbatim report illustrates some of my observations:

> I think for the both sides it has got to be done with sensitivity and consideration. I feel the frustration that the Maori people must feel at times that they are not listened to. I think they have to bear in mind that its a big mind set change for lots of people. Things even in our culture take time and when you're trying to bring two cultures together the time can be much slower. Are we keeping up with the Crown Health Enterprise or are we running ahead of it? That's part of the sensitivity of Maoridom to realise that, goodness me, our own culture of the bricks and mortar we work with. We're not in control of that yet so some other thoughts might just have to stand by for the moment. And I'm not saying they should be forgotten but I think Maoridom could actually score; if its a contest then showing sensitivity to the disruption that's occurring on the other side at the moment. This is a chance for Maoridom to be a bit sensitive. Absolutely. Its a sharing of knowledge, we've Maori ways and they have to learn ours.

As well as length, another noticeable feature overall was the use of a particular language. That is, a way of describing needs and events in words that have become common in the new era of health reforms. Yeatman (1990:157) identified this as the language and style of management where:

> Rhetoric now appears as the mobilisation of certain metaphors, situated in particular styles of discourse, which he has learned in the corridors of white, Anglo metropolitan and masculine power.

At the conclusion of this section all respondents were asked if they wished to add anything to their ideas of vision for a bicultural feature. None offered any additional ideas or comments.

Generally, this section found that the respondents had little knowledge of the organisations already well established official relationships with tangata whenua in the Bay of Plenty or with the organisations regular public advertising that biculturalism should permeate all our activities. Criteria of consistency with the Treaty of Waitangi, the already established relationship with Te Iwi Maori, the fundamentals of biculturalism, inclusion, partnership and participation, so that there was no longer a measurable connection between the initial concern about the low status of Maori health and immediate, medium or long term plans or visions for the future.

At the same time some respondents were struggling to deal with the issue of Maori health through the only model they knew, the new commercial approach, focusing on target populations, customers and the core business of the organisation. This is an approach which sidesteps the issues of the Treaty of Waitangi and fails to contribute to Maori development.

The section was designed to elicit the essential component of creativity in management. Creativity is a way of thinking that involves the generation of new

ideas and solutions. Koestler (1964:96) referred to creativity as "an act of liberation" the defeat of habit by originality."

Most modern management texts and models include sections on creativity which is considered an essential ingredient of the management of change. Schermerhorn (1989:519) has this to say about creativity:

> Megatrends, The Change Masters, Reinventing the Corporation, Thriving on Chaos, The Renewal Factor - these titles of recent best selling books communicate the urgency of dealing with our dynamic society in creative and progressive ways.

Many of the changes happening in organisation are as the result of factors outside the control of managers. For example, government law policies and regulations change, people change, their needs change and technology and knowledge change. In the New Zealand, health is an area where all those factors have and are still changing so that it requires strong relationships with Te Iwi Maori and creative courageous management to ensure that the organisations also change their policies, practice and services to be responsive to Maori rights and needs. Schermerhorn (1989:519) also notes that enlightened management can keep pace with these and other challenges over time.

RESEARCH RESPONSIVENESS

Do you think research is important?

The final section was designed to conclude the interviews on a topic that was based more comfortably in the security of research knowledge. The aim was to further test the relationship between thought and action by using a knowledge base that was known to be valued and to find out how the results of research, particularly New

Zealand research was used by managers of health services at a time when the Government was heralding changes towards the more effective use of resources.

All of the sample gave a very positive 'yes' response and volunteered the belief that they saw research as important for both planning and work results. Statistical data in particular was emphasised. As well as the generally positive response, all of those interviewed stated that they used research actively in the process of managing services, particularly when planning goals and outputs. One respondent focused on the importance of the addition of values to produce outcomes rather than simply numbers or outputs.

One response seemed to summarise by saying:

> Yes, one cannot be making judgements on anecdotal politicised data. Research provides the substance to base meaningful decisions on.

Do you use New Zealand research findings for improving service delivery?

The responses here were still favourable towards the usefulness of research, although when the focus turned to New Zealand research, the proportion basing their actions on it reduced to six of the ten managers who said they based their responsiveness planning and actions on New Zealand research, although none reported using research done by Maori researchers. The remaining four did not use New Zealand research and one said that he would if it was available. Although all of the managers in the sample worked in the part of the health service that was a medium sized hospital and were regularly involved with the collection of statistics, quality controls or professional reviews, only one recognised that they were engaged in doing research or contributing to New Zealand research.

SUMMARY OF RESULTS

Maori Health Status

The encouraging one hundred percent of the managers interviewed who at first stated that they were aware of the poor status of Maori health and that it was of concern for the organisation, shifted their replies only a few minutes later when the focus of the question was changed from the abstract idea of policies in the organisation to a more personal and action oriented practice. The numbers linking theory and practice to action in service delivery reduced to half. This dramatic fall off of fifty percent was though to reflect two main patterns. Firstly, an individualistic projection away from day to day responsibility to contribute to the whole, and a belief that only service managers were responsible for operational action, particularly those actions that led to major change. Secondly, a perception of low influence on decisions affecting Maori health status that was not congruent with the philosophy and practice of management and a limited knowledge of the circumstances which affect Maori health. Lastly, the results appeared also to reflect a lack of understanding and confidence about the theories and practice of change management which would have assisted in the translation of intention to action.

Biculturalism

Half of the sample had broad general understandings of what biculturalism meant, and therefore the potential for an operational base for bicultural action in practice. The other half of the sample either had not thought about it, had no understanding of the relationship between Maori and the Crown, or favoured multiculturalism without understanding the concepts.

Although some potentially useful background knowledge was held by some of the managers, only one felt that it was sufficient to translate into culturally appropriate practice. Knowledge of the formal relationship between the Bay of Plenty Area

Health Board and the Maori people, called the Tangata Whenua Health Accord, and which signified the existence of an effective relationship with Maori to go forward together was very low. Knowledge of the history of the need for such an agreement was equally low.

Bicultural Action

This aspect proved to be quite difficult for most of the managers and there were several comments to that effect. Two of the sample were able to give action oriented answers and also recognised the need for inclusion of Maori people.

None raised the issue of recruitment. Most responses indicated strongly, how difficult it was to move from the intention to the action especially as they did not believe any change was necessary; that all was well anyway.

The interviews also revealed significant resistance to the ideas of partnerships, power sharing, redistribution and gaining and losing that were implicit in the correction of injustice especially at a time when health budgets were capped or otherwise diminishing. One respondent described it in this way: "I don't like the word sharing because it means I've got something and you can take part of it. It should be a without prejudice thing."

The responsibility for action was projected on to others who were felt to be the appropriate responses. The projection was as far reaching as Area Health Boards and Regional Health Authorities, who were relied on for additional funding somewhere in the future. No connection was made with the idea of dealing with the issue of responsiveness by reallocating priorities and funding internally and whilst a series of service delivery plans were in place, none addressed the issues of Maori health nor was a bicultural plan accepted. The emphasis was on services for all people. The

popular, egalitarian, level playing field was firmly believed in by managers. As one manager stated it:

> I have recently spent quite some time preparing my business plan objectives for the Chief Executive. Maori initiatives are not identified specifically but are encompassed within each area as part of the overall strategy.

Goals And Training

One respondent reported a time limited bicultural training programme in place. No measurement of effectiveness was done. (Maori staff member who ran the programme and the section manager have now left the organisation.) Some sections have sought initial guidance and consultations with Te Puna Hauora on this matter. No priority has been accorded to the development of consistent programmes as a result. Several cited the usefulness of courses that had been offered in the past. The question addressing the inclusion of a bicultural objective in personal development plans fell broadly into three categories. Those with none, those who had one and let it drop and one manager who noted that one section of the staff had one, because it was an issue of professional development for social workers, rather than a management initiative.

Use Of Maori Language

Overall a very low recognition that New Zealand had two official languages, as well a low usage of Maori even in basic greetings. Few understood either the courtesies and respect involved in the use of New Zealand's indigenous language, or the issues of inclusion and partnership.

Two of the sample were able to claim efforts to change from one language to two using effective consultation and participatory processes with Maori. Internal and external signage had included both languages in several areas. Some interpreted the language partnerships to be unequal with Maori at the bottom of signs or in smaller print. None had attempted to recruit Maori staff to match the signage with culturally appropriate service within. None used Maori in correspondence and none in

newsletters or notices. The use of posters and pictures drew a similar response although several had such items. Some managers were able to answer the section by accident of "things left behind" by other staff or those provided by other organisations and special programmes such as the advertisement for immunisation which pictures Maori people and includes Te Reo Maori.

Vision

This question was answered clearly and unhesitantly by one respondent who stated a preference for building on the Tangata Whenua Accord, so that we "don't repeatedly reinvent the wheel." Most of the sample struggled to articulate their thoughts, avoided the issue or gave confused responses. The majority had not thought about the issue at all. None had any other ideas or had begun to think about new initiatives, or even refined old ideas, with regard to Maori health.

At this point in the study, there was no longer any connection between the managers initial concern about the low status of Maori health and immediate, medium or long term planned action to overcome this. There seemed no doubt that those in the sample would need to make more effort to located substantially and effectively in Aotearoa in the 1990's and to be able to plan and act in a way that was consistent with their organisational mission and practice statements.

Research Responsiveness

All of the managers gave a very positive yes responses and further volunteered the belief that they saw research as important for both planning and work results. Statistical data in particular was emphasised. As well, all stated that they used research actively in the process of managing services.

When the focus turned specifically to New Zealand research, the proportion basing their actions on it reduced to approximately half. None reported using research done

by Maori or that which had focused specifically on poor Maori health. One said he would use New Zealand research if it was available. Only one recognised that he was regularly involved in doing research or contributing to New Zealand research.

PART SIX:

ARCHIVAL RESEARCH AND PARTICIPANT OBSERVATION

CHAPTER 7

THE FORTNIGHTLY FLYER

As indicated earlier, the methodology of this research can be described as ethnographic. This refers to a characteristic blend or combination of methods. Ethnographic research involves some amount of social interaction in the field with the subjects of the study, some direct observation of relevant events, some formal and a great deal of informal interviewing, some systematic counting and some collection of documents and artefacts. Flexibility and insight are most likely to be provided by this domain of methods, accordingly, as well as the interviews data was collected through archival research and participant observation.

Those sources were an internal newsletter called *The Fortnightly Flyer*, a Strategic Management Retreat and four examples of consultation with Te Puna Hauora staff in relation to bicultural development in the organisation. All were assessed in terms of consistency with the Treaty of Waitangi, greater participation of Maori at all levels of the health sector (Health and Disability Services Bill 1992:21.) and the organisations advertised statement of intent that biculturalism should permeate all its activities. This statement had been part of the organisational culture since 1990.

The Fortnightly Flyer was an internal newsletter coordinated and distributed by the organisations Customer Services Department. The position of Customer Services Manager was created as part of the major restructuring of the Bay of Plenty Area Health Board's Western District in 1990. It was a focus largely on the new responsiveness to customer needs and a service orientation and this included the creation of new and improved relationships with both the public and the staff of the organisation through improved information to patients on admission, improved information to and between service areas, a more responsive complaints service and a

customer satisfaction survey. As these mechanisms developed with a new focus on quality of service to patients and families, there came a time to establish some intersections where quality was produced and to balance the attention given to communications externally and internally. The *Flyer* became one of internal vehicles and was designed to improved the information and communication between service areas. Staff from all service areas were invited to submit items and a fact sheet with space for the date, information and the contact person was attached. It began in July 1992.

