Enabled at last? A study of the development of three Maori health providers from 1994 – 2001

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Abstract

This thesis is a study of the experiences of three Maori health providers in the Heretaunga (Hawkes Bay) region, New Zealand. Focusing on the first six to seven years of their existence this study examines how government policies of devolution and the associated creation of appropriate health care organisations for Maori affected the operation of these organisations. The following topics were utilised throughout the thesis as a structure for analysis: the contracting model used, the reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies. Looking at the issue of tino rangatiratanga this thesis draws on these topics to determine whether or not this new policy environment has actually led to increased tino rangatiratanga for Maori – specifically Maori working in Maori health providers. The evidence provided in this thesis shows that in many respects this has not been the case. While increased tino rangatiratanga has been an outcome of the devolution process, the process has not delivered the extent of tino rangatiratanga that some hoped would be delivered through the devolution of service delivery to Maori. However, despite the relatively bleak picture that this thesis has painted of the experiences of these Maori health providers, their experiences should still be seen as an example of success. The changes in government policy which led to the creation of Maori service providers as discussed in this thesis have led to the creation of an environment in which a greater degree of Maori control over Maori health issues has been achieved. This thesis shows that unfortunately this change has not been to the extent that the women interviewed for this thesis hoped it would be when they first set up their organisations. The problem is that the policies, structures and processes, which they as Maori health practitioners and workers in Maori health provider organisations have had to work through, have at points, seemed to impede the operation of their organisations. However, despite these problems, shifts in government policy combined with their ongoing efforts have created a space in which they are able to assert their tino rangatiratanga through the practice of their mana wahine.

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Chapter One
Introduction

This thesis is a study of the experiences of three Maori health providers in the Heretaunga (Hawke's Bay) region. Focusing on the first six to seven years of their existence, this study asks how government policies of devolution and the associated creation of appropriate health care organisations for Maori affected the operation of these providers. This research examines whether or not this new policy environment has actually led to increased tino rangatiratanga for Maori - specifically those working in Maori health providers. This research will be useful to a range of readers including policy analysts at the Ministry of Health, Maori health providers and other social service providers. It is also hoped that the research will be useful to other Maori groups involved in service delivery, and not just those involved in health service delivery.

This study initially had two broad objectives. The first objective was to record the history of the development of three Maori health providers in Hawke's Bay between the years 1994 and 2001 from the perspectives of the women behind the organisations. The second objective was to determine the extent to which central government policies had enabled or constrained the establishment and operation of these organisations. This research was inspired by the 1984 election of the Labour Government - a major event that paved the way for a shift towards health provision for Maori by Maori. The first groups of Maori health providers were iwi health providers, enabled by the policy changes the Labour government made in the 1980s which were geared toward broad Maori development, rather than just health policy change.

The 1984 Hui Taumata prescribed a decade of Maori development within a framework of Maori self-sufficiency and Maori control. Reduced reliance on the state and increased confidence in tribal delivery systems were emphasized in order to enhance Maori social and economic advancement. While the major thrust was on economic initiatives, a paper on Maori health and several reports on Maori unemployment left no doubt that Maori people themselves were ready

to be the major agents for change (Durie, 1992). Thus, Durie affirmed that despite the call for a decade of Maori development from that hui, "the actual prescription bore more of the stamp of Government...missing was Maori control and ownership" (p. 5). Nevertheless, Maori development did progress with development of iwi systems. Following the Hui Whakaoranga in 1984, processes were put in place to form the Maori Health Standing Committee of the Board of Health. In 1987, the committee suggested iwi take responsibility for Maori health, similar to the social and economic programmes they were already running. However, Durie importantly added, "Those iwi committed to health advancement for their people quickly learned that their own input into the health system and, perhaps more importantly their ability to access funds, were very much governed by area health board attitudes and policies" (p. 6). Therefore, it was under these circumstances that Maori provision of primary health care for their people first arose. Those iwi that participated in health care were the first government endorsed Maori health providers.

Working as a registered nurse and midwife during this period, I became interested in seeing how this change would impact on Maori health generally. The government health policies in the 1980s had also led to hospital re-organisation, and at that time I worked in a hospital. I had witnessed first hand how Maori were treated 'differently' as patients, and how Maori reacted to the care they received while in hospital, from people who did not understand their culture. I was thus a close observer when, following the 1990 change in government, major reforms to the health system were indicated. The introduced reforms saw initiation of Maori health provision as experienced by the three Maori health providers in this study.

To a nurse working within the mainstream healthcare system, it seemed unlikely that Maori would be able to deliver adequate health care by Maori for Maori. For instance, there were very few Maori registered nurses at the hospital I worked at and for many years, I had been the only practicing Maori midwife. As a participant in the changes to the New Zealand health system over the 1980s and 1990s I was particularly interested in how Maori health providers had fared over that period. While some studies looked at Maori providers generally (Crengle,

1997), no study had looked closely at a specific set of Maori health providers through the lens of tino rangatiratanga.

As Durie (1994) points out tino rangatiratanga was an integral part of the Maori health movement of the 1980s and 1990s. The new Maori health initiatives such as the creation of Maori health providers were claimed by Maori as their own and as a way for them to achieve tino rangatiratanga. However, there were indications that this was not the case. Casual discussions with colleagues around Heretaunga who worked in the new Maori health providers pointed to almost continual fighting against the system. It seemed then the best methodology for this research would be to work with a number of Maori health providers. Given that major reforms to the New Zealand health system were underway once again in 2000 (this being the establishment of the District Health Boards), the period from the establishment of these three organisations in the mid-1990s through to 2000-2001 (when I interviewed my research participants) would provide a significant period of study.

Given my concern about whether or not the changes in the health system which had led to the establishment of Maori health providers had led to increased levels of tino rangatiratanga for Maori, I chose to focus my research on how government policies of devolution and the associated creation of appropriate health care organisations for Maori affected the operation of these organizations. I wanted to examine whether or not this new policy environment has actually led to increased tino rangatiratanga for Maori – specifically Maori working in Maori health providers.

As will be shown in chapter two and three, drawing on Durie (1994), I utilised a framework of analysis for my work with the three Maori health providers which connected five key issues to the issue of tino rangatiratanga, these being: the contracting model and reporting to the funder, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies.

Case Studies

The three health providers which are the subject of this thesis are based in the Heretaunga region and were chosen as they were all formed as a result of the initial push for the creation of Maori health providers in the early 1990s. And, despite the various changes that have occurred to the New Zealand health system in the intervening period they all continue to operate as health providers. Heretaunga was chosen as the area in which to do the research for this thesis as being a Ngati Kahungunu woman myself and a registered nurse by training who has lived and worked in Hawke's Bay most of my working life, I had the necessary connections to work with these providers and the women working within them. Because of this particular set of circumstances I operated as both an insider and outsider in the research process. I am an insider as a Maori woman employed as a health worker who lives and works in Heretaunga. I am an outsider as a researcher doing research for my thesis, who has never worked for any of these organisations.

Health Providers

Kahungunu Health Services (Choices)

Kahungunu Health Services is a charitable trust formed when Jean Te Huia decided to set up a Maori health provider organisation. Choices became a Maori health provider in 1995. In 2001, when the interviews for this thesis were conducted, Choices operated out of premises situated in Hastings, Hawke's Bay, with a geographic area of operation from Wairoa in the north to Takapau in the south. The Ministry of Health (MoH) contracts the organisation to deliver a range of health and disability services to Maori and others. Jean Te Huia, the founder of Choices, Erin Sandilands, Jean's sister, and Tangi Huata, Jean's sister-in-law were the interviewees from this organisation.

Te Kupenga Hauora

Te Kupenga Hauora (TKH) is a charitable trust formed in 1999. The original Te Kupenga Hauora began as the health arm of the Maori Women's Welfare League (MWWL) Heretaunga District Council in 1994. Their base was a disused ward at the then Napier Hospital, which they renamed Te Whare Hauora. By the end of 2001 TKH was providing an assortment of health, social and disability services to Maori, Pacific people and other New Zealanders, within the greater Napier area. Funding for these services came from the Health Funding Authority, Child Youth and Family Services, the Napier City Council, and the Corrections Department. I interviewed four women from TKH. Marj Joe, Audrey Robin and Huia Johnson were associated from the inception of TKH, with Marj being the matriarch of the organization. Donna Robin was the youngest of the interviewees and had joined THK in 1995 as an administrative person.

Te Taiwhenua o Heretaunga

Te Taiwhenua o Heretaunga (TTOH) is one of six taiwhenua that together make up Ngati Kahungunu Iwi Incorporated (NKII). TTOH was created as a charitable trust and it continues to operate as such. It was incorporated in 1988, and is governed by elective representatives of 17 marae within the taiwhenua designated area. The Trust considers all Maori residing within the boundaries as shareholders. The core business of TTOH is delivering Treaty based services of health, education, and social services. The organisation is led by the community, and has four divisions ('Rangatiratanga', 'Business and Corporate Services', 'Hauora', and 'Tautoko Whanau and Matauranga'). There were three interviewees from TTOH. Alayna Watene and Angeline Tangiora were still working for TTOH at the time of the interviews, while Rose Whenuaroa had been retired since 2000.

By working with the women who are the driving force behind the Maori health providers, I hope that I am able to bring their stories to light and to show how they have managed to keep their organisations afloat despite the various impediments to success. All three organisations are still operating. And so,

despite the negative aspects that this thesis will sometimes illuminate, it is ultimately a story of success as these organisations, largely through the efforts of these strong Maori women, who today continue to provide appropriate health care to the Heretaunga Maori population. This thesis, then, will foremost be of use to those Maori women whose voices I hope come through in the following chapters as it their work and commitment that helps those organisations to keep functioning. It will be of use to policy makers and students of social policy as a study of how government policies impact on issues such as tino rangatiratanga.

Chapter Outline

Chapter two outlines developments for Maori health provision within a broader social policy context. Key events are considered, including the Treaty of Waitangi Act 1975 and its amendment in 1984, and the Hui Whakaoranga and the Hui Taumata in 1984. Prevailing ideologies, most notably the swing to neo-liberal forms of government in the 1980s, are also discussed. This chapter shows the uneven development of Maori health providers and examines Maori control over health policies and institutions. It also reflects on to what extent government has empowered Maori health providers in a way that recognizes tino rangatiratanga.

Chapter three highlights the importance of Maori-centred research paradigms for analysing the history, structures, and daily affairs of the three selected Maori health providers that are the centrepiece of this thesis. The chapter then explains why the main specific qualitative research method employed in this research – semi-structured interviews – was chosen before then going on to explore the issues of case study selection, interviewing techniques and appropriate methods for data collection and analysis. The chapter ends with a small discussion on some of the ethical issues that needed to be addressed in obtaining ethical clearance for this research.

Chapter four is the first of the three case study chapters. This chapter explores the experiences of Choices, the trading arm of Kahungunu Health services. The focus of Choices has predominantly been for care of Maori women, along with

their pepi and whanau, before, during and after pregnancy. Through interviews with three key staff members this chapter explores the constraints that Choices has experienced in the years from its establishment through to 2001. As this chapter shows, the main issues the three women identified as problems to the operation of Choices and their ability to put into practice tino rangatiratanga were issues associated with the contracting model used, the types of reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and the short term focus of health system restructuring. These issues provide the basis for analysis in the subsequent case study chapters as well.

Chapter five examines the experiences of TKH - another of the Maori health providers that was created directly as a result of the 1993 National government reforms. Starting out with the history of this organization this chapter also explores the processes that the four interviewees in this case study felt limited their operation as a Maori health provider. The TKH interviewees raised similar issues to those discussed in the chapter on Choices – all of which have combined to negatively impact on the ability of TKH to put into practice tino rangatiratanga.

The final case study chapter looks at the experiences of TTOH. In addition to tracing the development of this organization from its inception in 1994 through to the end of 2001, chapter six also explores the processes that the three interviewees in this case study felt constrained their operation as a Maori health provider. And, as in the two earlier case studies, these issues negatively impact the ability of TTOH to put tino rangatiratanga into practice.

Chapter seven looks at the data presented in the earlier case study chapters in a more focused way drawing from all three case studies. After briefly discussing the idea of devolution of service delivery this chapter then uses the framework developed in the proceeding three chapters on the case studies to identify the issues that the Maori health providers named as limiting their work. The chapter ends by proposing that the process of devolution does not adequately provide for tino rangatiratanga.

In chapter eight the various strands of argument around the issues of the contracting model use, the types of reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies which have been present in the previous chapters are woven together and discussed in terms of both their impact on tino rangatiratanga and the original research question that this thesis posed.

Chapter Two

Setting the Scene – Maori in the New Zealand Health System

Maori have called for the provision of health care 'by Maori and for Maori' for many years. The past two decades have seen some movement towards this kind of service provision within New Zealand – a movement that can be contextualized within broader shifts in the social policies of governments of the day. This chapter outlines developments for Maori health provision within the broader social policy context. Key events such as the Treaty of Waitangi Act 1975 and its amendment in 1984, the Hui Whakaoranga in March 1984, and the Hui Taumata in October 1984 are considered. Prevailing ideologies, most notably the swing to neo-liberal forms of government in the 1980s, are also discussed. Most importantly, this chapter shows that the development of Maori health providers has been an uneven process and in closing asks whether or not there has been an increase of Maori control over these health policies and institutions. It also reflects on the extent to which the devolution of health care authority to Maori is merely empty rhetoric (in line with the neo-liberal policy agenda of successive left and right New Zealand governments) or has actually been a true attempt by government to empower Maori in a way that recognizes tino rangatiratanga.