The time frame for the examination of this data was from the time of the pilot interviews in December 1992, to August 1993, so that it included the time of major change from Area Health Boards to the funder provider split represented by the formation of Regional Health Authorities as purchasers of services and Crown Health Enterprises as service providers. This was considered critical, as one of the themes that emerged from the research, and discussed in a later chapter, was the important implications that constant change in the structure and management of health services had in the perpetuation of monoculturalism and institutional racism, for as Pomare and de Boer (1988:7.) noted, that while some changes have been made, our services remain essentially monocultural.

Findings And Progress

As well as an examination of the main aspects of the *Flyer* such as the format, visual presentation, regularity and content, I asked equal numbers of Maori and Pakeha staff, chosen at random in a variety of interactional settings, to provide informal information about their responses to it. The observations and interactions cited are not intended to be comprehensive or exhaustive. They do, however, provide important directional examples and alerts for planning and action and to illustrate how including biculturalism in the culture of the organisation required that people

became increasingly aware that those changes required the development of a new way of thinking that was consistently inclusive and part of day to day activities. It is recognised that almost any non Maori organisation would yield examples of similar findings but it also illustrated well, the point made earlier by Spoonley (1987:282.) that some of the questions of ethnographic research tend to look trivial and sometimes the conclusions self-evident.

Format And Visual Presentation

From the December 1992 edition, through to July 1993, the *Flyer* was produced as a utility, on a plain blue paper, with no letterhead or other particular identifying features. It was quite simply *Fortnightly Flyer*, Western Health District Staff Information Bulletin. At that time with changes happening regularly, the colour coding of information pamphlets was used to some extent to assist staff in identifying where the messages were coming from. The *Flyer* was printed on blue and the information was presented in discrete sections with a small heading indicating the type of message and ruled off at the end of each.

The presentation was utilitarian, frugal and monocultural, and no changes were made until July 1993, when the new Crown Health Enterprise logo was added. This read, Western Bay Health. Quality Care by Quality People. The colours of the logo and for all Western Bay Health stationery was blue and red but as the printing of the *Flyer* remained in black on pale blue, no other colour was introduced until much later. With regard to format and visual presentation, no evidence was found of efforts to indicate that Maori were important in the organisation, or to make it attractive to those Maori staff members who might be readers by including any of their cultural images, nor was any Maori language, even of basic greeting included. With regard to format and visual presentation the *Flyer* did not meet the organisational standard that biculturalism should permeate all our activities.

On the other hand, amongst those Pakeha questioned about it informally, there was agreement that the format was not as important for them as the fact that it was there and served a purpose. From the Maori staff asked, there was a different perspective, and several felt that it did not stand out well enough from anything else and because of its distinctly Pakeha format it did not captivate Maori readers.

Regularity, Content And Usefulness

On examination, the *Flyer* was found to be regular and well distributed amongst a wide range of staff, including individual Maori staff and the team called Te Puna Hauora. It was received promptly and simultaneously by all areas of the organisation and was open and available to the public if they wished.

All items of information submitted had been well received, carefully treated and published so that it had developed a reputation for some degree of integrity in dealing with other people's information, quite early in its life. The content was categorised into three major groupings. Firstly, notifications about procedures for particular occasions such as staffing arrangements for public holidays, the introduction of new staff and the farewelling of those senior staff leaving the organisation. Christmas greetings were listed from Customer Services and Te Puna Hauora, one in English and the other in Maori which gave something of an unusual balance to that edition. In February 1993, a section for bouquets was introduced and staff were encouraged to list letters or other marks of appreciation from customers.

The next grouping revolved around the notification of the availability and the location or cost of equipment such as sputum cups, wall planners, the siting of the shredder, daylight saving and the arrangements for staff to have flu vaccinations. A further grouping notified changes in the organisation itself, such as the change from Area Health Boards to Crown Health Enterprises. The events planned for the change over day on 1 July 1993 were advertised in the *Flyer* as was a thank you to all those who

participated and took on extra duties to commemorate the event. Generally the opinion from staff about the content was that it was a useful way of communicating day to day activities and developments.

The absence of any information about how each department or team was organising its bicultural approach or how it ensured that biculturalism permeated all its activities was noted. That was, no non Maori unit had submitted any items of planning or development that could be measured as progress towards services that impacted positively on Maori health. All the items concerning Maori development were submitted by Te Puna Hauora.

SUMMARY

The *Flyer* was found to be a regular, well distributed internal newsletter that reached a wide range of staff. It was received promptly by all areas of the organisation and the items submitted were well received and accurately published. A number of staff were asked for feedback about the *Flyer*. They were evenly Maori and non Maori. The general opinion was the *Flyer* was a useful information sheet.

On the other hand, it did not meet the criteria for progress towards bicultural or culturally appropriate services set by the organisation because, no attempt was made to indicate that non Maori in the organisation had developed a new mind set by making it inclusive of a Maori perspective, nor was there any attempt by non Maori to include both of New Zealand's official languages. A finding that did not bode well in terms of progress towards the provision of culturally appropriate or safe services, or the improvement in the effectiveness of health messages for Maori. With regard to the content, no non Maori unit or individual had submitted any item of planning,

development or intention that included bicultural development and as Awatere (1984:1.) emphasised:

> At its most conservative, (Maori Sovereignty) it could be interpreted as the desire for a bicultural society, one in which taha Maori received an equal consideration with, and equally determines the course of this country as, taha Pakeha. It certainly demands an end to monoculturalism.

MAORI INPUT INTO THE MANAGEMENT AND PLANNING PROCESS

The opportunity for the second aspect of the other data collected observed and analysed arose as part of the management planning which occurred in preparation for the new structures called Crown Health Enterprises which came into being to replace Area Health Boards on 1 July 1993. The occasion was a strategic planning, retreat type workshop, held off campus over a three day period for a group of approximately twenty senior managers and staff in March 1993. The information used for the study was obtained from notes taken by one of the participants and offered to me for use in the study.

It was facilitated by the consultants Coopers and Lybrand. There were no bilingual speakers or bicultural members of the consultancy group. No Maori staff were invited and I too as part of the Te Puna Hauora team was excluded. The exclusion of Maori participants and the Maori point of view was a fundamental error of partnerships, planning and participation which was felt keenly by the iwi mandated team of senior practitioners at Te Puna Hauora and was soon well known and negatively responded to in the Maori community. Our new organisation lost face with its Treaty Partner. As well as being interpreted as a major breach of the Treaty of Waitangi, it was contrary to the Government's requirements as set out in the Health and Disability Services Bill in 1992.

Maori staff are more usually, included in lower tier management meetings where the business of the day to day activities are addressed, rather than the arena where philosophies, directions, service statements or policies are made. Thus the results are more of the same rather the same rather than meaningful structural and value change. This critical example served to illustrate how Maori continued to be excluded, how Pakeha continued to colonise the process of planning for Maori health, how quality was compromised because the standards continued to be monocultural and how the fundamental principles of the Treaty of Waitangi and the principles of partnership and good faith were ignored.

"Securing the High Ground," the exclusively pakeha management retreat was commissioned to talk about change and set priorities for change. During the three days, talks and discussions ranged around the issues of change and on the first day topics included the concept of creativity, described by the facilitators as godlike, imaginative, productive or original. In order to challenge mindsets, the notion of "Breakpoint Redesign" was offered to draw together the idea of challenging the old ideas by maximising opportunities, and focusing on the core business process. Heady words like revolutionary, empowering teams, addressing new health development issues, getting close to communities and developing new patient focused systems were discussed in broad terms.

The second day included a presentation from the manager of the Midland Regional Health Authority, about priorities for change that had arise from the management of financial risk by Midland and the reality of capped funding. The manager spoke with authority and confidence I was told, to the group of monocultural managers and consultants, on Maori health and named it amongst the priorities, along with the issue raised by Maoridom, of more cultural appropriateness in the delivery of service. Some decisions about how the vision and directions of the new Western Bay Way

could be actioned, were made at the retreat. These included, customer excellence, being the best, and striving for excellence and responsiveness.

As well, a list of priorities was compiled and each of the service managers took some responsibility for the items on the list which they considered matched their area of management and expertise. The extension of the Te Kohanga Reo relationship, medical management for Maori, (with Bay Sports Foundation) and Outreach Surgical Outpatients clinics (Marae Focus) features as priorities and were made a joint responsibility between the manager of Community Services and the Clinical Director Medical Service.

The slogan that emerged and which was to carry on to the new organisation was, "failure today is the failure to change." At the time of this failure to include Maori, the organisation had a Maori team called Te Puna Hauora, with iwi mandated staff which was established in 1991 as a result of numerous requests from Maori people over many years. Maori had long recognised that Pakeha health services had failed to produce health for Maori people; there was an urgent need to respond to the documented poor health of Maori. It was time for change, to new creative and culturally appropriate ways of doing things.

Te Puna Hauora had the following unique features which were considered a useful resource for Maori and the organisation. Firstly and most importantly, its practices and procedures were consistent with the Treaty of Waitangi, the staff were experienced, senior, bicultural, bilingual, iwi mandated and the services were designed, planned and delivered by Maori for Maori. As well, the services operated on a model of practice that embraces whanau, rather than selectively treating diagnosed categories of illness only, and the model of practice was able to accommodate access to service, information, prevention and health promotion. It enabled families receiving no care at all to regain a place in the system and assist with

the provision of accurate data for Maori planning Maori health services. As a Maori unit, Te Puna Hauora had a specific role in the organisation. This was the role which was acknowledged by O'Reilly and Wood (1991:336.) They noted that:

> In general, Maori units have three main functions: policy development and overview, usually in liaison with iwi; coordinating and reviewing the implementation of Te Urupare Rangapu within an agency; and leadership and advice concerning protocol and the promotion of Tikanga Maori within an agency.

SUMMARY: BREAKPOINT REDESIGN

Briefly stated, the findings were of management and planning processes that continued to exclude Maori participants. No progress was able to be recorded. The opportunities for Maori participation in the management and planning process had not improved and Pakeha managers were still speaking for and deciding what was best for Maori.

By excluding Maori, the retreat was not consistent with the organisations commitment to the Treaty of Waitangi, nor was it consistent with the goal of greater participation of Maori at all levels of the health sector. Additionally, it failed to meet its own intention in terms of biculturalism permeating all its activities. Thus, when responsiveness measures were applied the behaviours involved in the retreat were seen to be those of continued colonisation and oppression, for as Harre Hindmarsh (1993:4.) observes:

> When minimising the importance of the Treaty of Waitangi, Pakeha intensify a process of cultural invasion and colonisation (Friere,1972.) where Pakeha views of the world, and thus Pakeha principles and priorities dominate even more, those of Maori.

Breakpoint Redesign was accordingly assessed as another socially and financially expensive monocultural exercise that was in reality a Breakpoint Reshuffle. It was however a critical re-learning for the Te Puna Hauora team who were forced to reassess and pursue new strategies in line with the repeated realisation of what Harre

Hindmarsh (1993:4.) had said, that policies and practices in the name of biculturalism have rarely addressed the dynamic of power. To think yet again, that they might, was an error not to be repeated for such naivety, as Kelsey (1993:44.) identifies, has no foundation in the history of liberation struggles.

CONSULTANCY: WHY AGENCIES SHOULD CONSULT

I chose consultation with Maori as the third aspect of archival and participant observation data collection because it provided another measure of inclusion and responsiveness. With regard to consultation the State Services Commission (1989:8.) noted that there were a number of reasons why we should consult and that collectively they comprise an imperative for effective government in contemporary New Zealand. Numerous statutes now contain reference to the Treaty of Waitangi and these typically enjoin us to:

> Pursue the "principles of the Treaty" or to conduct our business in "accordance" with them. The court of appeal defines the central principle of the Treaty as that of "Partnership" and then goes on the describe the Maori Crown relationship in partnership terms. One of the primary duties between partners is consultation.

As well as the many statutes, common law has a variety of decisions emerging that are as compelling as statutes. These included fisheries and resource law reliant on the principle of aboriginal rights.

Alongside the general thrust in Government policy which was inclusive of Maori interest of representation suggested that it was prudent to behave inclusively towards Maori and Maori interest and concerns. It did not enjoin us to tokenism simply to gain acceptance of initiatives:

> However, it does suggest administrative behaviour which is regularly reviewed and tested for its inclusiveness of a Maori dimension.
> (State Services Commission 1989:9.)

Lastly, pragmatism, the practical lessons of history were a significantly important dimension of the reasons why organisations should consult with Maori. Maori were a

growing component in New Zealand society. They were a greatly increased presence in our national way of life which was unlikely to diminish. In health, past deprivation, disadvantage and exclusion posed a major social and political challenge for management who were to effect improved Maori status from structures that had historically failed to produce health for Maori people and which were still inherently monocultural, exclusive and institutionally racist. In such circumstances, effective Maori consultation was practical administrative behaviour.

Between 1989 and 1991, several agencies such as Manatu Maori and the State Services Commission published handbooks aimed at introducing organisations to the processes of consultation and noted that those who were consulting should bear in mind as they worked their way through, that many of the roads were not well signposted; major issues such the ability to continue discussions where conflicts were likely to arise were not well charted, and the commitment to conflict resolution between the two races was not deeply bedded in our society.

THE OCCASIONS

The four occasions of consultancy which were included in this study were requests for Maori input into the organisations Child Abuse Policy, for the Treaty of Waitangi to be added to the H.I.V AIDS policy, the request for Maori staff to participate in the choice of layout and colour schemes for major building alterations and refurbishing of a major women's health facility, and Te Puna Hauora's ongoing pursuit of a cultural safety policy. They were selected because they all occurred with the time frame of the research. That was, shortly before or after the interviews were undertaken which allowed me to study a series of events which were connected belonged to the same period. The first three were fledging attempts by Pakeha staff to conform to the requirement of being "culturally sensitive" rather than major intentions to change.

The fourth, a request for the formulation and adoption of a cultural safety policy for Maori staff came from the Bay of Plenty Regional Maori Health Authority in 1992, and had been an ongoing process through several changes of management and structures.

The Maori input into the organisations Child Abuse Policy was, from the beginning, pursued with reluctance by the Pakeha partner. Several meetings were held with the advocate who had the brief to develop, but it was difficult to get acceptance or action on any of the requests from Maori. This was due in the main to the resistant attitudes of the Pakeha negotiator which were manifested in a deep seated conviction that the medical model, as dictated by Pakeha doctors was the correct procedure to follow. The consultation occurred because it was required and the attempt to be inclusive failed because the policy had already been presented and accepted by the medical and management groups without waiting for Maori input. Some attempts were made by the Maori team to "rescue" it, but these too were blocked by the attitudes of the negotiator. It seemed unlikely that requests such as the inclusion of Maori on the working party and assessment teams, would have come to fruition when it was so difficult to get blatantly racists items, such as tattoos and mongoloid spots as possible indicators of abuse, removed from the list.

A request for data regarding the number of Maori referred for assessment and care was also made and did not get a response. A more recent request met with a similar and evasive response which stated that owing to the fact that a new system was being introduced no figures were available, but with the added reassurance that when Maori are referred, every attempt is made to treat them in a culturally appropriate way. The area concerned had no Maori staff, nor had any requests been made to the Maori team.

The approach from the group developing the H.I.V/AIDS policy was by contrast, one of willingness to change things and in the words of one group member, "to do it right"

by beginning a pathway of consistency with the Treaty of Waitangi. In spite of that willingness, a completed document produced by a working party of expert staff, none of whom were Maori, was presented to Te Puna Hauora for the "addition" of the Treaty and whilst on that occasion, it was possible to quite simply, to significantly alter the content and the expectation of responsive practice for the future, when some Maori issues and concerns were written, the process did not meet the criteria of consultation or partnership participation.

The interaction regarding Maori input into the plans and process of building alterations and refurbishment of an important women's health facility raised the general issue of architecture. This was taken to include the internal arrangement of space and the climates that were created within the organisation with the use of European traditions in colours, shapes, images, art and other comforts which had always been part of the medically dominated, culturally inappropriate world of illness that contributed to the continued exclusion and colonisation of Maori, for as Beatson (1990:259) argued:

> Art is never innocent. It is always involved in the political conflicts of the society which surrounds it. Art creates images of the world. These images are often believed to be a neutral reflection of reality but they in fact distort the reality they reflect.

Spoonley, in the publication Racism and Ethnicity (1988:xii) further noted that architects did not have the experience to communicate with Maori and that they were as a group, expensive to train and they went on to be influential people who lacked the basic skills to operate in New Zealand. In his opinion, the cliché about Auckland being the Polynesian capital of the world finds little expression in the mirrored glass of modernity.

For Maori these distorted images of the world of world childbirth are known to affect access to information and service. Many Maori delay or defer their approach to

monocultural health care organisations because of discomfort, strangeness and alienation inherent in the surroundings.

A hui was organised by the Wellington Hospital Board Maori health group in 1985 to give Maori people the opportunity to speak up about the Pakeha health system and how it affects them by relating their own experiences of the strange and alien culture of a hospital where they encountered a specialised set of norms and values, shared by health professionals but not necessarily by patients. Broughton (1986:56) noted that when he went into hospital he was treated as a Pakeha, adding that was a cultural problem Maori were faced with.

Pomare (1986:56) also stated that:

> This is a Pakeha oriented system. To name just one thing, hospitals could serve Maori patients the foods they like and are used to. This could be done simply and inexpensively - all the Maori expertise is in the kitchen already.

For Maori this is often sufficient to incur avoidance or unsatisfied early discharge, or as Ropiha observes:

> The difference in physical, economic, political and social environment in which many Maori operate is very different from that of most non-Maori. Strategies must be developed and implemented to overcome the barriers which result from the different environments.

The term 'partnership' was found to be often used but also one that was imprecisely defined. The Bay of Plenty Area Health Board chose "Partnerships in Health" as its slogan and whilst it made no initial definition as to what partnership meant it noted (1991:2) that:

> Partnerships take many forms. On some occasions we led, on others we follow. At times we work closely with our partners, at others we act independently. Consultation with our communities and staff is an ongoing commitment of the Board and this is evidenced by the consultative networks that have been established. Such networks include: Te Whanau Poutirirangiora a Papa, the regional Maori health authority which helps us develop a greater understanding of Maori perspectives and visions for a bicultural approach to service design and delivery.

The Penguin English Dictionary (1973;515) defines a partner as a sharer in an act or enterprise.

Durie (1988:285) writes of partnerships and participation in relation to Maori health and (1994:3) of the partnership between Maori and the State, saying that:

> While the parameters of partnership range from devolution to mutual consultation, they have in common an acceptance of the Treaty of Waitangi as a basis for shared responsibility for Maori health and a joint commitment to the elimination of inequalities.

It is the common acceptance of the Treaty of Waitangi that is the basis for the use of the word 'partnership' in this study.

Similarly, Maori preferences or evidence of biculturalism found little expression in the latest refurbishments at Tauranga Hospital for they emerged with a Santa Fe style exterior and a European style interior and where the consultation with Maori had begun at the end, with a refined and ready to be accepted floor plan. Maori opinions about possible changes to the provision of and use of space to provide safe space for Maori women and families were ignored or overridden on the grounds that provision must be made for multicultural, rather than bicultural needs. The discussions were difficult because the frontline Pakeha managers were unable to see that they were talking multiculturalism and practising monoculturalism. Months later senior staff at the facility "consulted" with Te Puna Hauora about the choice of colour and designs of such items as wallpapers, carpets, pictures, posters and signage.

The shortlisting of these items had already been done and Maori were being asked to choose between Pakeha decided alternatives. Alternatives within which it was felt by Pakeha that Maori colour preferences at least, had been considered. Uppermost in Maori staff minds at the juncture were the words of the Right Reverend Whakahuihui Vercoe at Waitangi in 1990 when he reminded the Queen of England that:

> Since 1840 the partner that has been marginalised is me - the language of this land is yours, the custom is yours, the media by which we tell the world who we are is yours.

SUMMARY

The request for Maori input into the Child Abuse Policy raised some issues that were common to all the other consultations and communications. Notably, as with the *Flyer*, and the retreat, the issue was that of exclusion. In the case of the Child Abuse Policy, it had been written and accepted by Pakeha before Maori consultation was established. No consideration had been given to basic inclusions of quality such as the provision of Maori staff where Maori families and children were involved or in the interim, the need for levels of cultural competency of Pakeha staff. Some inclusions in the document were blatantly racially biased and there was resistance to deleting them.

Similarly with the timing of the request for input into the H.I.V. AIDS policy when the document was almost complete. Although the request was specifically for the inclusion of the Treaty of Waitangi and no resistance was therefore encountered, at the same time, no change was likely to result from it, nor was there likely to be any positive impact on Maori health associated with its usage because the underlying ideology remained Pakeha.

This superficial and condescending level of practice was evident again in the late request for participation in choosing refurbishings at a major women's health facility. The decisions had all been made, the colours chosen, the carpets and furnishings ordered and the rightness of the process established in the minds of the senior staff. After listening again to Pakeha justifications for speaking and deciding on behalf of Maori, the Te Puna Hauora team decided to make a small request. One that could have been easily fulfilled. This was that a New Zealand motif such as sea shells or native flowers replace the choice of the very British Peter Rabbit frieze intended for the special care babies nursery. The request also met with resistance, for staff were

already fixed in their desire for the more English choice and no changes were considered possible.

A CULTURAL SAFETY POLICY: MAURI ORANGA

The discussion of the development of a cultural safety policy was left until last because of its central importance to Maori, because of its long history of rejection and because it exposed the depth of resistance to including Maori as equal partners. It was considered a critical test of responsiveness because once established it could not be enacted superficially. The request for a cultural safety policy for Maori staff was made by the Bay of Plenty Regional Maori Health Authority, Te Whanau Poutirirangiora a Papa in September 1992. At that time, the Bay of Plenty Area Health Board comprised three districts, Southern, Eastern, and Western and a set of guidelines for the development of cultural safety policies was sent out to each of them.

Western District did not give it a high priority and in spite of reminders, enquiries about progress and Maori offers of assistance in preparing them for the district, nothing emerged. Meetings were arranged, and again and again and again they were cancelled by management who continued to place other issues ahead of them.

As time went on, the process of change that was activated by the health reforms began to add to the effect of personal and organisational resistance as managers sought better positions in newly emerging structures. Several managers who had been briefed about this policy and who had begun to understand its history and its importance to Maori people left our organisation. Those that remained eventually decided that it was better to wait until the health reforms were in place and then make the policy for the new Western Bay Crown Health Enterprise. This was a situation

where no progress could be reported in a year. Again initiated by Maori and after further long hours of work together with the new Pakeha management a final draft document with appropriate translations was prepared by Te Puna Hauora and forwarded to management in July 1993.

Between July and October 1993, regular enquiries were made as to its progress but none was reported. By December 1993, it was considered time for it to go out in what had become the usual way to staff for comment. At this time, all major documents which were considered to be "drivers" of the organisation were circulated in draft form so that the principle of involving staff and having them subscribe to some level of ownership of the policies was satisfied.

For Maori, there was another step, that was first taking time to orientate Maori staff in the organisation about the history, the content and the process of acceptance. One of the quality standards for Te Puna Hauora was that Maori staff always had access promptly to information that concerned Maori specifically, so that they were well prepared for it and had a good understanding of the issues and processes concerned. That process was completed early in 1994 and by February the document still had not been released to staff. On enquiry it was revealed that management had lost the final draft. Another was provided and again Maori waited. In March 1994, discussions began again about a new pathway that had been devised by management who now felt it less than useful to put out a cultural safety best practices handbook and not be able to action the requirements. A matching of theory and practice was required and as cultural safety practices had already begun to be included in job descriptions, contracts and reviews for staff and some basic Treaty training had been initiated for Pakeha staff it was considered best by management to wait until these processes began to intersect in an effective way.