Pre-colonisation to the 1970s

On initial visits to New Zealand, Cook and others described the people in general as being strong, muscular and lean. Bayly, an astronomer on the Adventure, 1773, reported: "the people in general are strong made healthy looking people" (Wright-St Clair, 1971, p. 11). Indeed, Tipene-Leach (1998) wrote of the uncertainty about whether there were diseases prevalent before any non-indigenous people arrived in New Zealand. Maori casualties generally came from old age, war wounds, drownings and burns, although chest, eye, and skin diseases have been recorded in oral history and were observed by Europeans in the early 1800s (Lange, 1972). Within this pre-colonial context Tohunga held prominent social positions as traditional healers and were credited with the

ability to use herbal remedies, set broken bones, direct public health, supervise midwifery, counsel, exorcise and participate in established religious and spiritual roles (Tipene-Leach, 1998). The health system experienced by Maori then was indicative of the presence of preventive, protective, promoting and curing powers (Tipene-Leach, 1998; Durie, 2003).

The health system Maori lived with was primitive but generally effective, with the twin concepts of noa and tapu providing helpful social and hygiene guidelines. With colonization, however, Maori increasingly suffered from venereal disease, tuberculosis, excessive alcohol intake and smoking, and higher rates of both obesity and suicide (Wright-St Clair, 1971). Maori also suffered more ill effects when, post-contact, they began to move from the hilltops to the swampy lands. Dampness combined with smoky sleeping conditions and the change to wearing of rugs in wet or dry conditions, increased their risk of suffering chest disease and rheumatism. Maori were also prone to epidemics of measles, influenza, chicken pox and small pox (Wright-St Clair, 1971).

Maori were thus thought to be verging on extinction by the 1890s. When Captain Cook first arrived in New Zealand in the late 1700s, the estimated Maori population was more than 100,000 and could have been up to 200,000 (Pool, 1991). By 1857, the population had declined to about 56,000. In order to help 'smooth the pillow' of this dying race, Wellington hospital and other public hospitals in New Zealand, were predominantly brought into operation in 1847 for use of at-risk groups – in this case both Maori and European paupers. During these years concern over Maori health was not restricted to official circles, with Maori also being pro-active in tackling Maori health issues.

The graduation of the first Maori doctor, Maui Pomare, occurred in 1899 in the United States of America, followed in the early twentieth century by three more Maori doctors (Day, 1999). Durie (1994) argues that these first Maori doctors went on to effectively deliver health services between 1900 and 1930 and were influential in forming the health policies during that time. Two distinct methods were at play, one supporting Maori autonomy and self determination, and the other supporting commitment to improvement within the pakeha dominated

Western model. Yet during these early years most healthcare was provided at home by the family with hospitals and doctors visits reserved for the most extreme cases. The big break for a more systematic approach to New Zealanders' health as a whole came with the 1938 Social Security Act.

Michael Joseph Savage and his Labour party were the authors of the 1938 Social Security Act. This was the most important driver of the Labour Party's policy reforms. The Act was funded through special taxation and its aim was to provide both income support and free health care (Cheyne, O'Brien, & Belgrave, 2000). The notion of free health care was not popular with the doctors who feared they would lose their independence and become state servants with the enactment of the policy. It was not until 1941 that a compromise was reached. This saw the doctors retain their right to charge fees, subsidised by a generous fee for service from the government which effectively negated the need for most patients to pay (Cheyne et al., 2000).

The original intention of the Act was to create an accessible system of health and well-being for all citizens of New Zealand. The Act achieved this by providing a "state-funded and state-run health care system" (Cheyne et al., 2000, p. 222). The state therefore became the main funder of general practitioner, hospital, and maternity services through taxation. As technology improved, so too extra services were added to the list. Yet despite the good intentions behind the 1938 Act some issues became increasingly problematic. Cheyne et al. (2000) have thus argued that increasing technology and pharmaceutical costs combined with rising inflation eventually eroded the free care so that by the 1970s a new way of providing health care was required in order to keep ahead of the rising costs of health care.

The increasing cost of health care since the passage of the 1938 Social Security Act had acted to marginalize Maori, the majority of whom were in the lower income bracket by the 1970s. However, localised initiatives helped to ameliorate some of these negative effects with the formation in Rotorua of the Women's Health League (WHL) in 1937 and the Maori Women's Welfare League (MWWL) 1951 helping to raise levels of Maori health. The WHL was instigated

by a New Zealander of European descent working as a district nurse in Rotorua. She had arrived in the district in 1931 and helped form the WHL so that Maori women could learn to better take care of their children. The broad objectives of the WHL were to "open a forum for understanding between Maori and European women; including health, improve the welfare of the Maori people; link tikanga Maori with principles of health" (Durie, 1994, p. 48). In 1986, the WHL opened a health centre at a marae in Rotorua. These early organizations can be seen as being the forerunners of Maori health providers.

The Maori Social and Economic Advancement Act was passed in 1945. Subsequently, tribal committees were formed and community workers were employed to address the new issues posed for Maori which occurred with wide scale urbanisation. Following this Act, the Controller of Maori Affairs instructed the Department of Maori Affairs welfare officers to set up committees throughout New Zealand, based on the WHL. These new committees became the basis of the MWWL. Their goals were similar to those of the WHL. However, in line with the key problems of the day, the major concerns of the MWWL were the issues of health, education and housing. By 1950, 165 MWWL committees existed throughout New Zealand. The aims of these organisations were wide but in effect they were to assist Maori women in mixing with pakeha, to provide venues for the discussion of health issues, to encourage healthy lifestyles and to aid those who were sick and misfortunate (Durie, 1994). Durie further informs us that the resolutions and submissions of the MWWL were taken seriously by government which is interesting because the aims of these organizations did not fit neatly in with the general assimilationist rhetoric of the day. In addition, the early 1950s saw a small but increasing number of Maori health professionals practising in different places in New Zealand, including as nurses, doctors and dentists.

Prior to colonisation, the main health issues for Maori related to minor skin and eye ailments. After contact, Maori were soon under siege from new diseases, the effects of migration to less healthy environments, changes in diet, and the introduction of alcohol and smoking – amongst other factors. Maori found themselves disadvantaged in their own lands not only politically and socially but

also in terms of health statistics. In response to this, government directives saw the creation of hospitals for managing these problems more directly, although it was not until 1938 that this management became a more systematic and nation-wide endeavour. Underlying the approaches by the Crown and New Zealand governments to Maori health was the prevailing policy view that, given the notion that the colonisers' ways of life were superior and given the inevitable end of the Maori race, assimilation provided the best option for all future approaches to social policy (Durie, 1994). However, the two most significant occurrences for Maori health advancement during this time period were the formation of both the WHL in 1937 and the MWWL in 1951. The emphasis on assimilation was one that lasted well into the latter half of the twentieth century – and so we now turn to the important decade of the 1970s where this emphasis on assimilation was challenged by broader civil rights and social movements.

Assimilationist thought continues – developments in the 1970s

By the 1970s public perception was that hospital services had deteriorated. General practitioners, hospitals, and regional health services were not working well together. There were marked variations in health funding between regions, and city residents were better served than country residents (Gauld, 2001). Further to these disparities between regions, continued discrepancies in health standing between Maori and pakeha were also identified in the 1960s and various studies in the 1970s also underlined these differences. (Gauld, 2001; Pomare, 1986). Yet although the problems with the health system along with disparities between regions was something that came to be addressed during the 1970s, the disparities between Maori and non-Maori were not addressed with any clear and directed governmental policy despite increasing social and political agitation from Maori civil rights groups.[2]

The lead up to greater health reform in the 1970s began when the third Labour government came to power in 1972. 'A Health Service for New Zealand' was the key document that government used for their health reform plan. The Labour

[2] For a timeline of these broader social events see Walker, 1990.

government felt that a solution to the woes of the health system lay within this document. The solutions proposed in the white paper were, however, very similar to previous structures (Gauld, 2001), and critics claimed that general practitioner and hospital problems remained despite the new policy document. These ideas were put in to practice by the following National government during their 1976-1979 term (Gauld, 2001). The new policy did little for Maori as the solutions for Maori health issues were still seen as being based in the process of assimilation. Yet some things were changing in the broader national policy environment. These changes were in part the result of the increased political action of urban Maori groups such as Nga Tamatoa (Barcham, 2004). Probably most significant for Maori development during this period was the introduction of the 1975 Treaty of Waitangi Act. This Act began the process of renegotiating the relationship between Maori and the Crown though this was largely restricted to the relationship between iwi and the Crown (something that became an issue later on as discussed below). In terms of direct writings on Maori health, Durie had published a document in 1977 that would be the beginning of writings which led to Maori interest in "reclaiming an active role in health and health care" (Durie, 1994, p. 54).

Prior to the 1980s, the 'problem' of Maori health was still simply seen as an issue to be overcome by assimilationist policies. No real governmental efforts were made to recognize that Maori might have different health needs in terms of treatments or access. Yet, during this period, other non-governmental sources began to promote policies that recognized that different people might have different health needs. Reid and Cram (2005) thus refer to a passage from a World Health Organisation study (World Health Organisation, 1977) which confirms that in the absence of policies supporting Indigenous communities, they are left to a life of "poverty and abandonment"(p. 45) which type casts them and their culture, in turn leading them to suffer institutional racism. Moreover, within New Zealand there were some stirrings of academic interest in this subject. As noted above, the subject of an article authored by Durie and published in the *New Zealand Medical Journal* in 1977 was "recognising Maori values in illness and medical treatment" (Durie, 1994, p. 54). This article can be seen as paving the way in terms of bringing to a wider pakeha world a consideration of "cultural"

differences. (p. 54). It also paved the way for debate among Maori, leading to recovery of previously active roles in health and health care. These ideas were given greater weight by the passage of the Treaty of Waitangi Act 1975 and its later amendment in 1984 which saw increased attention being placed on Maori issues in broader public debate. The 1980s then would be more fruitful in terms of Maori aims to pursue control of their own destinies in the field of health.

A neo-liberal swing – development in the 1980s

The 1980s was a decade of major public sector reforms. The public sector reforms were part of a broader global shift towards neo-liberal programmes of reform in Western Liberal democracies. These reforms stressed issues such as the separation of purchasers and providers, the devolution of service delivery to contractors (which could be community based) and a general restructuring and lessening of the state (Boston et. al., 1996). The changes were in part driven by economic theories in the United States (Gauld, 2001). In New Zealand, the reforms aimed to increase the efficiency of the public sector. This led to some devolution of authority to Maori with regards to health issues. However, the Maori worldview that health and society are key to Maori well being – hauora – was not well integrated into the health and development policies of the 1980s.

In some ways these moves can be traced back to a review of Maori health indicators conducted by Pomare (1986). Pomare's recommendations suggested that additional group studies and research into Maori specific diseases was required. Maori health care required better planning and evaluation, specific services to target those most at risk, and that (most importantly), Maori should be central to any service planning and execution of the plans. Not long after Pomare's review, aided at least in part by a change in government, New Zealand saw implementation of his recommendations. The election of the Labour government in 1984 was a major event in the shift towards Maori health provision for Maori. The incoming Labour government explicitly supported biculturalism and recognition of the Treaty of Waitangi, by then acknowledged as New Zealand's founding document. It is therefore no coincidence that in 1984 a number of events triggered the entry of Maori health provision on to the New

Zealand health scene. This new government was more open to the ideas that arose from Maori initiatives such as the Hui Taumata – but such provisions for Maori were still limited by the impact of the overall neo-liberal approach to governance of the day that "underpinned the actions of the fourth Labour government's term in office" (Barcham, 2004, p. 169).

The 1984 Hui Taumata (Maori economic summit) was a counterpart to the New Zealand Government Economic Summit. At this hui Maori founded a new policy agenda and framework for Maori self-sufficiency and control (Durie, 1994; Kelsey, 1990). Maori were frustrated with under funded Maori policy which was leading to poor outcomes. Instead Maori leaders at the Hui Taumata saw salvation for Maori in an iwi delivery model of some public services for Maori. Doctrines emerging from the Hui Taumata called for inclusive principles "to guide Maori development and to pioneer policies which would guarantee Iwi Development", and to foster "partnership between Maori and the Crown, based on Treaty principles" (Gauld, 2001, p. 75).

Thus, Durie (1992) reports that although the major drive of the hui was economic development, "a paper on Maori health and several on Maori unemployment focused the hui on social policies being vital to Maori development...Maori were ready for change but they wanted to be the change agents and they wanted the change to reflect their Maori heritage" (p. 3). According to Durie few, if any, of the hui objectives were accomplished, but at the time there was much hope placed in these kinds of meetings – as demonstrated by the Hui Whakaoranga that same year.