Maori had no disagreement with the matching of theory and practice which they regarded in the main as a Pakeha problem and one which there had been plenty of time to address. They did, however, have a disagreement with the process itself and the continued avoidance of action through unnecessary delays. Mostly though, Maori were again disenchanted with Pakeha defining their aspirations. If the organisations renewed commitment to the Treaty of Waitangi and the principles of partnership and good faith was to be real and the intention translated into action through the maxim of teamwork, openness and trust (Western Bay Health:1993.2.) then as King (1978:100.) suggests:

> I would contend that it must include the basic requirements that whatever the situation, where policies and decisions affect Maori people they must be consulted and their decisions and advice accepted.

The low priority assigned to this issue of importance to Maori, and the slow actioning of the request even when an agreed plan of action and an acceptance of the content was completed, meant that it failed to meet the criteria for responsiveness. Further, the time taken for non actioning of the request raised another issue, that of disrespect for the recognised authority of Te Whanau Poutirirangiora a Papa whose contribution had continued for so long to be resisted or redefined in Pakeha terms.

It was behaviour that led to the loss of existing goodwill between Maori and pakeha generally and in the health arena specifically. It was socially and politically therefore very expensive behaviour. Generally speaking, the attempts even with guidance from Maori, to make the move to genuine consultation which resulted in integrity of action and signified respect for Maori, simply degenerated into tokenism as the preferences of the dominant culture continued to prevail(1) 3.

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SOME LINKS WITH THE INTERVIEWS

The interviews with management revealed limited understandings of the context in which they practised, as well as a lack of responsiveness to the long history of unattended Maori requests and demands for action, respect for their culture and improved health. Those gaps in understanding and attitudes were passed on in practical, visible exclusive and measurable institutionally racist ways that impacted on the results in this section. The conclusion was that, in spite of the substantial verbal concern for Maori health and support for the use of research results revealed in the management interviews, neither action or development plans reflected that stated belief, nor did they reflect the researched reality of Maori. Responsiveness was poor as evidenced by the monocultural nature of the internal newsletter and the exclusion of Maori from major management meetings.

Additionally, requests to create culturally appropriate policies and plans added the Treaty of Waitangi as a last resort, rather than a fundamental underpinning of planning and practice, and consultations took place after the decisions had been made.

In the case of cultural safety, management behaviour was consistently resistant and eventually culminated in a decision, made entirely by Pakeha management, to alter the process accepted by both parties without consulting Maori.[3]

The perception that Pakeha had, that it was acceptable to speak for Maori on matters that affect their daily lives, was found to be still alive and well. This behaviour springs from what Williams (1992:92.) describes as racialism. She makes the useful distinction between the inter related concepts of racialism and racism, asserting that, racialism is not about power but about cultural superiority.

THE THEMES THAT EMERGED

The central focus of this study has been that the poor status of Maori health was in part due to lack of responsiveness in the management of health services as they relate to Maori, and as they affect the priority of services targeted to Maori. It was designed to have a balanced range of data collection methods so that the relationship between intention and action could be explored. Archival data, participant observation and the interviews with managers were regarded as being equal value and except for this early part of this section, the themes were revealed by all the data.

The willingness of managers to be interviewed is mentioned here because the process directly involved responsive human behaviour, and that it is known that being present does not necessarily elicit full participation or information. Arrien (1993:22) observes that:

> It's easy to choose not to be present: we may drift off in our thoughts, be emotionally embroiled in a past problem, be dreaming about future possibilities. In this case it can be truly said that we're "not all there".

This is what she describes as the shadow side of being present and can include being distracted, obscuring reality with politically correct language or to abstract oneself from any real responsibility for action.

This is what she describes as the shadow side of being present and can include being distracted, obscuring reality with politically correct language or to abstract oneself from any real responsibility for action.

The notion of doing more than attending; of showing up and choosing to be present is an important part of indigenous models of practice and is discussed by Arrien (1993:15) in the publication, The Four Fold Way, where she described the essence of showing up and choosing to be present in an in depth way as the Way of the Warrior. She observes that:

> My research has shown that universally there are three kinds of power: power of presence, power of communication and power of position. Being present means we are able to bring all four intelligences forward: mental, emotional, spiritual and physical.

In contemporary society, becoming an effective leader and manager in any field of endeavour means developing the inner Warrior, that is being able to take a stand and to communicate effectively.

Of the managers interviewed, only one "showed up" energetically with all four intelligences specifically focused in a way that led into an open minded wide ranging philosophical and practical discussion. A discussion that recognised and acknowledged gaps in information about Maori needs and aspirations and the need to develop care plans that which centred on the patient and "where they were" (respondents phrase) at the time. Whilst this response was ideologically a multicultural one which bypassed the issues of tangata whenua status, the Treaty of Waitangi and particular Maori needs, it did have the potential for Maori patients and whanau to be included in the design and plan for care at a level that catered for uniqueness and difference. This approach had the potential to provide what Durie (1994:103) called a better awareness of the Maori position and the introduction, albeit individualistically, of a Maori perspective in an otherwise unmodified mainstream organisation.

For the remainder who showed up willingly there was little evidence or awareness of the depth of presence and participation that was involved in such major structural, learning and practice changes as genuine biculturalism demanded in effecting new and improved outcomes for Maori health. Understandings of the historical, cultural, social, political and economic causes of poor Maori health were in the main absent, poorly articulated or superficial. Notions of what biculturalism meant in terms of thinking more widely and inclusively and the action that was required to practice in

real partnerships which raised not only the difficulty of translating the intention to action but that of actually generating the intention.

None of the respondents had "heard" Maori expressions of need, that was Maori needs as defined by Maori either the past or the present. None had recognised, or taken seriously, the implications of the shift in emphasis of service delivery prescribed in the health reforms that would require changed behaviour of them as Maori set the criteria for and began monitoring access to culturally appropriate services and their outcome.

As a result the content of the interviews raised a series of interrelated issues such as cultural reconciliation, collegiality, consultation and the validation Maori models and methods of care which were either not understood, or resisted in the belief that dominant Western models were the only possible or effective ones, or reduced to political expediency when Maori values were introduced into more inclusive accountability measures.

Some of this resistance was expressed as powerlessness. Many of the managers said that they either felt powerless or uninvolved in the issues and accordingly had not thought about their organisations stated intention that biculturalism should permeate all their activities.

For many non Maori New Zealanders, the prospect of being exposed to ideas that stand outside the one culture framework of ideas, beliefs and values that they believed so firmly in revealed a range of responses that included, resistance, unwillingness, boredom, fear, low priority, cultural superiority, rigid thinking and the reverse racism that has been called backlash, where Pakeha saw Maori as getting an unfair share, particularly when as Walker (1987:215) commented:

> As Maoris become better educated and more articulate in pursuing their cause, they beget a reaction from not so liberal-minded Pakehas. In modern parlance

> this is known as "white backlash". Maori leadership is put down by labelling it radical or intellectual.

As well as these aspects of how managers described themselves and their practice some major themes arose from the data. They were interpretations and action related to perceptions of power and influence; the dilemma of translating bicultural ideas and intentions into action; understandings and behaviour that centred around change; the language of change and the courage to create. Each has been allocated a section of the chapter.

PART SEVEN:
DISCUSSION OF FINDINGS

CHAPTER 8

INSTITUTIONAL RACISM

Spoonley (1990:18), noted that the way in which racialism is expressed ideologically varies and whilst he acknowledged that the insensitivity of many was very apparent in New Zealand, did not attempt to tie a particular ideological view to specific groups, but simply lists common world views that are racist in some way. He saw the term institutional racism (1990:24) as referring to the way in which groups are differently treated by institutions as a result of a set of organisational policies and procedures. Institutions such as the health system, education or justice contain or distribute a variety of resources and if a racial group cannot gain access to them for whatever reason, it is this differential access to scarce resources that indicates whether institutional racism exists.

The existence of institutional racism has been documented by various authors and researchers including The Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (1986:25) who identified and discussed three main forms of racism. They were, personal racism, cultural racism and institutional racism. Institutional racism is defined as a bias in our social and administrative institutions that automatically benefits the dominant race or culture, while penalising minority groups. It was noted that whilst personal and cultural racism may be intended and described in their own right, Institutional racism is to be observed from its effect and the effects are the statistics of inequality for as the Ministerial Advisory Committee on a Maori perspective for Social Welfare (1986:26) noted:

> For virtually every negative statistic in education, crime, child abuse, infant mortality, health and employment, the Maori figures are overwhelmingly dominant. In virtually every positive statistic in these areas, Maori are in miniscule proportion, if not entirely absent.

Tauroa (1982:14) argued that:

> New Zealand's present society is monocultural and ethnocentric, with the dominant Pakeha culture controlling all the major institutions and restricting other cultural expressions and with many of our racial problems stemming from this form of social control.

This view is supported by Yensen et al (1989:15) who noted that institutional racism in New Zealand describes:

> The fact that Pakeha as the norm makes it a racist society. Pakeha values and assumptions underlie all procedures and practices. Institutions follow Pakeha models and ideas and operate according to rules made by Pakeha people. Members of the dominant group (Pakeha) hold power and receive a disproportionate share of the resources.

Generally, accordingly to Spoonley (1988:23) racism can be defined as prejudice plus power, but in order to examine the effects of majority group power we need to look at the structures of New Zealand society. Here the emphasis is on behaviour and the policies and practices of dominant organisations. It was this aspect of behaviour, planning, policy and practice, the translation of intention to action, that was the focus for this study for, as Spoonley (1988:23) noted, racist beliefs do not necessarily result in discriminatory behaviour, but a critical factor is how they are translated into practice.

The major mechanism for domination is exclusion. Exclusion began with the notion of an uninhabited country and continued in New Zealand as a central part of the idea that British was best and, as Yensen et al (1989:47) recorded, the laws and values of indigenous peoples were dismissed as barbarous customs and replaced as quickly as possible with English law. Sharp (1990:209) refers to this as:

> The assumption that Pakeha culture, lifestyle and values are superior . . . that Pakeha values, beliefs and systems are "normal" . . . (also) the unshakeable belief in the cultural superiority of Europeans.

He went on to discuss (p209), as did the Ministerial Advisory Committee on a Maori Perspective for Social Welfare (p26), those instances when the power culture because of its assured attitudes of superiority, gives itself the right to select and use, without consultation, those aspects of Maoritanga it wishes to include in the general New

Zealand culture. Those selections range from the tail motif in our national airline to the inclusion of Maori words in the Dictionary of New Zealand English.

Spoonley (1988:21) raised further points that were significant to this study. Notably he argues that a key element in the definition of institutional racism is the acknowledgement that there may not be a conscious intent to such racial disadvantage.

He observed that there are many opinions which arise out of being socialised into the dominant culture, that are casually held and which the holder believes to be non offensive. It comes as a surprise to them to be confronted by someone who is offended.

This realisation says Spoonley (1988:18), should not be used to justify even relatively mild forms of racist expression, but it does explain why there is often bewilderment by those whose consciousness is poorly developed and why such unconscious, firmly held and unexamined belief in the superiority of one set of cultural values over another, is a fundamental aspect of the process by which racism continues.

It represents a particular issue for those concerned with anti racist work. For example, a recent management attempt at Western Bay Health to create a service position where one of the tasks was to be carrying patients luggage where necessary was perceived very differently by management and a Maori team. The Pakeha management wrote, and believed that they were doing it right, in relation to the low numbers of Maori staff and some small efforts to recruit more, that if the successful applicant were Maori that be considered a bonus Maori, on the other hand challenged (discussion. 11.10.1994) the racist nature of the concept and that fact that it would reinforce the subservient, role of Maori who are mainly in menial positions.

Thus, in a relatively prosaic way, Spoonley (1988:xii) argues, it is this invisibility, towards Maori values that encourages an anger, and it is repeated in many areas: justice, health, education, social welfare, employment. It seems Pakeha are simply not conscious of what has happened, or is happening, and why there should be so much anger. However, if those in positions of power and influence in institutions do not work to reduce and eliminate the monocultural bias that disadvantages Maori, they can (as argued by the Ministerial Committee on a Maori Perspective for the Department of Social Welfare (1986:26) be accused of collaborating with the system, and therefore being racist themselves. The committee concluded that racism can only be combated by a conscious effort to make our institutions more inclusive their character. To do this requires change that penetrates the recruitment and qualifications which shape the authority structures themselves; mere redecoration of waiting rooms so that clients feel more comfortable is insufficient.

In relation to changing racist systems, Sivanandan (1990:63) focuses on the belief that racism does not stay still, arguing that:

> It changes shape, size, contours, purpose, function - with changes in the economy, the social structure, the system and, above all the challenges, the resistances to that system.

He proposes that we need to understand these changes in the nature of racism if we are to understand how to sort out the struggles against peoples attitudes and the power to act out those attitudes in social and political terms for it is the acting out of racial prejudice, not racial prejudice itself that matters because racism is about power not about prejudice. Thus anti racist education for change becomes a critical issue and as (Sivanandan.1990:65) continues:

> Just to learn about other people's cultures is not to learn about the racism of one's own. To learn about the racism of ones own culture, on the other hand, is to approach other cultures objectively.

POWER AND INFLUENCE

During the interviews with management, half of the managers revealed that they had little or no influence to change things, that they did not feel involved in change as that happened more at the hands on service delivery area or that they felt in some sense powerless. This raised the theme or the elusive nature of power as well as manager ambivalence towards it. Power, is an essential leadership resource that managers use to achieve the interpersonal influence through which leadership is ultimately exercised, according to Schermerhorn (1984:299) who argues that:

> Power is a force or a capability that, when successfully activated, makes things happen. For many people, though, the word power carries a negative connotation that includes undertones of manipulation or political action.

This ambivalence about power has been highlighted by Quinn et al (1990:274) who noted that our perceptions about power are very revealing. They tell us as much about ourselves as they do about especially where misconceptions about power are concerned. Some of the popular misconceptions about power are identified by Quinn et al (1990:274), Rees (1991:54) and Flippo (1980:70) and they include the attitude that because I am the manager I can do anything; an attitude that confuses power and authority. The hierarchical belief that power is something that people in higher positions exercise on people in lower positions rather than an influence that exerts itself both ways and the belief that supervisors and middle managers are powerless. Quinn et al (1990:274) focus particularly on this aspect and propose however, that:

> Supervisors and managers are never powerless unless they choose to be. Claims of powerlessness are often forms of flight from responsibility.

Schermerhorn (1984:299) and Quinn et al (1990:276) both note that there are several sources of power that may be available to managers which include, position, power, personal power, reward power, expert power, conceive power. Opportunity power and information power are critical because often the difference between an effective leader and change agent and a merely competent administrator is, what Quinn et al (1990:277) have described as, depending upon access to information and the ability to

seize an opportunity or the timeliness of an intervention. Arrien (1993;22) in describing power in indigenous models of management and practice suggests an additional dimension acknowledging that:

> The archetype of the Warrior (leader) requires us to use power in an enlightened way that incorporates integrity, alignment of speech and action, honour and respect, and serves humanity fairly and justly . . . The right use of power allows us to empower ourselves and others.

The empowerment of others is an important concept in management theory and practice as is the distinction between power over people, and power to achieve goals which are liberating for others. Rees (1991:22) suggested:

> Three concepts as a means of enabling people to participate in discussing ways in which they were affected by contemporary social political and economic events. These three concepts or ideas were: struggle in context, continuity of experience and factors inhibiting spontaneity.

He also discussed the use of such concepts for the development of strategies of change because if in the unravelling of people's stories theirs is a focus on experiences of power and powerlessness, that should logically lead to an analysis of obstacles to empowerment and to well informed strategies for change.

According to Rees (1991:26) the group whose powerlessness is most deeply entrenched and for whom the step by step process of empowerment could have special relevance are those whose problems are longstanding and whose life is felt to be a never ending struggle against forces of injustice that are largely outside their control. They include people who have had long experience of exclusion from mainstream, of poverty, unemployment and poor health. These are people who, as Sivanandan (1990:76) notes, will make alliances with other groups to challenge conservative systems of power in institutions. Rees (1991:38) discusses the three-dimensional or radical conception of power proposed by Lukes (1974) which exposes the bias of the one dimensional view, as well as the behaviour of key personnel and also exposes the political dimensions of practice. He argues that, this three dimensional conception of power embodies the spirit and objectives of empowerment

for as Rees (1991:40) noted, politics is involved in any critique of the social order and in any challenge to domination in relationships.

THE DILEMMA OF TRANSLATING INTENTION TO ACTION

Since this study began, the results of other responsiveness studies have become available and were discussed more fully as part of the literature review. A consistent finding in those studies was the significant difference between what was written into major organisational documents such as statements of purpose, or mission statements, and what actually happened in day to day practice. For example, the review team found that there was a large gap between what the State Services Commission said and what it actually did. Nor was there any real biculturalism in either processes or outputs. Some senior managers in the commission appeared hostile to the idea of partnership. On the other hand, it was acknowledged that the Commission had for two years or so, or up to the months of the 1990 election, provided at times what would have been called a "courageous steer" on Maori issues and the requirements of the State Sector to be responsive. Since that time, as political rhetoric, or commitment waned, it had along with much of the rest of the sector been relatively acquiescent.

The findings in this study provided a parallel to those at the State Services Commission and a large mismatch was found between the stated concern of managers about Maori health and their inability to act in response to known and well researched conditions of low health status. The study found only one respondent who had been able to match the concern with some action. That was in the proper use of Maori language on signs and where the appropriate Maori processes had been respected. This action, seen as a very minimal and superficial beginning, was not further substantiated by having, or planning a culturally appropriate service within. Several

other small actions were claimed, particularly in relation to posters and decorations that reflected images inclusive of two cultures. All of these had been left behind by previous staff and only served to substantiate the findings of the study.

At the time of the study, none of the managers had either ideas or concrete plans for consulting with Maori about ways of acting to improved their services for Maori, or of setting guidelines and criteria for monitoring the effectiveness of such a service. None related their management practice to Government perceived need in the Maori health arena.

The inability to act was consistent with the data that revealed that few, if any, of those interviewed had sufficient knowledge of the circumstances that affect Maori health, to generate the intention to act in a responsive or inclusive way. Neither did they offer any knowledge of new paradigms of service that included value shifts. All change was thought of within existing value systems and there was no expressed willingness to change that.

That constellation of factors was considered crucial, for as Sivanandan (1990:43.) notes in the context of the women's movement:

> The touchstone of any issue based or identity based politics has to be the lowest common denominators in our society. A women's movement that does not derive its politics from the needs, freedoms, rights of the most disadvantaged among them is by that very token reformists and elitist.

The inability to act became predictable from the data which showed that the majority had insufficient knowledge or support in order to act confidently for change focused on low Maori health status. Nor were they able to incorporate the wider issues of fairness and social justice, believing as they did that the playing field was either level or tilted in favour of Maori.

CHANGE BUT NO CHANGE: THE KALEIDOSCOPE MODEL

The recent publication from Te Puni Kokiri, Kete Matatiki Hauora, (1993:64.) noted that change is unlikely to advantage Maori people, for, when Maori views stood in the way of "progress", they were ignored or legislated out of contention. The failure to include the Treaty of Waitangi in the Health and Disability Services Bill (1991) was one such example and led to the development of a later Maori health document to supplement the legislation. Thus the first of the lesson learnt by Maori was that restructuring carries with it, the ongoing likelihood of exclusion and that the emergence of new institutions would require fresh approaches from iwi because the partnerships so carefully negotiated with precursors of the new structures cannot be assumed to have any ongoing significance with Regional Health Authorities or Crown Health Enterprises. Maori had to reopen their case for special consideration based either on Treaty obligations or the low status of Maori health and the greater participation of Maori at all levels of the health sector. Under these unchanging circumstances it had become a wasteful war of attrition and already scarce Maori resources continued to be used to develop strategies of survival and maintenance against continued Pakeha arrogance and exclusion.

Not surprisingly it was noted by Te Puni Kokiri (1993:65.) that Maori wondered whether it was worth repeating the exercise. The experiences documented by Maori, since 1840, were substantiated in this study where the notions and practices of change were found to be simply a reconstellation of existing values; a new structure made of the same building blocks or a new pattern of the same images moved about. That was why I likened the boundaries of management thinking to the boundaries contained in a kaleidoscope.

In spite of the talk of change, and of new ways of pursuing the business of health that was part of the exchange of the health reforms, this study highlighted two major

issues of Maori health development. Firstly, a continuation of the entirely monocultural, institutionally racist approach to the development of practices and procedures which had always dominated the health services. Davis (1981:22.) observed that:

> The dominant perspective in health care is scientific medicine. It is this perspective which dominates our thinking about health problems, and which governs the deployment of resources in the health area.

A minimally recognised but significant issue was the issue of change itself where the reinforcement of monocultural control and more sophisticated forms of institutional racism were raised in sharp reality. That this reinforcement occurred each time the management and the structures changed became clear in each of the situations studied. I was able to trace changes in management locally during the health reforms. From the last days of the Tauranga Hospital Board in 1989, through the transition to the Bay of Plenty Area Health Board in 1990 and then the Regional Health Authorities and Crown Health Enterprises in 1991 - 1992, the organisation in which this study was conducted had eight changes of managers. Fifty percent of the managers interviewed for the study have now left the organisation. Of those, all were in their management positions for less than three years. Few of them exhibited any real understanding of the history of Aotearoa or active concern for the health of Tangata Whenua and only one was able to anchor a change in Maori health that stabilised a small platform for further struggle and development.

In the new climate that had been discerned in the 1980's when the Labour Government assumed office, some understandings began and an atmosphere of partnership and cooperation had slowly evolved but as Te Puni Kokiri (1993:65.) noted:

> In the case of Health services a strong partnership between Maori and the Department of Health amounted to little more than a pleasant memory when Area Health Boards assumed responsibility for funding health services.

Given that Maori people, values, views and preferences had not easily found credibility in the organisations of the state, it was seen that any small improvements in the situation of Maori that had been gained in a particular era, were at risk of being lost or obstacles again in the next, because few managers wished to refine or go forward with the arrangements of their predecessors in respect to their relationship with Te Iwi Maori, so the "wheel" as it were, kept getting reinvented as Maori were excluded again and again from the information, planning and resources required to make the changes, and critically, forced by the dominant order to renegotiate their position as Tangata Whenua. It has been the way that this repeated exclusion of Maori from participation in the mainstream of New Zealand society that Spoonley (1988:xii.) identifies as a major cause of disharmony. Additionally, each of the managers who left the organisation was to be replaced and past experience indicated that the negotiating process would need to be begun again by Maori when replacement staff arrived.