Backed by the Department of Health, the Hui Whakaoranga was convened at Hoani Waititi Marae, Auckland. The key focus of the hui was Maori health advancement. It should be noted though that a small number of Maori health initiatives were already in progress. Two such programmes showcased at the hui were the Waahi Marae project and the Whaioranga Trust based in Tauranga (a marae based programme which delivered some health promotion programmes). As a result of the success of these programmes several other iwi began to look to deliver health programmes. While the main focus of the hui was still on

'traditional' issues such as "land, education, and welfare" (Durie, 1994, p. 157), the Standing Committee on Maori Health delivered a discussion document where health was identified as fundamental to Maori development. The Standing Committee recommended to iwi authorities that they include health in their agenda. Avenues discussed were health promotion, health care, health protection, the training of health workers, and health planning.

These two hui led to increased governmental interest in possible alternative avenues for developing Maori health – though the context for Maori to have these alternatives open to them was increasingly being restricted to Maori as members of iwi. The Treaty of Waitangi Amendment Act (1985) was vital here in recognising iwi as legitimate descendants of Maori society (Barcham, 2004). The 1980s thus saw increased recognition by government that best outcomes for Maori would occur through partnerships with Maori.

This shift towards devolution to Maori was matched by a devolution of funding to the local level. These shifts – as they related to neo-liberal ideals of devolution and community empowerment – were seen in the health sector in the devolution of funding to Area Health Boards (AHBs) which had been created in 1983 (Gauld, 2001). During this period Maori became more involved in health service delivery but had only restricted involvement in largely small scale forms of health service provision. This period also saw iwi begin to link with AHBs in the development of Maori focused health initiatives. However, as Gauld (2001) has argued, these shifts were still not leading to true Maori autonomy in terms of health provision – they were friendly to Maori but were not Maori centred. The emergence of programmes such as the Waahi Marae project and the Whaioranga Trust can be identified as among the first readily identifiable forms of early Maori health providers. The partnerships of iwi with AHBs reinforced the links between Maori groups and Maori service provision, but it was not until the reforms of the early 1990s that Maori health providers as we now recognize them truly emerged.

In leading up to these later reforms a number of government documents began to lay the groundwork for increased devolution to Maori. A discussion document,

He Tirohanga Rangapu: Partnership Perspectives, was released by the then Minister of Maori Affairs, Koro Wetere, in 1988. The document was produced in the hope that it would help reshape relationships between Maori and the Crown. The document was very broad in scope in looking to restructure the Department of Maori Affairs in line with increasing public sector efficiency. In the reform process the Department was to be split in two to form a policy development and a monitoring ministry, as well as an iwi transition agency that was to be responsible for devolving social service programmes to iwi authorities. The report effectively "anticipated the complete devolution of programmes to Iwi authorities" (Cunningham & Durie, 2005, p. 215). Most importantly for this thesis, the document aimed to devolve health programmes to iwi authorities.

Durie (1994) states that at this time, although there was not much engagement between tribes and the Crown, tribes were reportedly happy to collaborate with the Department of Health, Area Health Boards, and, later, regional health authorities. This document was therefore very significant in foreshadowing some devolution of control over Maori health provision to non-state agencies. Indeed, the document clearly aimed to achieve "consultation with iwi and government agencies over policies of concern to the iwi" (Wetere, 1988, p. 12).

The ideas disseminated in *He Tirohanga Rangapu* were then officially accepted in the document *Te Urupare Rangapu* (Wetere, 1989). This was the policy document which became the formal government document used to implement Maori policy. Centred on the "philosophy of iwi/tribal development", the policy had planned for "complete devolution of programmes to iwi authorities" (Cunningham & Durie, 2005, p. 215). These were the steps necessary for greater participation by Maori in the health arena.

The emergence of more widespread Maori debate on the subjects of health and health care during the early 1980s, on marae and at hui throughout New Zealand, has been mentioned above. Those who had worked for increased Maori control over health issues were rewarded with new policy approaches towards Maori health development in the 1980s. The election of a Labour government – and their shift towards the adoption of neo-liberal policies of community devolution

– came just when Maori voices were increasingly calling for improvements in Maori standing in all spheres of society. There were calls not only for the improvement in the health statistics of Maori but also for greater control over the mechanisms for improving those health statistics. As the Fourth Labour Government's reforms came into play devolution began to occur. Indeed, although short lived, in 1990 the Runanga Iwi Act moved to provide iwi with a corporate identity, and "provided for Iwi development and the redistribution of resources to Iwi according to population" (Durie, 1994, p. 127). The Act was brought in to enable iwi to participate as fully as possible in the contracting world, and was a requisite for iwi to conduct business with the Crown. Yet some limitations remained – with two main issues at stake: one general and one more specific.

In general the 1980s saw changes to Maori health development and health provision within the shift to neo-liberal policies that recommended a relaxation of state control over a number of functions of government (such as transportation, communications and health). However, the relaxation of state control did not necessarily mean a complimentary ability of other agents to pick up those governance tasks. As Barcham (2004) argues, "government concern with increased Maori (meaning tribal) control of the resources allocated them could on a more cynical reading thus be seen as just an extension of this new, more general policy line of devolving responsibility away from the state and onto communities" (p. 169). This process of devolution therefore may have shifted responsibility to Maori to look after Maori health but this did not necessary mean that they always had the resources or power to actually do this job well. In particular some problems arose from the fact that the focus was almost exclusively on iwi (leaving no clear roles for non-iwi or pan-iwi groupings such as Urban Authorities) and the benefits given to Maori were often unevenly spread with rural communities being favoured (Barcham 2004). However, government's focus on iwi was soon to be challenged.

Increased devolution to Maori? – developments in the 1990s

The election of a National government in 1990 resulted in some notable changes in health policy directions. *Ka Awatea* was a report prepared by the Ministerial Planning Group in 1991. It suggested concentration on four key areas of government policy, one of which was health. Added to this was the oversight of the Minister who changed the policy setting emphasis from an iwi-development policy to a Maori-development one. In doing this, the Minister "enabled ....Maori urban authorities and traditional non-iwi organisations such as the Maori Women's Welfare League and the Ratana church, to deliver services in their own right" (Cunningham & Durie, 2005, p. 216). Two main strategies for health suggested were "a health promotion programme, and a strengthened health policy function for the new ministry" (Durie, 1992, p. 7). However, the document did not provide for a role for iwi, and the issue of how different (iwi or otherwise) dealt in their own ways with Maori health provision is explored in the empirical chapters of this thesis.

It was after the reforms of the early 1990s that the first true Maori health providers emerged. Earp (1998) saw the 1991 health reforms as a positive opportunity for Maori. Indeed, Maori health provider numbers grew from 20 in 1993, to more than 233 in 2003. The increase in provider numbers was attributed to an increase in funding of over $30 million in the 1997 financial year. Moreover in 1993 the Government had also committed to improving the status of Maori health and guaranteeing for the future "that Maori would have the same opportunity to enjoy at least the same level of health as non-Maori" (Manchester, 1998, p. 12). These developments were pushed along by other reforms during the period.

The Health and Disability Services Act which came into effect on 1 July 1993 was intended to reform the health system as a whole and in doing so had a big effect on Maori health. The Act was a response to a 1991 Health Services Taskforce which had made five key recommendations: separation of the purchaser and provider roles, integration of primary and secondary care, definition of core health services, establishing systems for public and personal

health, and integration of funding. From here Area Health Boards were replaced by four Regional Health Authorities (RHAs) that acted as Government purchasing agents, while 23 Crown Health Enterprises (CHEs) ran the restructured hospitals and were expected to produce a profit.

These RHAs and CHEs then negotiated contracts with providers (private hospitals and community agencies and so on) for health services. This was intended, in line with broader neo-liberal ideals, to create competition, increase efficiency and reduce costs. This was a significant policy move that had major impact for Maori health options. RHAs were supposed to encourage greater participation by Maori, to promote resource allocation priorities that took account of Maori health needs and perspectives, and to develop culturally appropriate practices and procedures (Gauld, 2001). As Durie (1992) notes, iwi were very interested in these reforms as it meant that they could tender to provide services under regional health authorities (p. 15). The very considerable experience already gained in health delivery, in geriatric care, community health work and health counselling would place some Maori providers in an advantaged position to continue those services on contract and without area health board domination. But of particular significance to Maori was the possibility that, as an alternative to regional health authorities, iwi could establish their own health care plans to provide a comprehensive range of health services on receipt of bulk funding (Durie, 1992).

During this period the notion of health provision 'by Maori and for Maori' started to become increasingly popular with the result being an explosion in the numbers of Maori health providers – though there was no single official model or template for the structures that were to be used for those agencies actually providing these health services.

The National-NZ First Coalition government that came to power in 1996 went on to undertake further health reforms which affected Maori health providers. The RHAs were replaced by one health funding body and this body was to focus on health outcomes rather than profits (Steering Group, 1996). Within the reforms, two main objectives for Maori health were also identified. The first was the

further development of Maori health providers. The professional Maori workforce and their administrative and organisational expertise was to be developed; Maori leadership within the Ministry of Health was to be invested with provider approval, monitoring and evaluation functions; and increased public health resources were to be made available for Maori provider development. The second objective aimed to fund preferred Maori providers to supply primary healthcare, community-based health and disability services (Steering Group, 1996).

The next major policy shift in the health sector came with the introduction of the Labour government's 'Closing the Gaps' agenda. Cunningham and Durie (2005) discuss how reports released during this time by Te Puni Kokiri highlighted "health status gaps; disparities in a range of health determinants for Maori; and evidence of increasing gaps in disparities between Maori and non Maori" (p. 215). But Cunningham and Durie also point out that the next Minister of Health in 1999 moved to focus on "addressing disparities in outcomes for all New Zealanders" (p. 215). This new focus on Maori health disparities did not really impact Maori health providers who carried on with business as usual. The only real change in the 1990s was in the total number of contracts being run by Maori health providers something which has increased over time.

Since the New Zealand Health Strategy was introduced in 2000 the present government has changed tactic once again. The progress of Maori health providers has evolved to the extent that in today's climate their funding is allocated through the Planning and Funding Division of the District Health Boards. The Planning and Funding Divisions have taken more responsibility for the oversight of Maori health providers and have become their own monitoring and evaluation arm. Some Maori health providers have joined Public Health Organisations (PHOs) while others have remained as they were. These moves over the period from 1993 to 2001 and how they impacted the three Maori health providers in this study will be explored in more detail in the following chapters.

Issues and problems – true devolution or empty rhetoric?

Global reform of the public sector in New Zealand took place throughout the 1980s and 1990s. Global health reform followed shortly after the public sector reforms. Gauld (2001) notes that both developed and developing countries engaged in these significant changes. As noted above these neo-liberal reforms were underpinned by economic theories whose origins lay in the United States, such as public choice theory and monetarism (Gauld, 2001). In New Zealand, the main emphasis of the reforms was to increase the efficiency of the public sector. In 2002 it was reported that the early 1990s marked an increase in the pace of reforms by expanding to include the social policy areas of health, education and welfare (The International Research Institute for Maori and Indigenous Education, 2002).

Durie (2005) has argued that a new period of health for Maori began in 1987 when the New Zealand Board of Health promoted the Treaty of Waitangi as a document that was applicable to health. Significant recognition of the Treaty by the Crown in 1987 marked the beginning of the following implementation of health reforms that have led to specific strategies for Maori health. Not least among these have been the 1993 National government's health reforms. The emphases of these reforms were "deregulation, devolution and contestability" which "provided a further opportunity for Maori health groups to tender for the delivery of services, mostly in primary health care, disability support and mental health" (Durie, 2005, p. 13). This opportunity for Maori to 'take control' of their own health care must thus be understood in terms of a broader shift taking place in New Zealand society at that time of devolution of responsibility for service delivery away from the government and towards the community. And so, while the 1993 National government's reforms directly paved the way for distinctly Maori organisations to provide health care to a mainly Maori population, with a wholly Maori workforce, we must be aware that these reforms were merely part of a much broader range of reforms. Indeed we must be mindful to the extent to which this talk of devolution to the community was merely empty rhetoric. As the case study chapters will show it appears that despite 'talking the talk' of devolution of health care to community providers, in this case Maori providers,

government (and management too) appeared unwilling in many aspects to 'walk the walk'.

New Zealand thus experienced radical health reform – particularly in the later 1980s and throughout the 1990s. This reorganization was not always restricted to the local context, indeed the New Zealand experience drew heavily from American theories of managerialism and public choice in the creation of these reforms packages (Gauld, 2001, p. 78). New Zealand too has contributed to the wider global scene as some of the policies pushed under the neo-liberal agenda have been quite revolutionary. Part of the reason these policies were revolutionary stemmed from the fact that this reform process was driven by a pressing need to deal with an outdated welfare system and, indeed increasingly uncontrollable, costs within the health sector. Moreover these broader policy shifts had significant impact upon government approaches to the issue of Maori health provision.

New Zealand thus saw some major policy shifts occurring within a relatively short time. For example, shortly after the wide adoption of neo-liberal modes of governance major changes occurred in the methods of contracting for services and service delivery and in the introduction of the philosophy of health care 'by Maori for Maori'. Gauld (2001) offers a useful framework for tracing government approaches to health issues in the last few decades by identifying four major periods of restructuring:

- the Labour government created an Area Health Board system (1983-1991);
- the 1991 National government 'health reforms' commenced in 1993 and chief among the changes was the split of provider function, from funding;
- the National led coalition government's reformation of the health sector was driven by problems with health reforms, and with some prompting from the governing partner; and
- the Labour led coalition government of 1999-2001 developed the district health board system (p. 3).