It was also noted, that Maori were expected to provide the main input into the development of biculturalism, and were often observed to be at risk of failing in the Pakeha system because of those extra duties. For example, a senior Maori man left the organisation because he was unable to perform the duties of Maori leadership of Pakeha groups going to the marae or other Maori venues, and still successfully pursue the role that he was employed for; several Maori staff were stressed by requests for Maori language lessons and the teaching of waiata over and above they were employed for. Those poorly informed and thoughtless attitudes of Pakeha, not only violated Maori protocols and cultural integrity but also put Maori staff at risk of failure in a Pakeha system, by doubling their workload, as if curing monoculturalism were a Maori responsibility. Yet as Yensen et al (1989:8.) note, we believe it is a collective Pakeha Responsibility to honour the Treaty: it is our side of the agreement which has been dishonoured, and it is we who must put it right. Walker (1987:21.) when asked whether he was able to assess how effective his lectures on subjects from

the Maori viewpoint had been, commented that they were part of a consciousness raising process and where liberals who attended them were in influential position, they could obviously work towards social change. But he added:

> It is a tiresome process educating Pakehas because there are so many of them. For each one whose consciousness gets raised there's another ten, twenty, a hundred out there waiting the wings for you to repeat the process.

THE NEW LANGUAGE OF SAMENESS

Management literature and language in recent times has been replete with talk of change, of doings things in new ways, of innovation, creativity, of "thinking outside the squares", lateral thinking, improving quality, customer excellence responsiveness: even of challenging mindsets. But above all of being pro active in this exciting world of opportunities where we did not have problems, only challenges. Somewhere in all of this talk of change, I, like Tim McCreanor (1989:10.) had developed an interest in the role of language in maintaining Pakeha power.

In the new reformed and managed health service, Crown Health Enterprises for example were to establish more effective business, management operations and planning practices. This was seen as an important step in preparation for the contestable marketplace that would follow the health reforms. (Western Bay Health 1993:1.)

The emphasis on results - oriented, scientific management, reduced the purpose to the effective, efficient and economic management of human and financial resources whilst at the same time declaring a commitment to a shift to community service and to serving the public, an orientation which, according the Yeatman (1990:35.) could not be pursued within the constraints of scientific management practices and has led to the adoption of rhetoric and measures which were designed to show that we still had an efficient public sector. She went on to discuss the significant changes in the

Australian and New Zealand public bureaucratic cultures and noted that it was in essence characterised by the adoption of the discourse of management. (1990:13.) She saw that it sat uncomfortably with and tended to exclude reference to substantive public service obligations such as citizen right of access to fair and equitable government administration, and providing high quality community services.

In a reference to the national Government's slogan for the 1990 general election, "Creating a Decent Society," the Maori Law Bulletin, Te Whakamarama (1991:8.4.) referred to the behaviour; political acts, that rendered the phrases meaningless and went on to point out that both Labour and National Governments became, with the help of knowledgeable wordsmiths in Treasury, experts in a bicultural newspeak, or double speak:

> Thus the political vocabulary now includes words like: Kawanatanga, Mana and Iwi, as well as the long list of redefined English terms such as market deregulation, contestability, level playing field, efficiency and equity.

Although it was not an intention of the research to make an indepth study of the use of language, the inclusion of a question about the use of New Zealand's other official language was intended to highlight if that was the case, the enormous damage done not only to the material and broader culture of Maori by the continued effect of colonisation by exclusion, but also the exclusive function of the new fashionable but meaningless language of the new era. Rees (1991:54) noted that:

> the jargon of management included prescriptions such as "mainstream human management systems" which could mean cutting back on the money previously invested in so-called non-productive welfare services.

It is described by Haraway (1987:30) as "language politics": Contests for the meaning of writing are a major form of contemporary political struggle, for example the ongoing debate about the different meanings of the Maori and the English versions of the Treaty of Waitangi and of biculturalism.

The political nature of language is further discussed by Yeatman (1990:155) who calls it the politics of discourse noting that:

> Discourse is the power to create reality by naming and giving it meaning. As Foucault (1984) argues, this power to create is always a distributive politics. It selectively constitutes what is to be counted as real and true, and, in so doing, discourse determines a politics of inclusion and exclusion.

Much of the language used by the managers in the interviews fitted those descriptions. It was imprecise, unfocused, protective and either allowed for avoidance of issues or successfully fudged them. The language made the analysis difficult as the words appeared to come philosophically, ideologically, or politically from nowhere in particular. They did not reflect the old or classic discourse of management nor did they accurately portray scientific, humanistic, or open systems thought. The analysis of the taped interviews resulted in a lot of words as many of the answers were lengthy even as they lacked content that was related to the question.

Many of the respondents replied in broad brush stroke ways that were suggestive of at least some universal truths but in language that was bland, and lacked passion, action or politics. None was used that did not include the current management buzz words, nor were there any words or phrases that indicated more than one dimensional thinking. It reflected a confusion of both purpose and identity. None of the managers had a plan or a strategy that was designed to improved Maori health, yet health care was to be more effective in improving the health of the population; numbers in the sample of managers perceived themselves as powerless. A factor which added to the case of confusion of both role and identity. Yeatman (1990:157.) recognised this phenomena in a discussion about the politics of difference in a post colonial era and noted:

> That it was an era of the multiplication of struggles for emancipation from various essentialist principles of domination. Preeminently an era such as this is one of contested identity, where old essentialist understandings of identity crumble into dust.

Sivanandan (1990:45.) wrote about what he call the hocum of new times and called it the big waffle. He argued that:

> What New Times represents, in sum, is a shift in focus from economic determinism to cultural determinism, from changing the world to changing the word, from class in and for itself to the individual in and for himself.

COURAGEOUS MANAGERS WHERE ARE YOU?

The "courageous steer" noted by a respondents in the Responsiveness Review of the State Services Commission (1991:58.) and referred to earlier was found to be a scarce commodity in this study. Analysis of the data raised questions about where were the well informed managers of change who had the heart for it; who understood that effective participation was not satisfied by the appointment of Maori individuals to Boards, working parties and committees; who were prepared to encourage and action collegiality not hierarchy; to share rather than to hold power; to face the reality that Maori health is such that managers with a commitment to the improvement of health status would as Garlick (1990) noted, find themselves doing only Maori health.

Where then were the managers with the knowledge and the willingness to change not just the structures, but the ideology and intent that informs them. To promote develop and use models of planning and service delivery not imported from others parts of the Western world, but proudly and effectively developed here in Aotearoa for Aotearoa in the 1990's. Were there any who could and trust and assign the sufficiency of resources to Maori health that will be required to redress the effects of history as well as quickly support the development of Maori systems and Maori measures of success; who could effect a "Breakpoint Redesign" rather than a reshuffle of old ideas.

It has generally been assumed by Pakeha, that Maori do not have the qualifications, experience or skills in management. This perception arises from the erroneous and racialist belief that Maori have no effective management systems or practices, yet in a

recent edition of the New Zealand Management Journal, Pearson (1991:21.) wrote a timely article headed "Marae a Font of Advice", and suggested that New Zealander managers should adopt tried and true systems of management and training instead of embracing the latest monocultural overseas methods.

He went further to point out that many of the improvements responsible for the "Japanese Miracle" were available to New Zealand managers if they had studied leadership, goal setting, teamwork and motivation on the marae, which is basically in Pakeha terms about teamwork, trust, efficiency effectiveness, motivation and enjoyment. However, most Pakeha managers do not know, or seek to know how to discover the appropriate Maori knowledge and may not even recognise its existence and if they do, fail to treat it with respect. Instead they seek to amalgamate it in the dominant paradigm and thus own it for themselves. Some managers did, as the study found profess a commitment tested. Others adopted the outward veneer of biculturalism, and gave their organisations or units Maori names and adopting some Maori rituals on special occasions. These practices were seen to enhance the reputation of the genuine cultural sharing, the breaking down of attitudes of cultural superiority, or to developing for the organisation, and inclusive, essentially New Zealand set of practices. Nor was any real understanding of the circumstances that affect Maori health elicited.

Quinn et al, (1990:v.) writing about Becoming a Master Manager in a changing world noted that organisations that hire graduates from management education process, for all agree that modern organisations, as never before, were in need of competent managerial leaders and that, this means both technical competence and interpersonal excellence. Management is both a technical and a social enterprise. In New Zealand, this also means competence to change, firstly to share power and then to learn to work in another new environment alongside their Maori equal partner as well as the

ability to manage and provide cultural safety for a bicultural workforce and a bicultural community.

PART EIGHT:

KO TE TAHA MAORI O NGA TAHA O TENEI WHENUA

THE MAORI PERSPECTIVE IS AN IMPORTANT DIMENSION IN THIS LAND

CHAPTER 9

KO TE TAHA MAORI O NGA TAHA O TENEI WHENUA

THE MAORI PERSPECTIVE IS AN IMPORTANT DIMENSION IN THIS LAND (Te Puni Kokiri.1993:6.)

I began this study with two broad objectives: one was to record the standpoint of managers with regard to biculturalism and, Maori health development; the other, to test the strength and consistency of those ideas as they were applied to policy, planning and action from evidence accessed in archival data and participant observation.

The reason for my interest in the standpoint, intentions and actions of management arose from being a participant observer and noting that the substantial energy, effort, innovation and struggles of competent Maori and Pakeha health workers who worked as change agents seeking biculturalism were being largely wasted. Much of this was thought to be because of the poor management support for equal partnerships in health care and their connection to the organisations obligations inherent in the Treaty of Waitangi.

Much of the research related to Maori health in the past had been done by Pakeha about Maori. That is the powerful studying the powerless or the rich studying the poor. I found Nader's (1979:289) discussion about inverting this approach to the issues a useful and thought provoking one. She suggested that the whole enterprise of fieldwork depended on certain power relationships and asked:

> What if, in reinventing anthropology, anthropologists were to study the colonists, the culture of power rather than the culture of powerlessness, the culture of affluence rather than the culture of poverty.

Whilst the changes in health structures and in health service delivery during the health reforms have been consistent and fast, the emphasis has been on privatisation and doing more with less, therefore most of the changes have been concerned with institutional self preservation rather than bicultural developments. Nairn (1988:88) observed that although some smaller organisations such as Women's refuges shared their resources with Maori:

> The large and or wealthy bodies were able to devote resources to the rhetoric of change while firming up their controls. I know of no larger institution which underwent major transformation in the late 1980's - by which I mean irreversible power sharing.

Because the research was undertaken at a time when the health reform were being actioned, it highlighted some of the very negative issues for Maori that are contained in the reality of what has been promoted as constant change, but has become more of the same in terms of acting on the priority of Maori health. In some cases it was less of the same as managers failed to share existing resources and projected Maori development priorities into the future, when Regional Health Authorities, it was hoped, would provide extra money. The themes that emerged were all considered significant ones and although the negative effects of change on Maori development became a visible theme, so did that issue of cultural competence and management responsiveness.

The study was a value explicit one. It was openly in support of the development of change that would more adequately address the issue of poor Maori health. It was always about change that did not go far enough; about change in the ideology and values that underpin the structures and systems of health care in New Zealand, in the attitudes and systems of health care in New Zealand, in the attitudes and who manage it, and in the knowledge and practice of the researcher, for as Mahatma Ghandi once said, "We must be the change we seek in the world". (Television New Zealand.31.7.1994)

The final chapters of the study have attempted to draw together some of the issues by examining the question of whether biculturalism as used in the definition of terms worked in practice contributes to the improvement of Maori health in Aotearoa is contained more effectively in the concept of Maori health development proposed by Durie (1994:103) which includes both bicultural goals and a continuum of structural arrangements.

BICULTURALISM AND MAORI HEALTH DEVELOPMENT: THE PAST, THE PRESENT AND THE FUTURE

At the beginning of this study it was acknowledged that there were different definitions and understandings of biculturalism. Unfortunately, as O'Reilly and Wood (1991:321) noted, there is no widely accepted definition of biculturalism in New Zealand Health Service and the reasons that it had failed to produce health for Maori people. This knowledge gap in turn limited the capacity for the development of strategies for change. In relation to this facility, Kelsey (1990:267) argues that:

> Many public sector officials have taken on board the rhetoric and occasionally the practice, of a more culturally sensitive form of assimilation called biculturalism.