Within these four periods there have been a number of corresponding changes in approaches to Maori health that were supposed to not only improve the statistics regarding levels of health amongst Maori but that were also intended to devolve control and responsibility to Maori agencies so that they might provide health services 'by Maori and for Maori'.

In addressing the background and development of Maori health providers, Boulton et. al. (2004) commented that for a long time Maori have recognised that they require health services for Maori to be delivered by Maori. However, it has only been within the last ten years that Government has accepted Maori are the best caregivers, for some types of health. Again we need to be mindful to the extent that this acknowledgement of the role of Maori in delivering health care to Maori is a true acknowledgment of the value of culture and to what extent it was merely a way for the government to devolve responsibility and costs (but not true power) in line with its adoption of a neo-liberal ideology.

Nonetheless, the goals of the reforms were that Maori health providers would be easily accessible and incorporate their care with Maori culture, values and aims. These characteristics of the service would in theory enhance health care for Maori and so Maori would be more willing to access that care. This first group of Maori health providers was enabled through iwi services, which were usually marae based (Boulton et. al., 2004). As noted above, however, Maori health providers have not only flourished from there being only 20 in 1993 to there being 286 in 2006, but the political climate has also changed to recognize the roles played by non-iwi or pan-iwi groups as well.

However, going back to the question of whether these reforms were largely a matter of rhetoric or were truly designed to empower Maori groups (and so too Maori health) we should note that as early as 1994 Durie had identified the connection between tino rangatiratanga, devolution, and the reality of what actually happened for Maori with health system restructuring in the 1990s era as follows:

> Tino rangatiratanga (Maori control and determination) had become part of the new Maori health movement and Maori health initiatives were claimed by Maori as their own. Often they were, but seldom was it that clear. Instead, inadequate funding, professional intolerance, health system restructuring, and short-term policies combined to marginalize many initiatives and force them into narrow roles prescribed by area health boards and at odds with Maori aspirations and priorities. Sometimes ownership of an initiative had never been clearly established and conflict followed when it was discovered that the institution retained control, not Maori. What had not been lost, however, was a new awareness that Maori could, and should, play decisive roles in addressing Maori health needs (p. 57).

A few years later, Durie (1997) further noted that although government was seen to be connecting with Maori, contract wording did little to encourage Maori sovereignty or purpose. And so, while Maori were delivering services, they had no input into policy design. The devolution programme undertaken by government therefore "pushed responsibility for service delivery on to Maori providers...with limited scope for Maori involvement in determining the shape of Maori development" (pp. 150-1). Indeed Cunningham and Durie (2005) have recorded seven barriers to progress that confront Maori who are attempting to deliver health care. In terms of this thesis it is the first of these barriers that is of the most importance. Cunningham and Durie thus argue that Maori provider capacity is insufficient to meet the needs of Maori. This is reflected in the number of new providers that have not been allowed to obtain contracts. The numbers of providers, (over 200) have remained static since the 1990s in spite of the Maori population increase experienced during this period. The Health Workforce Advisory Committee in 2001 identified only 5.4% of the health workforce as Maori despite Maori making up over 15% of the national population. Other tensions have also remained, including the tension between iwi and non-iwi based health care provision and the ability of health funders to take seriously the broader health view of hauora espoused by many Maori health providers and the more limited medical (and contractual) issues that funders have traditionally dealt with in the funder-provider split.

Conclusion

While Maori health providers have come a long way in the last two decades we must be mindful to what extent the devolution of health care authority to Maori represents a true attempt to empower Maori and provide them with tino rangatiratanga. In many instances, devolution appears to amount to empty rhetoric. Maori health providers have faced a number of difficulties to get to where they are today, and this is a process that will be explored in the next three chapters through detailed investigations of three case studies.

Chapter Three

Research Design – Maori-Centred Research

This thesis draws on a number of important methodological principles, and these principles and guiding frameworks are set out in this chapter. In doing this the chapter first of all highlights the importance of Maori-centred research paradigms for analysing the history, structures, and daily affairs of the three selected Maori health providers that are the centrepiece of this thesis. This chapter then explores why the main specific qualitative research method employed in this research – semi-structured interviews – was chosen before then going on to explore the issues of case study selection, interviewing techniques and appropriate methods for data collection and analysis. The chapter ends with a discussion of some of the ethical issues that needed to be addressed in obtaining ethical approval for this research.

This thesis is a study of the experiences of three Maori health providers in the Heretaunga (Hawke's Bay) region. Focusing on the first six to seven years of their existence this study asks how government policies of devolution and the associated creation of appropriate health care organisations for Maori affected the operation of these organisations. Looking at the issue of tino rangatiratanga this thesis asks whether or not this new policy environment has actually led to increased tino rangatiratanga for Maori – specifically Maori working in Maori health providers.

Given the topic of this research is heavily dependent on a Maori world view, I was especially interested in research methodologies that would allow me to take that world view into consideration. A survey of literature seemed to suggest that Maori-centred research would be the best fit in terms of a methodology for answering the research question this thesis was asking, and what follows, is a discussion of the reasons for drawing this conclusion. Also included in this section is a discussion of the qualitative research methods and how they were most suited to this research. Finally, the study design is considered in detail.

Maori-centred research

Much previous research about Maori was carried out by non-Maori researchers who primarily aimed to reinforce European perceptions of Maori as a primitive people, and to promote the idea that they were a culturally superior people – thereby legitimating the process of colonisation (Bishop, 1997). In this process Maori knowledge was undermined, disadvantaged and even belittled by non-Maori who relegated Maori knowledge and history to being invisible, primitive, and invalid. Vercoe (1997) informs us that under early non-Maori research there was "a progressive 'watering down' of the strength and articulacy of Maori knowledge...[with] Western theories of knowledge [acting to] 'crowd out' tikanga Maori by assuming that the pursuit of knowledge is individualistic rather than collective" (p. 42) Further to this claim, Smith (1999) explains that the "single narrative story" approach to research of much non-Maori research on or with Maori, has resulted in Maori having a deep distrust and suspicion of research. Walker (1987) sees this denial of Maori knowledge and history as an essential part of the assertion of the colonising ideology and mission:

> Since the coming of pakeha to New Zealand in the nineteenth century, millions of words have been written about Maori people by pakeha authors in books, magazines, and newspapers. The result has been a mishmash of romanticism, myth-making, fact and fiction with liberal lashings of stereotyping, denigration and distortion of history (p. 11).

In response to these perceived wrongdoings a number of new approaches to research have been devised by Maori scholars. Smith (1999) has therefore promoted a system of 'decolonising' research methodologies in order to enhance 'Kaupapa Maori' designed methods of investigation. She affirms that decolonisation is about theory and research from a Maori perspective, and for the colonizer's own purpose. More specifically, Smith argues that Indigenous peoples want to tell their own stories – in their own ways and for their own purposes. Jahnke and Taiapa (1999) also emphasise the need to ensure that, when research into Maori lives and communities is carried out, it is for the benefit of Maori and their wellbeing – to encompass a "Maori designed theoretical framework" (p. 39).

In response to this fairly recent paradigm shift the methodological approach employed by this thesis is based on a Maori-centred approach to research. The emergence of the Maori-centred approach came out of concerns that research be carried out not only about Maori but also for Maori and by Maori – to enhance the lives of Maori and to enable Maori to have some control over research that is being carried out (Durie, 1997). Within this particular paradigm of Maori-centred research, the range of research methods is not ignored but Maori people and Maori experiences are placed at "the centre of the research activity" (Durie, 1997, p. 2). This Maori-centred framework therefore emerges as a distinct framework which Maori are able to use to promote their own well-being and to allow their voices to be heard. Drawing on Western perspectives such as critical theory, it also utilises methods of explanation and analysis based on a Maori worldview (Tomlins-Jahnke, 1996). Durie (1996) relates this theory as one which "enables Maori to take control of their own lives" (p. 4) and in doing so thus enhances Maori communities. For Durie, Maori gains in research will "advance the aims, goals and processes of positive Maori development" (p. 4). As this particular study analyses the history of three Maori health providers it is both necessary and most useful to use philosophies consistent with present day Maori world views.

Yet we need to make an important distinction between this Maori-centred research and the approach, mentioned briefly above, that is known as 'Kaupapa Maori' research. Unlike Kaupapa Maori theory, which requires that the community engages and drives the research (Smith, 1997), Maori-centred research allows the researcher to choose the topic and direct the project, hence the project does not necessarily have to flow entirely from the community. In this particular case Maori-centred approaches are more appropriate given the differing interests and demands of the communities that both established and utilised the three Maori health providers which were the subject of this research. This 'Maori-centred' paradigm allows for the use of a number of methodological devices including more general qualitative methodological approaches which are most suitable to the aims of this research, as demonstrated in the following section.

Qualitative research

According to Davidson and Tolich (1999, p. 122), when selecting appropriate methods for undertaking research the researcher must acknowledge the importance of three guiding questions:

- What do you want to know?
- From whom do you want to know it?
- What resources do you have?

With regards to the first question of 'what do you want to know' this thesis explores the experiences of three of the Maori organisations that took advantage of the opportunity to deliver health 'by Maori for Maori' in Hawke's Bay. In terms of the question of from 'whom do you want to know it', the research objectives can only be met by talking to those who have been involved in the establishment and running of these three Maori health providers. Lastly, in terms of resources, the project is limited by both funding and time constraints. Resource limitations are addressed further on when considering technical questions of questionnaire design, such as sample selection and interview techniques. However, from a broader perspective, it became increasingly obvious as the research project progressed that, in addition to a Maori-centred approach, the general qualities of a qualitative approach would best suit the needs of this particular research project. Beside these considerations, the most important element of this thesis was providing a space for the voices of those involved in the establishment and daily workings of these health providers.

Qualitative methodology is a collective term encompassing a number of distinct traditions. The relevant strengths of qualitative research that apply to this research are that the model describes the subject's views, offers 'thick' contextual descriptions, and the information gathered is in a detailed verbal and inclusive form (Sarantakos, 2005). The emphasis is on understanding people, rather than measuring them. Since the focus is on communication, researcher subjectivity and personal commitment are valued. The qualitative model is also constructive in this particular case in that it offers explanations for the

complexities of the modern world and takes a small-scale approach (Patton, 1990; Sarantakos, 2005) most appropriate where, as in this instance, a small number of cases analysed means that quantitative techniques such as statistical analyses are not practical nor accurate.

Qualitative research employs a variety of materials to describe routine and problematic moments of meanings in individuals' lives, and researchers are able to employ a wide range of interconnected methods. Correct use of a qualitative research methodology should allow the researcher to match the research with an 'appropriate' set of investigative strategies (Smith, 1999). A number of particular qualitative methods have relevance to the research undertaken in this thesis. The types of answers that are sought by the researcher's questions involve people's personal experiences and meanings within their own contexts. The histories of the three Maori health providers as related to the researcher were dynamic and multifaceted, including as they did: facets of political, structural, procedural, power relationships, and issues afforded by the interface of two different cultural systems, one the funder and one the provider. The fact that qualitative approaches provide for 'rich' data that values personal involvement, is flexible, and works better with smaller groups, fits well with the overall objectives of the research undertaken for this thesis (Davidson & Tolich, 1999). Given these aims, qualitative methods, including textual analysis of policy documents, questionnaires and the use of interviews, were most suited to this research as they allowed for an increased understanding of the complexity of the three case studies under investigation.

Study Design

Case study and informant selection

Yin (2003) describes the case study approach as the preferred strategy when posing "how" or "why" questions, when the investigator has minimal control over events, and when the focus is on a contemporary phenomenon within some real-life context (p. 1). Sarantakos (2005) lists the basic criteria of case study research – it must: be conducted in a natural setting suitable for pursuing depth

analysis, study whole and not aspects of units, entail a single or few typical cases only, perceive respondents as experts rather than data sources, employ many and diverse methods, and utilise several sources of information" (p. 212). Choosing to focus on three Maori health providers meets the criteria listed above They are suitable for depth analysis due to their status as being three of the earliest and largest Maori health providers established in Hawke's Bay. Three cases were selected as this is a manageable number for consideration within the limits of a Masters thesis, while at the same time constituting a large enough sample to provide for some interesting contrasts and comparisons.

Further decisions also had to be made about who to talk to within these case studies. The study sample was made up of key interviewees chosen from each of the three Maori health providers, with a total of ten interviewees participating in the research. The rationale for selecting these key interviewees was to gain a variety of perspectives from the three Maori health providers, which would in turn enable a 'thicker' history to be narrated. The selection of individual participants was thus based on the theory of purposeful sampling. Patton (1990) informs us that the logic and power of this method of sampling lies in selecting information-rich cases for study. One example of this approach is snowballing, where a small number of respondents are asked to recommend other people who may be relevant to the research (Davidson & Tolich, 1999). This is a reliable way of creating contact with other people who share in the activity that is being researched. This particular method can be helpful in that it is sometimes difficult for the researcher to know whom to access especially when the study is an historical one (Parahoo, 1997). Snowballing was therefore used in this case to extend the sample from the original three managers of the Maori health providers included in this research.

Prior to the study being taken to supervisors at Massey University, I first personally approached the managers of the Maori health providers. Each manager was at that time, asked to participate, and each agreed to the study being done. Using the snowballing technique, they then gave names of others who had worked for the Maori health providers during their inception. Following informant selection, then, further decisions were required regarding the most

appropriate methods for obtaining information about quite complex organisations, policies and relationships. Here the use of in-depth interviews was selected as an invaluable information-gathering and relationship-building tool.