Boston et al (1991:321) clarifies the same issue in saying that, while suggestions that genuine biculturalism necessarily leads to assimilation is erroneous, it was clear that:

> Much of what has been practised in the public sector to date is not a genuine form of biculturalism. For example, the corporate "culture" of most departments still seems to be predominantly Pakeha culture.

Although biculturalism had become a goal for government organisations as a result of the higher profile given to the Treaty of Waitangi by the Labour Government, the understanding of the theory and practice of biculturalism was incomplete and there was little uniformity coordinated effort or agreement on what it really meant in

practical terms. Those who sought to begin on the pathway to biculturalism was taken to mean an inclusion of Maori values and at another it suggested the development of specific parallel institutions to meet Maori needs.

Durie (1994:103) discussing the issues of biculturalism and Maori development, proposes two continuum. The first which addresses the need for mainstream organisations to become more responsive to Maori so that service delivery is more culturally safe for Maori and realises its potential to impact positively on Maori health. The potential for this level of responsiveness has not yet been realised although government (1992:21) recognises:

> The potential of the health system to address the following Maori health concerns; greater participation of Maori people at all levels of the health sector; resource allocations 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 services.

The second applies to structural arrangements beginning at one end with an unmodified mainstream organisation and proceeding to and an independent Maori one at the other. They both focus on biculturalism as a basis for Maori policy, planning and action and both include elements of political action, equality of status and function and improved service delivery.

The actions required to work each continuum are consistent with the government's recognition of the Treaty of Waitangi as New Zealand's founding document or as Durie (1994:101) argues, the unifying framework which accommodated partnership and power sharing. This approach includes the appreciation of tino rangatiratanga and Maori understandings of the guarantees contained in the Treaty of Waitangi. In the current discussion about the notion of rangatiratanga, many people limit the korero to the Treaty of Waitangi. They then, according to Jackson (1993:73), assume that the concept was both created by and limited to the terms in article two. They see it only as property right which can be limited to the Crown when in fact, the authority of rangatira had existed for centuries. As Jackson (1993:73) further discusses:

> The Treaty of Waitangi acknowledged the fact: it did not, indeed it could not create or restrict it, for the concept which rangatiratanga represents in a Maori cultural and political context is not new, it is ancient and derived from tipuna.

As well as the lack of clarity about the meaning of biculturalism the study revealed a similar lack of management understanding of the rationale for responsiveness to Maori that was reflected in all the data O'Reilly and Wood (1981:330). Boston et al note that the responsiveness policies in New Zealand can be traced to at least four sources, ranging from the international quest for administrative responsiveness to the imperatives of the Treaty of Waitangi, arguing that, only the Treaty of Waitangi provides the basis for a bicultural public service. Administrative responsiveness is essentially a client centred approach which included according to Harper (1988:3) ensuring that consumers are fully informed, relevance in meeting consumer needs, active participation in design and delivery, and real alteration in access to services through the removal of any social, physical or psychological impediments. The application of these concepts requires government agencies, such as health services, to adopt more culturally appropriate, inclusive organisational practices but as Wetere (1988:14) observed:

> It is evident that without commitment at the top level of any organisation there is little prospect of major changes in attitude and behaviour for the organisation as a whole.

Continued white supremacy and the exclusion of Maori from power, participation and decision making has been identified by writers such as Awatere (1993:108), as the most devastating mechanism in the maintenance monoculturalism and in preventing the development of a true biculturalism in Aotearoa. She argued, in discussions about sovereignty that:

> At it's most conservative it (sovereignty) could be interpreted as the desire for a bicultural society, one in which taha Maori received an equal consideration with, and equally determines the course of this country, as taha Pakeha. It certainly demands an end to monoculturalism.

At the same time, there was the likelihood that the monocultural organisation will remain relatively intact and continue to substantially represent the dominant value system for the foreseeable future for as Walker (1987:230) noted:

> The indigenous culture of the Maori has fought a running battle for a century and a half with the capitalist ethos of metropolitan culture. If all Pakehas realise that their human interests coincide with those of the tangata whenua then that is what biculturalism is about. Only when that connection is made can enough pressure be mounted to force politicians to make decisions congenial to human interests instead of succumbing meekly to the aggressive thrust of capitalism.

The continued Maori experience of poor health status reinforced that monoculturalism was alive and well. Biculturalism if the idea and the intention was accepted, had always meant an unequal partnership, with power and control being held by mainstream organisations, or further, that tokenist behaviours had only enhanced Pakeha reputations, not produced a positive impact on Maori health. Three factors, the repetitive exclusion of Maori that arises from the combination of racialism, institutional racism and the regular restructuring of the health services has continued to seriously disadvantage Maori health. They have been lethal combination which has remained in the main unchanged by Pakeha.

The situation has raised questions about the successful pathway to the future for Maori health. Some authors, such as Kelsey (1990:45.) and Harre Hindmarsh 1993:481.) have raised the issue of continued colonisation through the promotion of tokenist and diluted form of biculturalism. This manifestation bears no relationship to biculturalism in the ideal sense, which assumes full participation of Maori in society and with both cultures sharing control over resources and decision making. Instead biculturalism has assumed another meaning, it means as Kelsey notes:

> A policy (although not often a practice) whereby Maori staff and cultural behaviours are accommodated within the broader framework of neo-colonial institutions, while Maori community agencies are given superficial administrative responsibility but remain dependent and subservient to Pakeha power brokers.

Policies and practices in the name of biculturalism have not addressed the dynamics of power and most attempts at change in the name of partnership or biculturalism have often continued to preserve the ultimate power of Pakeha.

Managers and decision makers come and go; some are more enlightened than others, but it's very resilience and persuasiveness of monoculturalism enables it to accommodate to every kind of tactic without effecting real changes. At the same time, there remained the two fold need of making existing health services more responsive to Maori needs and assisting Maori on the pathway to self determination under the terms of tino rangatiratanga, mana whakahaere mai ra ano. (Te Whakamarama.8:4.) Both are potentially difficult pathways that are strewn with obstacles and resistances from both Pakeha and Maori. Mainstream organisations have it in their power to assist in the achievement of this by supporting the kaupapa that Maori have pursued for so long. It would require an end to exclusion and its subsequent disadvantage, an end to the notion of cultural superiority, positive action on the sharing of power and resources and inherently the creation of real change. It would require culturally competent Maori and Pakeha managers.

At the end of this study it is my contention, that having historically been party to the creation of the situation of Maori dependence and poor health, it is now time for Tauiwi to make the redress that Maori seek and for modern organisations in Aotearoa to make themselves a place in history that identifies their integrity, courage and commitment to a decent society. It is now time to be on the leading edge of a new health movement, that is, to support Tangata Whenua driving for their right of independence and self determination in health. For most, this will require an attitude change and a willingness to do things differently in the face of ignorance and fear, a vision, a new way of thinking and the courage to persevere for as Indira Ghandi said to David Lange in 1984; "In order to discover new oceans we must first have the courage to lose sight of the shore".

Maori are disenchanted with the unresponsiveness of mainstream health systems and services and wish to develop their own in a culturally active way. They are saying, as Rolleston (1988-1989:12.) reported that the time has come for Maori to speak for themselves. Their voices have not been heard, for Maori health needs as shown in this study, continued to be assessed from the viewpoint of Pakeha management in a context that was noted by Manatu Maori (1990:40.) to be influenced by two factors:

> The economic, political, social and cultural environments which can either stifle or encourage the attainment of Maori health outcomes and the dominance of one set of values over another.

If Maori health is to address future Maori needs, then it must be driven by longer term Maori agendas based on Maori priorities rather than short term political agendas.

It cannot be honestly promoted that the health reforms were designed in the best interests of Maori, but even as they wondered whether it will be worth continuing to try and form relationships with the managers of the new remote and more commercially oriented structures it was realistic, as Te Puni Kokiri (1993:65.) saw, that Maori people have continued to participate in the changes. They had to, for without an overall belief in equality amongst managers and behaviours that acted it out, health care for Maori was not consistent with the Treaty of Waitangi and there were few restraints on the continued development of monoculturalism. Spoonley et al (1990:149.) reminded readers that health and health care were shaped by the larger social contexts in which they occurred, and that these contexts were characterised by the enduring relations of economic, ethnic, gender and political power so that, they distribute illness amongst their people in ways that are reflective of general patterns of inequality. In other words:

> If working in a lower status job, being poorer and less educated already significantly increases the risk of death, the social consequences of being Maori adds further to that risk.

The case for the reality of the inequality between Maori and non Maori health status needed no further support. Nor did the major causes for its continuance. Many

credible Maori and non Maori research publications going back over generations have provided evidence of it. Some have been quoted in this study. Thus, the information for correcting the situation had been available for decades, yet little response or recorded improvement had resulted. Rolleston (1988/1989:12.) recorded the comment from a Maori participant who said:

> We are the most researched people in the world and yet we seem to be remain the sickest. If we are not getting any better, what is the point of the research when there are no follow up explanations.

At the 1993, Public Health Association of New Zealand Conference, (Public Health Association Newsletter.1993:5.) an Indigenous Australian speaker made a plea in support of the improvement of Maori health and noted that of all the research done, only five percent ever gets mentioned again by people other than the authors and less than five percent is put into action. He went on to add that it was the responsibility of all New Zealanders to end the sadness and ill health of Maori people, and emphasised:

> Let us be clear, the knowledge to do this exists. What is lacking is the drive to see it at an end. The key is to act. The real trick is to move from a position of being theoretically correct to being practically able.

In examining the potential for change towards a genuine biculturalism in health services this study explored the concern, knowledge, attitudes, intentions and achievements of a group of managers towards the improvement of Maori health as well as the flow on that was revealed in archival material. In doing so, it also looked at some of the structural limitations imposed by the State, organisations and individuals within them and the ways in which Maori have expressed their dissatisfaction and sought to overcome them. The study raised some critical issues such as the distinction between genuine biculturalism and what Kelsey (1990:44.) had called the vested interests in biculturalism. By this she meant the growth industry founded on Treaty Training, and which operates on the misconception that changing the hearts and minds of personnel will produce and enlightened state where people will see the light and hand over part of their power. She was emphatic that such naivety had no foundation in the history of liberation and equally, that biculturalism

was not tino rangatiratanga. Jackson (1988:209) too, argues that current notions of biculturalism are inadequate, saying:

> That biculturalism is a practical partnership requiring the sharing of power, resources and responsibility between two cultures . . . it requires an acceptance that rangatiratanga is a political authority.

Jackson's definition is strong and proposes the view that proper biculturalism is tino rangatiratanga and extends to the establishment of separate or parallel administrative legal, social and political institutions, a view that is included in the continuum explained by Durie.

STRATEGIES FOR CHANGE: CONFRONTING TREATY ISSUES

The Ministerial Advisory Committee on a Maori Perspective for the Department of Social Welfare (1986:27) proposed that:

> The first stage of change to a more culturally inclusive New Zealand is the recognition of biculturalism. This involves both the place and the status of Maoritanga in our institutional arrangements.

As Henare (1994:126) suggests, the Treaty promised rangatiratanga, so at issue is the relationship between Maori and the Crown. She goes on to note that if the Crown had performed its Treaty obligations a position for Maori could have been entrenched in the political process. The Royal Commission on Electoral Reform noted: Maori desire for a measure of self determination has been a constant theme in Maori - Pakeha relations since the Treaty was signed.

No one can deny there have been changes, but these changes have resulted always from what Kelsey (1991:43) described as consistent pressure from Maori levied against a fundamentally reluctant government and Pakeha dominated organisations, such as health, welfare and justice, where, as Henare (1994:127) argues, Maori are

always the supplicant. Yet as Vaughan (1972:113) wrote, two decades ago, we must ask ourselves where does the ultimate responsibility for improvement in the situation of Maori lie. Awatere goes further than the question and defines the problem as a Pakeha one and Walker (1974:110) specifically labels generalised attitudes and behaviour of Pakeha toward Maori as White Racism.