In-depth Interviews and the Questionnaire

In-depth interviews were chosen as the method of data collection for this study. Bowling (1997) contends that the true meanings individuals allocate to activities, and their multifaceted attitudes, behaviours and experiences, are revealed with these kinds of in-depth interviews. This method thereby enabled the researcher to gather a range of perspectives from the diverse participants in the research and to gain understanding and insight of the issues that were important to the individuals and the health providers participating in this research. In order to achieve these goals a questionnaire was designed which would provide structure and guidance for the interviews (see Appendix A).

The questionnaire was developed to fulfil the purpose of eliciting information on the following, regarding each of the three health providers:

- the reason for establishment;
- how were they established, including original contracts;
- any issues faced on establishment and how they were resolved;
- any continuing issues from establishment up to 2001;
- the nature of services to be provided and to whom they would be provided;
- contracts to date;
- how changing government policies affected the Maori health providers; and
- the vision of interviewees for Maori health providers in the future.

The development of the questionnaire was therefore based on what was required to write an accurate reflection of the experiences of the three Maori health providers and the people behind the organisations. It was also based on the method that would be used to best deliver these questions – a semi-structured

interview format. This technique allowed the guiding questions to be determined in advance but the interviewer retained discretion to modify their order, change the wording, or add an explanation, depending on the context of the interview (Robson, 1993). It also recognised the fact that some questions may have been more appropriate for different participants, as well as allowing each participant sufficient time to answer the questions based on individual needs. In addition, the nature of the questionnaire enabled one of the intended interviewees who was unable to attend a scheduled interview, to complete the questionnaire without a face-to-face interview.

Data collection and analysis

Places of interviews were carefully chosen to ensure a quiet environment and an uninterrupted flow of information. Interviewees chose the places of interview which ranged from their own homes, the researcher's home and place of business. The interviews varied in length from one to two hours. Information was gathered in the form of written notes, and with the prior permission of the participants, tape recordings. The tape recordings were then transcribed by one of the researcher's colleagues who was professionally employed as a medical notes transcriber. The only difficulty experienced by the transcriber was with pronunciation and spelling of Maori words and names. I later rectified this by re-listening to the tapes and correcting mistakes.

Data analysis was performed using a general inductive approach. The transcriptions were read thoroughly, several times, and were then coded into themed categories. The categories were first grouped into questionnaire categories and refined further from there. The major topics of analysis were drawn from Durie (1994), and are: the contracting model used; the types of reporting required by the funders; inadequate funding; professional intolerance[3];

[3] I use the term professional intolerance as this is the term used by Durie (1994, p. 57) and so it is best, for reasons of coherency, to maintain the same terms in the writing of this thesis. This term, however, covers a broad range of concepts within personal relationships including intolerance, racism, economic patch protection, cultural difference and different ideas about what constitutes a professional-client relationship.

competition for resources; and health system restructuring resulting in short term policies (p. 57).

At an initial analysis these issues all appeared to link through to an overarching concern with the concept of tino rangatiratanga – or more specifically, its absence.

In utilising the Maori-centred approach it was important that this thesis portrayed the thoughts and feelings of the participants as the participants intended them. In order to do this the findings are written up in the following three chapters under the categories identified above. Interpretations and quotes are used where necessary, to add extra emphasis to the meanings the participants conveyed during the interview.

Apart from the participants validating their interview information, no formal feedback has been given to the participants. In order to ensure accuracy, participants were given copies of the transcriptions, on which they made corrections. From those transcription corrections, the participants were then asked if they would like to further read the corrections. However, without exception, the participants did not want to. Feedback has instead been on an informal basis throughout the progress of the thesis.

Interviewees

One of the key factors behind the creation and success of the three Maori health providers discussed in this thesis were the women who founded and ran them. They will be introduced in the following chapter.

Ethical issues

All of the processes undertaken for purposes of this research have been carried out with clear regard for ethical considerations (A copy of the Ethics Application, the letters sent asking for participation, the Approval Letters, the Consent Form and the Information Sheet are attached at Appendix B). Ethical

approval for this research has been obtained from the Massey University Human Ethics Committee (MUHEC) which provides guidelines for undertaking ethically-acceptable research. MUHEC bases the considerations of approval for research involving human subjects on their Massey University Handbook, Code of Ethical Conduct for Research and Teaching Involving Human Subjects. According to MUHEC, the major principles of the Ethical Code are:

- Informed consent of the participants
- Confidentiality of the data and the individuals providing it
- Minimising of harm to participants, researchers, and transcribers
- Truthfulness, or the avoidance of unnecessary deception
- Social sensitivity to the age, gender, culture, religion, and social class of the subjects

The application to MUHEC to undertake this particular research considered all these facets of ethics. The application form clearly shows:

- The identity of the applicant
- The title of the project
- The justification for the research
- The objectives of the research
- Procedures planned for recruiting participants and obtaining informed consent
- Procedures for handling information and material produced in the course of the research including raw data and final research reports
- Procedures for sharing information with the research participants
- Arrangements for storage and security, return, disposal or destruction of data

However, some specific ethical concerns needed to be considered when carrying out the research including: access to participants; informed consent; anonymity and confidentiality; potential harm to participants; the researcher and the University; and the status of the researcher as a Masters student. Many of the ethical issues were addressed by adhering to Maori-centred research principles whereby the research was expressly carried out as research by Maori, for Maori

rather than constituting research 'about' Maori. The participating organisations and interviewees have been identified with their consent. This was necessary as the organisations would have been identified, whether their permission to identify was gained or not. Under these circumstances, it was prudent and ethical to seek permission to identify the researched organisations. In terms of other ethical and process issues, it is important to note that all the interviewees and the researcher had a professional history, and that the researcher was trusted by the participants. No complaints have been received from any of the participants and they have readily agreed to all requests from this researcher.

Finally, it is necessary to consider that participant's answers may have been influenced by their relationship to the researcher. As noted in the introduction, Heretaunga was chosen as the area in which to do the research for this thesis as being a Ngati Kahungunu woman myself and a nurse by training who has lived and worked in Hawke's Bay most of my working life, I had the necessary connections to work with these three organisations. However, because of this particular set of circumstances, I operate as both an insider and outsider in the research process. I am an insider as I am a Maori woman employed as a health worker who lives and works in Heretaunga. I am an outsider as I am a researcher doing research for my thesis and have never worked for any of these organisations. This set of circumstances means that in all likelihood, the participants' responses were influenced by who I was as the researcher. This web of social relationships must be borne in mind when considering the research outcomes.

Being an insider and outsider brings both strengths and weaknesses to this thesis. Strengths include my personal experience of the changes to the health system and familiarity with the people working within the health providers. Weaknesses include the fact that the women I interviewed might not have been as open in some respects with me as they would have been with an outsider. These should not be seen as excuses for the outcomes of this thesis. Instead, they should be seen for what they are: the particular relationship that I as a researcher have with the people I worked with in the research for this thesis.

Conclusion

This chapter has delineated the basic qualities of Maori-centred research and demonstrated why it was the most appropriate research methodology for this thesis. Indeed, this researcher's main goal was to provide a space for the voices of those involved in the establishment of these health providers to talk about their experiences. A qualitative approach, in particular the use of a semi-structured interview, was the most suitable methodology to achieve that goal. A structure for analysis largely based on Durie's (1994) topics of analysis was then employed.

In the following three chapters each case study is discussed in-depth, leading to a thorough analysis which draws the data together in the discussion chapter.

Chapter Four

Choices

This chapter introduces Choices, the trading arm of Kahungunu Health services. The focus of Choices has predominantly been the care of Maori women and their pepi and whanau, before, during and after pregnancy. Through interviews with three key staff members this chapter will explore the constraints that Choices has experienced in the years from its establishment through to 2001. In this chapter these issues are discussed in terms of the Durie's (1994) topics: the contracting model used, the reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies. This chapter also shows how the main issues as identified by the three women interviewed impacted on their ability to put into practice tino rangatiratanga.

Documentary evidence in this chapter came from a proposal application for the Family Start programme documented at end 1999, Trustee Meeting reports, and a Maori Provider Profile for the Hawke's Bay District Health Board in July 2001.

Kahungunu Health Services (Choices)

Kahungunu Health Services is a Charitable Trust formed when Jean Te Huia decided to set up a Maori health provider organisation. Choices became a Maori health provider in 1995. She chose 'Choices' as a trading name to indicate that Choices offered an acceptable alternative for Maori women that gave them an increased choice of caregiver. Previously, there had been no other 'user friendly' services for pregnant Maori women and their whanau to attend for care.

In 2001, Choices operated out of premises situated in Hastings, Hawke's Bay, with a geographic area of operation from Wairoa in the north to Takapau in the south. The Ministry of Health contracts the organisation to deliver a range of health and disability services to Maori and others. The Kahungunu Health Services Mission statement in 2001 was to deliver trustworthy healthcare.

Extension of the statement means that the Maori workers of Choices deliver healthcare services in a culturally sensitive way to a mainly Maori population.

Choices was one of the many Maori health providers that came about during the period of health reform when health provision 'by Maori and for Maori' was the rhetoric of the time. Many Maori, among them Jean Te Huia, saw this as an opportunity to put ideas into practice – ideas Jean long held about being able to deliver health services to Maori within the Hastings district that would be affordable, accessible and effective. Another component of the delivery was that it would by "by Maori for Maori." This enhanced the ability to deliver services based on the Treaty of Waitangi, and in a Maori way, using a Maori model of health such as Te Whare Tapa Wha that included the four cornerstones of Maori health, recognised by Maori as Te Taha Tinana, Te Taha Hinengaro, Te Taha Wairua and Te Taha Whanau (see Appendix C). This was strengthened by Maori membership of the organisation in all facets of staffing.

Jean Te Huia

The origins of Choices date from 1993 to 1994 when Jean Te Hui attended several hui held by the Central Regional Health Authority (CRHA) Maori Manager and his team, in different areas of the Central Health Region. Jean recalled this time period, "I went to several hui... [and] they identified that there needed to be programmes appropriate by Maori for Maori." In light of this Jean decided to try and acquire a contract to further the goal of the delivery of health programmes for Maori by Maori. After sending in a number of proposals, one was finally accepted in 1994, to start in 1995. Referring to this first contract Jean stated:

> I wanted to do midwifery after I had finished my nursing training at Eastern Institute of Technology....I knew there was a huge gap in services for young Maori women in the system and a huge gap for young Maori babies born to these women.

In fact, Jean's ideas had been strengthened by conversations she had with a group of other strong minded Maori women when she was in Wellington doing her

midwifery training. It was during this time that Jean was inspired to become a Maori health provider. Most importantly, Jean animatedly recalled:

> It was fortunate that while I was in Wellington I had an opportunity to be in close contact with not only Mara Andrews (who worked for Maori Central Regional Health Authority), but also with Huia Ormsby, and Doctor Paparangi Reid, who both worked at Te Roopu Rangahau Hauora (Wellington School of Medicine, Health Research Centre). I would meet with them and they would talk about some of the things in ante natal classes that would be important for young Maori women [and] so when I put my proposal together and sent it first to Mara, they were quite in agreement to help...if I set it up in modules looking at the different stages of the pregnancy, being antenatal, the birth and then the post natal. And looking at support services that needed to be in place for these women.

Thus was born the basis of Jean's concept for Choices.

The successful proposal was for ante-natal/post-natal care and support for mothers and their pepi. Jean recalled, "They said yes we would fund your programme but it would [only] be a twelve month pilot." She became official Coordinator of Choices in 1995. Jean completed her Diploma of Comprehensive Nursing at EIT, Taradale, Hawke's Bay at the end of 1993. In early 1994, Jean began study at the Wellington Polytechnic towards her midwifery qualification, which she completed in mid-1997. In 2001 Jean was working as a midwife from Choices. Additionally, she was the Coordinator of Choices and a Kahungunu Health Services Board of Trustees member. Her and her sister-in-law Erin chose to be interviewed together for the purposes of providing information for this thesis.

Erin Sandilands

In 2001 Erin Sandilands' role at Choices was as a Community Health Worker. At the same time, she was undertaking her Comprehensive Nurse Training at the EIT, which she began in 2000. The time spent at EIT took precedence over the time she spent working for Choices. Erin recounted how in 1995 she came on board "as a support worker doing whanau support....The work wasn't hard but it

was long, like you would do long hours here." Erin then completed a Community Work Certificate at EIT in 1996, and an Introduction to Counselling Skills course in 1997. Erin's role as Community Health worker was broad. Erin also recounted the nature of her work:

> I worked with Tangi in admin signing the cheques. There has [sic] been times when the telephone lady and the receptionist might go on holiday so I have to be the receptionist. And there has [sic] been times when I have had to be the practice Nurse, a taxi, a social worker, counsellor, midwife, antenatal pregnancy support, postnatal/ antenatal education. Teaching the women how to bath babies and breast feeding, everything.

Before joining Choices in 1995, Erin had worked in woolsheds for 20 years, Wattie's Canneries factory for eight years and in apple packing sheds for 10 years. This varied career background meant that she brought many different life skills to the organisation.

Tangi Huata

In 2001 Tangi Huata was the administrator for Choices, doing all the administration work, formatting the contracts and handling the finances. Tangi joined Choices in mid-1995, at the same time as Erin. In the beginning, everyone shared all the work. Tangi remembered, "When Choices was set up I had to make sure that the administration was able to meet all contractual requirements as set out by the MoH." Her specific job had always been as administrator, but the scope had developed since 1995. Tangi had worked in administrative positions before coming to work at Choices, and she was and remains treasurer of their local marae committee. This history, together with a trusted whanau connection as Jean's sister-in-law, had been a deciding factor in Jean asking Tangi to work at Choices. Tangi was unavailable for a face-to-face interview for this study and chose to answer the interview questions via email in May 2003. Prior to answering the questionnaire, Tangi and I met in order for her to read and sign the informed consent sheet.

Health services provided by Choices

Choices provides health services funded by the MoH, derived from seven contracts. The services are targeted toward pregnant women and their whanau, with a special emphasis on pepi and tamariki. The main messages of the organization are based on healthy lifestyles for Maori. Choices staff deliver the services from a range of settings that include Choices headquarters, homes, schools, marae and the Hastings hospital.

Although it is not the only model of Maori health available, Choices uses the Te Whare Tapa Wha model with emphasis being placed on the delivery of care that encompasses these four cornerstones of Maori health (see Appendix C for a more detailed explanation of the model). At the time a client is registered, the person assessing the client asks them about their relationship or needs as they see themselves, in relation to the Whare Tapa Wha model. If clients do not have an understanding of these concepts, the concepts are explained simply to them. It is then up to the client to accept or reject the associated care. The model, as used here, relates taha wairua to spiritual aspects of Maori and non-Maori, taha hinengaro to mental health services, taha tinana to health services, and taha whanau to Social services/family well-being. The model may be used this way in both individual and family situations. At intervals, the model is revisited and reworked, dependent on what stage of the model requires working on for the client or whanau. If a service is delivered at marae, or in a marae-like situation, the model is not closely followed. However, adherence is observed to kaupapa Maori relative to powhiri or whakatau, whanaungatanga, and whakapapa.

Overview of Ministry of Health contracted services

An overview of the Choices contracted services is outlined in Appendix D. A feature of all the contracts is that if required, the person is referred to other services. For example, a child with ear discharge may be referred to a specialist ear doctor. Transport may be provided with some contracts, but this is not a contract requirement. Each contract is holistic in nature. For instance, there will always be an inclusion of whanau in the various services delivered. Although the

practice is essentially 'by Maori for Maori', anyone requiring care is welcome to access the service. The diverse staff providing the health services and the range of contracts funded, are an indication of the clinical and specialist midwifery training required. As well, Choices is the only specialised Maori midwife service in Hawke's Bay and is actually one of only a few Maori midwife services in New Zealand. Choices is the only Hawke's Bay Maori health provider with a contract for the smoke-free service, and the only one with a contract for smoking cessation. Specialised training is required before a person is eligible to become a Quit Card provider. The Quit Group hold a MoH contract for Quit Smoking services. They in turn manage the Quit Card programme, which enables the contracted, subsidized, smoking cessation services. Specialised training is required to gain the qualification to become a Quit Card provider, and therefore administer a smoking cessation service.

Issues facing Choices

The main issues the Choices interviewees identified, occurred within the first three years of operation and some had not changed by 2001. The issues were reflective of the interviewees' positions in the Choices organisation, and their understanding of how the funder and the Choices organisation worked.

The contracting model and reporting to the funder

The health reforms between 1991 and 1993 set up a managed market for health Services (Barnett & Barnett, 1999). They also devolved funding and contracting for Maori health providers to District Health Boards (DHBs). The reforms thus marked the appearance of several models of contracting which by 1994, lay within the CRHA. The experience of Choices would tend to suggest that the CRHA model proved autocratic, and left little room for true tino rangatiratanga to be put into practice. Jean reports she felt constrained by the opportunities afforded by the contracts to truly deliver the services most required by Maori in their region. Jean recalls, "there was no room in the contract wording that let us look after the adult whanau of the patient."

Discussing the very first contract Choices acquired, Jean remarked on how they immediately became busy. For instance, about six months after Choices began, when Jean was applying for access as a midwife to the Hastings hospital, she recalls, "Only three independent midwives (pakeha) would work with me...We were having 20 and 30 pregnant women a month, and so we were having to give those three midwives six to seven of the women each per month."

In addition to the low capacity of the organisation, especially in the early days of its existence, Choices found the audit and reporting system particularly severe. Jean recalled that every quarter, they were required to provide all their statistics to the MoH:

> These statistics included all the number of visits we have done, the number of new clients we have taken on board, the age, the ethnicity, the number of home visits, the number of clinic visits, how much money you have received in that time, how much money we have spent, what we have spent it on. And we are still having to do this eight years later, but thank goodness we now have someone who deals with that part of things!

Jean, and the other staff members at Choices, felt overwhelmed by this reporting, particularly given that "within about two or three months of starting we were absolutely inundated and we could not keep up with the number of referrals – self-referrals coming to us, and we couldn't keep up with the number of pregnant girls walking in the door." The heavy reporting load required by the contractual forms favoured by funders, meant that valuable service delivery time was often taken up by compliance work. This issue of heavy compliance work placing a strain on an already over-stretched capacity of Maori health providers was, as will be seen in subsequent chapters, a theme present for all three health providers. Despite this, the staff at Choices remained committed to their work. As Erin stated in her interview, "It used to be scary at first but you just get on with it!"

Inadequate funding

The continuation of central control in contrast to the rhetoric of devolution was further manifest in contract funding that organisations like Choices received for

the services they delivered. Jean and Erin thus both strongly indicated in their interviews the inadequacy of financial resourcing they received - a problem they attributed to continued control of funding by central government agencies. As further evidence of this, Jean explained that when you put in a proposal, "the money you got was not what you had proposed, but what the government had decided you should have. It had nothing to do with the numbers of people you thought you could care for." Jean also claimed that:

> we early on identified that we were under resourced and over worked, and I don't believe ever, that they [the funders] have taken any of that into account and so when we say, 'but we are only funded to look after 200 women per year, and we have got 2000 on the books,' they go 'oh that's ok, you are doing a really good job'. But the reality is that it takes a lot more effort to do the extra, and they say 'well don't do them'. Of course this is not how we work as Maori.

Jean, Erin and Tangi all argued that they had received inadequate levels of funding right from the start. According to Jean, "At the beginning we didn't have any money for three months from the start of the contract. We had no money to pay wages, to rent a place or to rent cars." Erin agreed, arguing that "we were living on a promise. And no one would join Jean except us, the whanau." In the beginning, all three women, along with Beverley (another sister of Jean and Erin), did all the jobs, with no monetary reward. Tangi stated, "financially it should have been a disaster but with a lot of cost cutting and making do with what we had, and a lot of hard work by all staff, we were coping."

Choices experience with the Maori Provider Development Service (MPDS) is an example of the marginalisation and lack of "ownership" of initiatives experienced by health providers like Choices. The MPDS is a service funded by the MoH to enable Maori health providers to apply for funding for training for any level which began in 1998. Choices, though, was unaware of the scheme until 1999, when they first found out about it from a relative rather than through more official channels. Jean comments on the experience:

> You know, we didn't even know about it until my niece and her husband, who work as lawyers in Wellington, came home one weekend and told us about it. They had found out because a MHP in Wellington had gone to

them for assistance to apply for some funding for training purposes. So we made sure to find out about it and every year we apply now, for money for training of our staff.

This is the fund for which Te Kupenga Hauora are now distributors - having the contract to do so from 2006 to 2009.

Although Jean received some management training through this fund in 1999, she states that "we needed that training right at the beginning!" The problems of inadequate funding and centralised control of funding Choices, was thus compounded by a feeling of isolation and neglect when vital management training opportunities like the MPDS scheme were not identified as options to them – especially given the capacity issues faced by health providers like Choices as discussed herein.

Professional intolerance

In addition, in establishing and running Choices, all three women endured some form of professional intolerance from other pakeha health providers. Instances commented on involved the experiences of midwives, Plunket nurses, public health nurses, registered nurses and doctors.

Jean related how, prior to becoming a midwife herself, she had difficulty with two of the three midwives she engaged to care for but mainly deliver, the pregnant women who came to Choices. The main issue was that two of the midwives engaged by Jean did not pay her for her part in engaging the clients. Other problems arose of when the patient would want Jean to be present as support during the delivery, something akin to Maori wanting those they know and regard as whanau, close to them in unfamiliar places such as the hospital. Similarly hospital staff, before Jean had gained access to work within the hospital as a midwife, would tell Jean and Erin they could not be with the pregnant women during their labour as support persons. This was only resolved after Jean rang and spoke to Mara Andrews from the Ministry of Health who in turn spoke to Maternity Management.

Jean also described the initial problems with the Plunket nurses. When Jean began the tamariki ora/well child contract there was some conflict with some Plunket nurses who saw Jean's staff as a threat to their patch. The conflict began with Jean's first contract in 1996 involving well-child checks for children up to two years of age. The tamariki ora/well child contract eventually became a universal programme to some of the larger Maori health providers in 1999. Jean commented on the program:

> Admittedly there has been some sense of duplication and competition with Plunket. When we first began our programmes the women chose to have their babies checked with Choices staff. At first the Plunket nurse in their area would continue to visit these women. Often the well-child book would have several entries in the same week by both the Choices midwife and the Plunket nurse. Now an understanding concerning handover has been unofficially agreed upon, where the women choose who their carer will be after the baby is 6 weeks old. Some stay with Choices, and some choose to move to Plunket care. An official referral is sent to Plunket from Choices midwife, if the latter occurs.

While Jean felt that most of the problems were since resolved, she believes these feelings of competition remain in 2007.

Similar feelings of suspicion against the Maori health providers existed among public health nurses. During my time working in the same building from which the Hasting public health nurses worked, there was much discussion by the nurses on the perceived effects the entry of the Maori health provider entry to the scene would have on their work. This was around 1999, when the Maori health providers obtained their School Based Nurse contract. The conversations were concerned with speculation as to what expertise the Maori health providers would have and whether their entry would cause redundancies for the hospital based public health nurses. Jean also reported hearing comparable discussions. Despite the concerns, in reality the Choices' contract did not wholly overlap with the work of the public health nurses. The School Based Nursing contract Choices obtained in 1999 was far more explicit than that of the public health nurses, specifying, among other things, the target group of Maori children and Maori schools through which the delivery of services would be facilitated. Despite

these clear boundaries, problems arose with some public health nurses who thought Jean's staff would encroach on their "patch" when Choices obtained the school based nurse contract.

There was also tension between the Maori health providers and the registered nurses working in the same area. For instance, Tangi had been told by a nurse familiar to her that Choices staff were not doing their job right nor were they practising ethically. Tangi believed the nurse meant that Choices staff were not practicing in a manner that a registered nurse might. Perhaps these concerns were due to the fact that in the beginning Jean was the only registered nurse and the other staff helping her were what are today known as community health workers. In fact, although they were fulfilling a government contract, they all continued to have whanau relationships with many of their clients and the lines at time became blurred. It is likely that the registered nurses had difficulty fully understanding the approach to health care taken by the Maori health providers and this would have been the cause of this tension.

Finally, there were also issues that arose relating to the logistics of contracting with a doctor for services. For example, there were restrictions placed on doctors as to which Maori health providers they might work with. A doctor Jean had employed part-time, who was also employed part time at a city doctor practice, was told by his manager from the city clinic that he could only practice part-time at other health providers that were situated 2 miles outside the city boundary. Choices, of course, were within the 2 mile limit. Jean believes the reason for this was concern she would take their clients. In 2006, though, this changed with Choices signing a Memorandum of Understanding with the Hastings Health Centre, which enabled Choices to contract for adequate general practitioner hours to have a doctor service at the Flaxmere clinic.

All three interviewees thus felt that professional intolerance by other non-Maori health providers and professionals was present in the early years of Choices operation. While this did not necessarily hinder their operations, it meant that they had to operate in an environment that was not very supportive of their work

– something which acted to compound the feelings of being over-worked and fighting the system within which these women worked.

Competition for resources

Another key theme emerging from all three interviews was the problem of competition for scarce resources – both money and people – faced by Choices. Maori health providers compete amongst themselves for the monetary resource allocated by the MoH for Maori health provision. Personal knowledge gained in discussion with managers from TKH and TTOH, and the manager of the Hawke's Bay DHB Maori health unit (2003) indicates the MoH annually allocates a certain amount of money specifically for Maori health provider contracts. However, the allocation method is not public knowledge. The uncertainty of funding levels available, due to their variability over the years, exacerbated the uncertain environment within which Choices had to operate.

In addition, the shortage of Maori health professional and health workers for the number of available jobs placed increased pressure on Choices to deliver the services it was contracted to deliver – particularly given the massive growth in numbers of persons requiring care in their first few years of existence. As the Choices case study demonstrated, in some cases, whanau affiliation was an indicator of the place where one will work. Choices confronts an ongoing problem of finding qualified Maori staff to fill their positions. In particular, all three interviewees commented on a lack of qualified Maori midwives and Registered Nurses. This was solved, in part, by both Jean and Erin obtaining these qualifications. In addition, Jean's daughter became a qualified midwife and joined the practice in 1999. In 2002, Jean resorted to employing a pakeha registered nurse for the tamariki ora programme, as "no Maori had applied for the job."