An answer according to Rothman (1977:289) can be found in inclusion and participation. That is, social power can be used to bring both parties to the relationship into status relationships where issues can be discussed, examined and compromised. He noted that:

> There are no supplicants or petitioners and no condescending controllers in a negotiating relation. By the very nature of the case, interacts occupy equal positions of both status and strength.

Recently as Kelsey (1991:43) suggested, resistance to honouring the Treaty has been more subtle. Pakeha have at times quite deliberately promoted divisions between Maori pragmatists, who have taken what was on offer in the belief that something was better than nothing, but says Kelsey (1991:43) the Maori realists point out that a parcel of nothing gift wrapped, is still a parcel of nothing. The struggle was fought and fought mainly on the level of ideology and in particular, in the name of bicultural partnership under the principles of the Treaty of Waitangi. Jackson, S. (1989:45) writing about continued colonisation observed that:

> Biculturalism of course did not give us any of the power suggested by the term; its fatal flaw was that our culture would be forever unequal and subservient to the dominant culture and never able to wrest from them the power and privilege they hold.

Biculturalism has become according to Kelsey (1991:44) a soft option:

> One which avoids addressing Maori self determination and provides a modern day, more culturally sensitive form of assimilation . . . Refusing to deal with tino rangatiratanga comes at a heavy price.

Far from making it go away, this strategy of lip service to the Treaty engenders a new frustration and a sense of Maori militancy reminiscent of earlier decades. In response to this realisation by some Pakeha and many Maori other options have been explored

in the 1990's. Three positions were identified by Harre Hindmarsh (1993:482). Firstly, a racist position, which has allowed us to continue to actively pursue racist policies through which we fail to acknowledge the dynamics of racism as a pervasive force in our society, or an anti-racist position. This latter stance according to Hindmarsh (1993:482) requires that Pakeha managers and practitioners:

> Recognise the privileges we enjoy by our whiteness and strive to remove these institutional, cultural and personal benefits even whilst still receiving them.

The writings of both Maori and Pakeha authors such as R Walker, (1987) M Jackson (1991), S Jackson (1993), D Awatere (1986) H Hindmarsh and Kelsey (1991) set the scene for major structural changes in our society and its organisations and service delivery systems, for as Sharp (1990:227), noted the time for talking was over and to adopt a way of speaking was not necessarily to adopt the policy. Translating the intention to the action had become a stumbling block for most Pakeha organisations in the late 1980's and the 1990's. The difficulties as measured in this study related to the belief that no change was necessary, or unwillingness to change, a multicultural perspective rather than a bicultural one and a feeling of powerlessness.

Allen (1992:6) in a discussion about the connections between research and policy, noted that the process of innovative change had several steps which included:

> Identifying need or opportunity, adopting or adapting existing approaches to meet the need or exploit the opportunity, inventing where necessary and transferring concepts into products and services.

Allen (1992:7) further noted, as did Te Puni Kokiri, (1993:61-73) that in the wider research and development environment, we immediately observe recurring themes that strike a familiar chord. That is problems in development, such as Maori projects which once underway or completed, do not fit in with the corporate strategy or business focus. Other reasons listed by Allen (1992:8) were, dithering, chronic crisis caused by re-prioritisation repeatedly and routinely, eternal back burner, lost projects, return to drawing board and what are described as esdel projects, that is where power

dynamics promote projects which would sink like a stone alone - unfair allocation of resource.

The diabetic service at Western Bay Health provides an example. Diabetes is a major health problem for Maori and the numbers of Maori who have the disease is 14% compared to 4% of non Maori. These figures are reproduced in both local and National publications, for example the Bay of Plenty Area Health Board Health Status Review (1991). Te Puni Kokiri noted that Maori are twice as likely to be suffering from this illness as their non Maori counterparts, yet the service remains completely in the hands of Pakeha doctors, nurses and administrators who fail to plan a more effective service with and for Maori.

Allen (1992:5) suggested that effective policy advice and planning required that services were based on a relevant research and information base, a clear assessment of the feasibility and costs of policy and planning options, an accurate assessment of the impact of policy changes on the people and a clear understanding of the broader context of social and economic policy formation. Manatu Maori (1989/91:8) asserted that a Government agency would be responsive in meeting the needs of Maori when:

> Its day to day business reflects the Treaty of Waitangi and it has the ability to account clearly for the impact of the organisation on Maori.

The results of this study identified gaps in participation, policy and planning that indicated the need for a coordinated, consistent, equitably distributed resources and measurable organisational plan for the improvement of Maori health. A plan that was inclusive of proper Maori representation and input throughout the development of all processes and procedures, for as Te Puni Kokiri (1993:67) found:

> The message is clear. If Maori development is to address future needs, then it must be driven by longer term Maori agendas based on Maori needs rather than short term political agendas.

This approach has continued to remain an option for Tauiwi, policy makers and planners, even though managers such as those at Western Bay Health and Midlands

argued that in the days of capped budgets, leaner resources and tougher decisions about priorities that Maori health would have to wait until the new funding round, when what managing for improved outcomes has always meant was the reordering and sharing of existing resources. That is fair and equitable inclusion in the sharing of old as well as new monies.

Jackson discussed at the management and planning hui at Te Puna Hauora (1993), a simple basic planning framework encompassing four main processes which need to be accounted for when change is planned. Those processes are, educate, consolidate, agitate and liberate; a reciprocal framework which could be used to develop a Maori health plan for any organisation that was willing.

Both Kelsey (1990:44) and Harre Hindmarsh (1993:483) have given examples of the practical roles that Tauiwi could play in assisting the development of genuine biculturalism and tino rangatiratanga. Their starting point too, was education and they included Anti Racism workshops designed to foster understanding of the history of repression as well as understanding of the Treaty of Waitangi.

Te Puni Kokiri (1993:57) published the recommendations from the Third Runanga Kuia where a high priority was given to:

> The need to address the fundamental and ongoing conflict between Maori values and Western clinical values in the health system.

Protest in such circumstances has been required by Maori in circumstances of continued exclusion and repression. Kelsey (1991:47) noted that protest with clearly established goals has its place and Allen (1992:11) provided some approaches to the issue of relationships that must be strategised as protests and which included:

> Extensively documenting and refuting assertions, ignoring the assertions and going on with the research anyway on the basis that the client is unlikely to find any other researcher who could do it faster anyway, providing an interim solution as far as possible to critical problems and educate clients regarding the nature of research - focus on why it is in their best interests to follow a systematic process so that solutions developed are valid, appropriate to the problem and provide significant benefits.

Ramsden (1994:Treaty Training) supported some of the suggestions made in Waitangi workshops in Christchurch in response to the question, what can we do as individuals and in organisations? The requirement for individuals centred on ongoing learning and the attitude change that developed through accurate information and greater understanding as well as actively supported and resourcing Maori projects.

For organisations they centre on Maori partnership in policies, decision-making partnership, affirmative action procedures, recruitment and training and organisational support of Maori causes such as culturally appropriate health development. Circumstances such as, the continued exclusion of Maori from their place as tangata whenua and the failure of the health system to produce health for Maori resulted in a response noted by Harre Hindmarsh (1993:483) that:

> In response to this realisation by some Pakeha and many Maori, alternative options are being explored in the 1990's. More emphasis is given to tino rangatiratanga and Pakeha anti-racists define their focus as to work to support tino rangatiratanga.

Each of these authors noted that education in decolonisation and anti-racism training would continue to assist but they also went further to alert readers that only analysis must extend to understandings and strategies that are in the realms of political procedures. These ideas are not new but they are increasingly urgent and they have been publicised over decades, for example, just one decade ago, Tauroa (1982:82) wrote in Race Against Time that:

> It is now time to re-examine the foundations of our society and the possible need to replace them with stronger social principles.

The Iwi Transition Agency (1990:3) in a paper called Discussion Paper for the Year 2000 noted the need for a plan that would guide Maori people to the year 2000 and projected the image of the ideal Maori, Pakeha and Environment that were part of the plan for change. Some of the attributes of the ideal Pakeha were described as a person who was supportive of the ideal Maori, who spoke and understood Maori, who was

visionary, committed to Aotearoa and to the Treaty of Waitangi. The continued and increasing demand for responsiveness to Maori rights and needs has raised again the issue of future options for Tauiwi. The New Zealand Listener (March 11 1995:7) in an editorial comment about Treaty issues indicated just as Tauroa (1982) had more than a decade ago, the urgency for all New Zealanders to understand their history and to give a priority to the issues of the Treaty of Waitangi for after Waitangi Day 1995, there was felt to be a lingering suspicion that the white community is judging the issue with only half the facts and that:

> After 155 years the government is being given the message; semi polite coercion in the guise of willing partnership won't work in the 1990's.

In this critical climate of relationships between Tangata Whenua and Tauiwi, Harre Hindmarsh (1993:483) has challenged, that in the pursuit of new strategies:

> Pakeha must work alongside, and in close liaison with Maori. We must respond to any requests that Maori make to provide them with more detailed knowledge of how Pakeha dominated systems operate and how to challenge and change these. We must assist Maori moves towards self determination and tino rangatiratanga in all spheres of life.

This aspect of support for Maori health development was considered a critical requirement for as Ihimaera (1993:18) has signalled:

> In the 1980's Te Maori was a sign of our cultural strength. But we have now transformed ourselves into a political force - and an economic one. In the 1990's we intend to manage our lands, our fisheries and a growing number of corporations.
>
> In no other period in Maori history have our people moved so far and so fast. The signs are everywhere - and we are still moving. We are regaining Aotearoa. Kokiri, kokiri, kokiri.

We have taken control of our destiny.

TAUIWI - PAKEHA RECOMMENDATIONS

TOWARDS GENUINE PARTICIPATION

Western Bay Health (1994:2) has a commitment to the Treaty of Waitangi and the principles of partnership and good faith. As an organisation it has acknowledged its obligations in respect of the Treaty. It is, therefore, recommended that in order to give substance to a well defined and well understood form of biculturalism that is consistent with the continuum proposed by Durie (1994:104) Western Bay Health is partnership with its iwi mandated Maori health team develop and action:

- A monitored and measured Maori health development plan for the organisation which reflects commitment, consistency and progress, that is fully participated in by Maori, properly supported by management and covers a range from mainstream to tino rangatiratanga.
- A regular, ongoing education programme that supports the Maori health development plan designed to provide consistency and progress in cultural safety and assist managers in an understanding of;
    a) The relationships established by the Treaty of Waitangi and how to action them
    b) the relationship of the Treaty to improved Maori health
    c) the ways in which monocultural practice impacts on the maintenance of poor Maori health
    d) the recognition that biculturalism is a continuum with a graduation of goals, a number of structural arrangements and reflects diverse Maori realities.

The issue of Pakeha responsiveness to poor Maori health is no less urgent in 1995 than it was in 1980 when as Tauroa (1982:5) suggested, the situation was already urgent:

> Race Against Time is a report which seeks not only a change in direction, but also a renewed emphasis on race relations in the next decade. Its major emphasis is on social change, on better understanding between people, on the deliberate elimination of "institutionalised discrimination through traditional practice."

Even in 1995 there remains an over-representation of Maori in all areas of poor and according to the Bay of Plenty Times 25 March (1995:3) Maori health in the Western Bay Health Crown Health Enterprise area remains worse than any other group, Maori or non Maori in New Zealand and as Durie (1995:13) noted:

> The themes captured in the Year of Maori Language, the decade of Indigenous Peoples and the United Nations Year of Tolerance are essentially about the same issues.

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