Health system restructuring resulting in short term policies

The final problem identified by the interviewees was one that was common to all Maori health providers: the ongoing restructuring of the New Zealand health

system results in continuous uncertainty as to the status of Choices as an organisation. On the individual level it raises questions such as 'Is my job safe?''Will we keep getting paid?''What happens if they don't give us another contract?' and 'How can we plan properly for our work if this keeps up?' As the initiator of Choices, Jean was most vocal about the impact of policy changes:

> You know, you think you are secure in your role and in your area and you think this is great, we are going to be going for a long time. Whatever, then it suddenly changes again, and government changes again and then changes the policies. It changes who is in charge of you and those people who were once saying to you 'oh you are doing a great job, this is going to carry on, you are going to be here forever.' Suddenly they are not here themselves. And you think 'oh my gosh, if they can get rid of them, they will get rid of us.' And it has been very difficult as a Maori provider to maintain your sense of security.

This uncertainty led to reluctance among other professionals joining Jean when she was first looking for professional staff. It was not until 1999, when the three Maori health providers were given the common tamariki ora/ well child contract that Jean, Erin, and Tangi became more relaxed with the rapid timeframe change in policies that typified the New Zealand health system in the late 1990s. Jean recalls the change in sentiment, "Somehow it just seemed to us that we would be pretty safe, no matter how long the contracts were for."

Tino rangatiratanga

As demonstrated in the previous section, the interviewees of Choices expressed problems at every level, especially in their early years of existence. This unfortunately continually compromised Choices operation as a Maori health. To what extent this empirical evidence maps on to concerns that the devolution of authority and control to Maori health providers was more rhetoric than action will be further explored in the following two case studies. Suffice to say that all three interviewees felt that Choices did not have true control over their work, arguing instead that firm government control remained the norm.

Some specific examples in this regard were related by Jean:

> They said yes we would fund your programme but it would be a 12 month pilot. [And] so it was difficult to get people on board who had any expertise in the area...I think the government saw an opportunity because they were sympathetic to the needs of Maori people and I believe they had an idea that here would be Maori providers by Maori for Maori, but I don't really believe the government set us up to achieve anything...I think that we were guinea pigs. They threw money at us...because they needed to be able to have the satisfaction of saying we are doing something for Maori health...but they weren't because they were giving us a pittance...and then expecting us to achieve what they couldn't on their millions and millions of dollars.

Jean stated that "we are still struggling after eight years, with the system as it is, with the change to the DHBs". This was a government lead initiative, with no prior consultation with the Maori health providers that were set up in the early 1990s and that still existed.

Recalling the problem of inadequate staff, Jean stated, "There is no workforce available to do the work...I think it should have been a government responsibility." On discussing contracts, the free contraceptive contract was one that Jean wrote a Request for Proposals (RFP) out for, but for which the government funded two providers to deliver that contract. There had been no consultation, just direction from the government. Given that Jean was the forefront person for Choices, her recollection of the issues can be taken as reliable evidence of the lack of control and direction, of tino rangatiratanga, experienced by Maori health providers of the time.

Conclusion

This chapter has introduced Choices, the trading arm of Kahungunu Health services. The focus of Choices has predominantly been for care of Maori women during pregnancy. This chapter has followed Choices from the beginning, to its greater journey to 2001. From humble beginnings, Choices grew into a larger, credible, functioning organisation by 2001, due in large part to the personal

strength and commitment of the women who worked at Choices. Perennial government health delivery issues arose along the way. Despite these barriers, by 2001, Choices had grown well as an organisation, both in terms of the number of contracts they delivered but also the increased numbers to whom they were able to safely and professionally deliver services. While the mother and her baby are still the centre of care for Choices today, the care radiates to include members of whanau of all ages and gender. This is a truly holistic kaupapa Maori model of health care.

The following chapter will follow the same format as this chapter and introduce the second Maori health provider.

Chapter Five

Te Kupenga Hauora

This chapter is about Te Kupenga Hauora (TKH) another of the distinctly Maori organisations for which the 1993 National government reforms directly paved the way. Similar to Choices, TKH took advantage of the opportunity to deliver health 'by Maori for Maori.' Starting with the history of this organisation, this chapter also explores the processes that the four individuals interviewed in this study felt limited their operation as a Maori health provider. The material collected in the interviews is sorted through the same lens as used in the previous chapter, these being: the contracting model used, the reporting required by the funders, inadequate funding, professional intolerance, and competition for resources. Another major theme is health system restructuring resulting in short term policies. Similarly to the discussion in the Choices section, these various issues combined have negatively impacted on the ability of TKH to practice tino rangatiratanga. As will be demonstrated, TKH management hold decision making power on the finer aspects of contract delivery, and to this extent enjoy some degree of tino rangatiratanga, but this is not to the extent desired by the women behind the organization.

Te Kupenga Hauora

Te Kupenga Hauora (TKH) is a charitable trust formed in 1999. The original Te Kupenga Hauora began as the health arm of the Maori Women's Welfare League (MWWL) Heretaunga District Council in 1994. Their base was a disused ward at the then Napier Hospital, which they renamed Te Whare Hauora. A prime reason for setting up Maori Women's Welfare League branches was to "advance Maori health" (Durie, 1994, p. 50). Thus, the MWWL Heretaunga District Council saw becoming a Maori health provider in the 1990s as an extension of the health work they had already been providing for Maori. The MWWL Heretaunga District Council was strongly supportive of somehow providing health care to Maori, more so during the 10 years prior to 1994. MWWL

members warmly welcomed the entry of TKH into the Maori health provider field.

Marj Joe, Audrey Robin, and Huia Johnson – three of the women interviewed from TKH - have all related how the interest in becoming a Maori health provider was galvanized in the early 1980s when Dr Barry, a paediatrician, returned from a health conference in Auckland and spoke to some of Marj's Maori Affairs colleagues. Dr Barry suggested that in light of the poor state of Maori child health, a Maori health group be formed. This group was formalised as Te Oranganui ki Takitimu, with members from the medical community, the Maori community, and the MWWL community. They met monthly and during their time held two health hui. The first was attended by mainly pakeha medical staff and the second by a few more members of the public. Marj expressed Maori sentiment regarding the hui, "Maori felt the first hui was not for them because there were more pakeha than Maori there. So at the next hui we organized for more Maori health professionals to be doing the talking."

In 1986-1987 a Maori Advisory Board to the Area Health Board (AHB) was set up, composed of local Maori. Marj and Audrey were members of this group, and feeling this was a way for them to contribute to Maori health. Then, in 1988, the Napier City Council, disillusioned with the AHB and discussion of the Napier hospital closing, formed a Napier Health group, composed of both Maori and pakeha that was proactive on Napier health issues. Marj also joined this group. In 1989-1990 the Te Oranganui ki Takitimu group approached the AHB Chief Executive Officer in an attempt to obtain funding for their health plan, but according to Marj, they were refused:

> We were refused with advice to find a focus on what we really wanted to do – specifically what programme and what target groups. We did not stop trying. We did a lot of team building activities where we could think about what we wanted to do, design and come up with ideas – it was a good time.

Thus the MWWL was strategically positioned and thoroughly prepared when the National government was elected in 1993 and restructured the health sector. The first contract TKH acquired, in 1994, was to provide accommodation and support

for whanau of patients at Napier Hospital (Health Funding Authority, 1998). Their base for this service was a disused ward at the then Napier Hospital, which they renamed Te Whare Hauora. By the end of 2001, TKH was providing an assortment of health, social and disability services to Maori, Pacific people and other New Zealanders, within their nominated areas (see Appendix E) of Ngati Kahungunu Iwi. Funding for these services came from the Health Funding Authority (HFA), Child Youth and Family Services (CYFS), the Napier City Council, and the Corrections Department.

Values of tikanga underlie the strategic direction of TKH. The values acknowledge the Treaty of Waitangi, health being recognised and delivered within the context of whanau, hapu and tribal development and the Te Whare Tapa Wha Maori model of health. Te Whare Tapa Wha model includes supporting traditional Maori methods for treating some health conditions, and may include the use of Rongoa Maori. These values ultimately serve to enhance Maori health and well being (Te Kupenga Hauora, 2001).

TKH bases its values and principles on the premise of their commitment to the Treaty of Waitangi, its tikanga, and its commitment to the Ottawa Charter. In this context, TKH strongly supports and follows the five principles of the Charter: Building healthy public policies, Creating supportive environments, Strengthening community action, Developing personal skills, and Reorienting health services (Te Kupenga Hauora, 2001). Within that base, TKH promote the need for Maori to be able to experience equity and accessibility of services, and positive outcomes. TKH describe their values and principles as the foundations upon which the organisation and strategic direction are built (Te Kupenga Hauora, 2001). The TKH mission statement thus aims to: "Manage a fully integrated system for the purchase and delivery of health, social and disability services to Maori, Pacific people and other New Zealanders" (Te Kupenga Hauora, 2001, p. 4).

Marj Joe

Marj Joe is the matriarch of TKH in terms of age, membership of MWWL and experience in working within Maori organisations and with the Maori public at large. Marj is a long-standing member of the MWWL. She was one among the first group of women who began the Maori health provider known as TKH in July 1994. Also in that first year, her MWWL colleagues elected Marj as manager based on her experience gained while working with Maori Affairs. That position evolved into Marj becoming Business Director in 1997, and continuing in that role in 1998 and 1999. In 1999, Marj was elected to the new Board of Trustees. Subsequently, the new Board of Trustees in 2000, elected Marj as Chairperson. In December 2001, Marj was the Chairperson of TKH Board.

Audrey Robin

Audrey Robin is also a long-standing member of the MWWL. Audrey was another MWWL stalwart who worked "hands on" when the health component of TKH acquired their first contract. In 1993, she became the TKH's Chairperson for their health committee. Audrey was re-elected to the position of Chairperson for three years, with that term ending at the end of the 1997 financial and reporting year. Audrey remained as a Board of Trustees member and was then elected to the position of Operations Manager from June 1998. She continued in this position until she was elected to her next managerial role of Chief Executive Officer in December 2001.

Huia Johnson

In December 2001, Huia Johnson was a member on the TKH Board of Trustees. Huia was also a long-time member of the MWWL. Huia was elected to the position of Secretary of the first health committee of the MWWL that convened in 1993. When TKH established as a service provider in 1994 she remained as Secretary. Huia continued to be strongly involved with the formation and growth of TKH and remained an elected member of the Board of Trustees after the

transition of TKH from MWWL. Huia continued with her ordinary job as a teacher during the period from 1994 to 2001.

Donna Robin

In December 2001, Donna Robin was the Administration Manager of TKH. She was the youngest of the interviewees. Donna, unlike the three other interviewees, was not and never has been a MWWL member. The only involvement she had with MWWL was as a visitor to a few meetings with her grandmother (the late Lil Robin, who had been a staunch MWWL member). Donna first joined TKH in May 1995 as an Administration person, under the management of Marj. She was an elected member of the Board of Trustees since 1995 and remained so until her resignation in May 2001. Donna resigned from the Board of Trustees in May 2001, so she could become the Secretary to the Board, a reflection of the Board and TKH expansion. Her new role as Administration Manager was still in force in December 2001.

The health services provided by TKH and to whom

TKH provides health services funded by the Ministry of Health that derive from six contracts. The services are holistic in that they cover the health of the whole family, from newborns through the age groups to the elderly and provide education to improve all facets of whanau lifestyles. If required, a person is referred to other services. TKH staff deliver the services from a range of settings, including the TKH headquarters, homes, schools, other buildings, and marae. Staff works within the values of TKH to deliver their services to clients, and especially endeavour to use the kaupapa Maori and whanau concepts which involve all four Whare Tapa Wha elements.

When TKH first began in 1994, they confined their area of service to within the Napier City boundaries. However, TKH has grown since 1994, leading to service delivery within a larger area that encompasses the boundaries of Te Taiwhenua o Whanganui a Orutu from Tutira in the north, to Takapau in the south. The

Annual Plans of THK indicate that an increase in regional coverage was associated with an increase in contracts from one in 1994 to six in 2001.

Overview of Ministry of Health contracted services

An overview of the TKH, MoH contracted services is seen in Appendix F. The health services provided by TKH are holistic, diverse and aimed at enhancing the lifestyles of Maori, Pacific people and other New Zealanders, resident within the Napier area. TKH has two contracts that are not in common with Choices or TTOH, namely the Whanau Ora – Kuia/Koroua contract, and the Kaupapa Maori Mental Health – Rangatahi Ora/ Oranga Hinengaro Services contract. TKH and TTOH share the youth suicide prevention contract, and TKH and Choices do not have a dentist service.

Issues facing Te Kupenga Hauora

As with Choices, the main issues the TKH interviewees identified in their interviews generally occurred within the first three years of operation. However, as for Choices, some of these problems had not changed by 2001. The issues were reflective of the interviewees' positions in the TKH organisation, and their understanding of how the funder and the TKH organisation worked.

The contracting model and reporting to the funder

TKHs first contract was the Whare whanau contract, one of the ten sustainable contracts the CRHA Maori group planned to pilot in their region (Durie, 1994). Durie describes how the Maori health strategy decided upon for the CRHA focused on contracting ten sustainable Maori health initiatives "at strategic points throughout the region and to increase Iwi involvement in primary health care, mental health, older people, and psychiatric and mental disability" (1994, p. 192). It is worth noting at this point in the discussion that this is a prime example of Maori health providers not being able to practice tino rangatiratanga as the terms of these 10 sustainable contracts were entirely decided by government.

Soon after their first contract Marj argued that:

> Kohanga Reo people from out of the area were dissatisfied with the services from Healthcare Hawke's Bay. They wanted us to do the vision and hearing, and well child too, and so we got the mandate from the Trust (Kohanga Reo) that we could do that and go in to their areas and that was from Tuai (west from Wairoa, northern Hawke's Bay), Mahia (north east from Wairoa), right down to Takapau. [And] actually Iritana (an official from Te Kohanga Reo) wanted us to go to Wairarapa as well, and I said no. The Trust gave us permission to apply to the MoH with a Request for proposal (RFP), and we were successful.

During the period described by Marj, Te Kohanga Reo National Trust[4] was seeking health providers to service their Kohanga Reo, to improve the health of their whanau. Later on, when CRHA began contracting for Tamariki Ora/Well child services in about 1998, for TKH, the Kohanga Reo fit into that contract. However, in 1999, that Tamariki Ora/Well Child contract was rolled out, throughout Hawke's Bay, one of the first universal contracts to Maori health providers. A RFP system for applying for other contracts followed early on from the first CRHA contracts. That method is still in place, although few new contracts have been offered.

Marj, Audrey and Huia were all public servants during the early days of TKH, and at different times, they held office in the MWWL. This combination of expertise helped them deal with the reporting models they were required to use in reporting back to the health funders for the various health services that they provided. Despite this carry over of expertise, the compliance costs of the reporting placed a high degree of pressure on TKH staff. Donna thus found collecting the statistics for the reports "a headache...I had to get all the nurses' reports, which were handwritten, and get all the stuff out for the reports first." In a sense it was the extensive experience of senior staff like Marj that helped keep TKH functioning despite the heavy load on the newer staff's ability to keep up as Donna relates how in the early days, she would collect the data from the nurses, but Marj would collate it and send it off to CRHA. Although minimally faster

[4] Te Kohanga Reo are 'language nests' which began in the 1980s, to allow Maori children to attend these kindergarten type places, especially to build the capacity of Maori language.

than hand writing, a type writer was used in the first two years, until a computer was afforded.

Marj and Audrey both participated in the Diploma of Management training offered through MPDS in 1999. This training has allowed them to become more knowledgeable about resources required and in 2001 a much more efficient way of dealing with the contract reporting was put in place. The type of information required is similar to that articulated in the Choices chapter.

Inadequate funding

Inadequate funding was another issue also perceived by TKH. Audrey commented on the effects on daily affairs:

> The ward...we had to improvise with renovations because of the cost...we made it look decent, and we just had a stove and little furniture....I think that they felt that was good enough, never mind that the staff didn't want us to use their facilities that they had blocked off. So I think that we were treated badly ...but in the end I didn't pay any rent the 3 or 4 years we were there. I kept saying, this was awful and that was awful, so in the end, they didn't insist that we pay the rent. ...So we just kind of tolerated that. I think that's what Maori organisations end up doing – you tolerate putting up with them. We tolerated the behaviour of people, the limited resources that you have to deliver a job.

She speculated that:

> There is nowhere in the world that a pakeha organisation or the hospital would have been able to deliver the deliverables that we delivered on the resources that we were given....You couldn't be paid to do everything you did. And if you did get paid you weren't fairly and reasonably remunerated for what you did cause that is all we could afford.

Marj, Audrey, Huia and Donna all commented that central control is manifest in contract funding despite policy rhetoric of devolution. In Audrey's opinion:

> It was difficult for Maori providers to get ample resources to cover the services that they were expected to deliver...we couldn't buy or lease a

> car. We went second hand with money we got from the League...we didn't have enough money to resource the service for the contracts...we were lucky with strong women, and careful with our limited resources...Other issues would be personal development – we just didn't have the money to do that...In my view our contracts did not reflect a component to encourage personal development.

Huia commented that at the beginning there were only "one or two paid staff and the rest was [sic] voluntary." By 1995 the funding was still insufficient with Donna claiming that "when I started we didn't have a computer, we had little paper, only one pen...No. There was no training. It wasn't until about 3 years ago (1998) that, when I started training – and that was to do accounting work." Similar to Choices, inadequate funding for the provision of health services was seen by all interviewed at TKH, as hampering their ability to deliver the services they were contracted to deliver.

Professional intolerance

Marj and Audrey are the only TKH interviewees that reported enduring some form of intolerance from other health providers who worked in mainstream services. The intolerance shown them was from staff of the then Napier Hospital. TKH began delivering the whare whanau contract from an old disused ward at the Napier hospital, in 1994, as recounted above. Marj first related the experiences:

> We began to tidy the place up and it fell through because...somebody stole our Electrolux, and staff had some problem with us being there...so we were moved to another ward and we even had problems there. They just didn't want us there, to the point they chained the middle doors and then on top of that they built a wall behind that...and they tried to crowd us out of parking spaces too....Accommodation and parking spaces was a big hassle. From there we had stuff stolen too...a washing machine and a dryer, microwave and a radio.

Audrey expanded on the subject begun by Marj. She reported of the poor conditions of the workplace:

> old tumbledown place the ward we went to...I think they thought that is all we are worthy of...treated with huge disrespect. I think that they felt that was good enough...never mind that the staff didn't want us to use their facilities, which they had blocked [us] off.

Both Marj and Audrey were of the opinion the behaviour occurred because TKH were a Maori organisation, and because of a sentiment that since TKH had no Registered Nurses, it should not be delivering services having to do with health. On reflection Audrey speculated that:

> Maybe that is why the nurses objected to some of us as a provider, being in that hospital, was because they weren't registered nurses, they were health workers from the community and they were going in to the community...may have been that feeling of unskilled people taking over the work of skilled people.

Competition for resources

As discussed in the previous chapter, Maori Health Providers compete with each other for both the monetary resource allocated by the Ministry of Health for Maori health provision and for the services of Maori health professionals.

When TKH was still in the 'ideas' stage, the thought around employing staff was that they would first approach MWWL members. However, Marj informed that even though TKH "were not contracted to provide any clinical services – just health promotion and education were the first components. So that required us to recruit two nurses." Their Kohanga Reo contract was to deliver health promotion and education to the children and their whanau, and the first group of Kohanga numbered eight, and the target area was Napier. This contract was the main reason two Registered Nurses were employed. On reflection, both Audrey and Marj commented that the MWWL members were already carrying out, within their groups, a form of health promotion and education. Subsequent health contracts from 2000 included the staff mix required to deliver the contracts.

A lack of available qualified Maori meant that in 2002, as Choices had done, TKH resorted to employing a pakeha nurse. In order to overcome the problem of

a shortage of qualified Maori health workers Marj and Audrey both actively worked with EIT to recruit from their nursing students. In 2001, they not only spoke to the second year nurses about what services TKH provides, but they took second year nurses 'on placement' - meaning that the students come to TKH for some of their required practical experience. The latter means TKH is well enough known for nurses to feel comfortable accessing TKH. In Marj's words:

> We used our contacts in EIT, I sit on the Council there,...we would hear about them before they were graduating and we would talk to them and offer them a position to start on a certain date....As we grew, we did do some advertising for positions, but however our workers came to us, we always interviewed them.

Being closely aligned with MWWL has also been positive for TKH in terms of staffing. In the beginning a lot of voluntary work was done by MWWL members, and that continues to be the case up to the present day. All four respondents felt that competition for resources, when combined with the general inadequacy of funding received, had a negative impact on their ability to deliver the services they were contracted to deliver.

Health system restructuring resulting in short term policies

As in the case of Choices discussed above, the uncertainty created by short term policies continues to impact negatively on the work being done by TKH. In TKH's case, Audrey explained that from the start:

> The contracts were yearly, until 1998 when we had 3-year contracts. However, in June 2002, the 3-year contracts had just been rolled over....Well you know, we are into November now and we should have had in my view, providers should have known by December as to what their position is, because we need as much time to project as the funders do.... About four or so years ago, we had the scenario when we had a short time...we can't plan properly. Because if it comes around January or February, they [Health Funding Authority] tell us 'Oh! We are a bit behind so we will only give you a year contract.' That leaves us with – we can't plan things with our staff...it's just crazy, it's ridiculous. And it is their planning that is impeding our ability to better forecast.

When asked if changing government policies affected the organisation, Huia's response was "they keep changing the goalposts so when you make application for things you sometimes have to resubmit proposals." Huia argued that the problem of the destabilising effect of Government policies and changes is that "you think you are on the right track and they go and change the goal posts."

Tino rangatiratanga

As with other Maori health providers, TKH did not control what contracts they were given. However, TKH appears to have had a closer relationship with the CRHA Maori team. Marj had known the manager for a long time and they had been work colleagues. Marj agrees when Audrey recounts "Rongo and Mara and the CRHA unit, they just opened it up for us." However, Audrey was at pains to argue despite this "we still had to lobby for funding...Mara was only given so much money to spread around the Central region."

Further thoughts on tino rangatiratanga were added by Huia:

> Often like, health is driven by people who think different to how Maori think and so what Maori have to do is we have to change our whakaaro around to the person who holds the purse strings, so that they have some sort of understanding of what we are talking about. I guess until we get to the stage where we have of having better control of all the resources and we are better resourced then we might be able to make bigger changes but I can't see that in the foreseeable future.

Marj and Audrey were generally positive about the impact of TKHs work on tino rangatiratanga. They saw their work in TKH as contributing to tino rangatiratanga as they were able to deliver services, admittedly within the constraints of the contracts, in a way that was acceptable to Maori. That said, all four interviewees felt that more needed to be done if true tino rangatiratanga was to be achieved for Maori working in the health provision area. The various issues discussed above including inadequate funding and competition for resources were seen by all four as preventing them as Maori being able to deliver as efficiently as they wanted, the services that they wanted to deliver to local Maori.

Conclusion

This chapter has described the early establishment of TKH as well as the processes that the four individuals interviewed in this case study felt limited their operation as a Maori health provider. Like the Choices chapter before, the interviewees felt that various issues such as inadequate funding, professional intolerance, and competition for resources have negatively impacted on the ability of TKH to put into practice tino rangatiratanga. The women of TKH see tino rangatiratanga as being the ability for Maori to be able to experience equity and accessibility of services and positive outcomes.

The next chapter looks at the experiences of the last of the three organisations of this thesis – that being Te Taiwhenua o Heretaunga.

Chapter Six

Te Taiwhenua o Heretaunga

This chapter is about Te Taiwhenua o Heretaunga (TTOH) one of the three Maori health providers in this study. In addition to tracing the history of this organization from its inception in 1994 through to the end of 2001, this chapter also explores the processes that the three interviewees from TTOH felt constrained their operation as a Maori health provider. As in the chapters on the two earlier organizations this data is structured around the issues of the contracting model used, the types of reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies. And, as for the two earlier chapters, the way in which these issues negatively impact TTOH to put tino rangatiratanga into practice is discussed.

Te Taiwhenua o Heretaunga

Te Taiwhenua o Heretaunga (TTOH) is one of six taiwhenua that together make up Ngati Kahungunu Iwi Incorporated (NKII). The geographical area stretches from the Ngaruroro River in the North to Mangakuri River in the South, across to Taihape in the West. TTOH was created as a direct response to the restructuring of wider New Zealand society in the mid and late 1980s that was discussed in Chapter two of this thesis.

The emergence of TTOH can be traced back to the creation of a Kahungunu Runanganui in the mid-1980s (Barcham, 2004). These early moves were then further consolidated through government policy in the late 1980s. As noted above, an important recommendation emerging from the Hui Taumata in October 1984 was that iwi development ought to be a conduit for Maori progress and so enable "Maori solutions to Maori problems" (Durie, 1994, p. 162). This was recognised and supported by Labour Government policy. Therefore, in order to implement this shift of resources to iwi bodies and thereby bring into practice the ideal of Maori providing for Maori, the Labour government passed the Maori

Affairs Restructuring Act 1989. The Act was designed to restructure the Maori Affairs department in order to facilitate and strengthen the development of iwi structures. In addition, an Iwi Transition Agency was set up to assist with iwi development and the relocation of some service delivery capacity to them. Durie comments on this move as being encouraging to Maori, and revealing a chance for them to exercise tino rangatiratanga, with the move acknowledging "the fundamental strengths of Maori society – whanau, hapu, Iwi" (Durie, 1994, p. 162). These newly empowered iwi bodies ran a number of programmes including those geared towards health, social service and education.

NKII, like many other iwi around the country, took advantage of the funding and opportunities that were available to it during this period in terms of consolidating its existence. However, as NKII is an iwi of considerable size, it was divided into six geographical areas (taiwhenua) for easier management. TTOH was thus established as the body designed to provide services for NKII in the Heretaunga taiwhenua. TTOH was created as a charitable trust that was incorporated in 1988, and it continues to operate as such. TTOH is governed by elective representatives of 17 marae within the taiwhenua designated area. The Trust considers all Maori residing within the boundaries as shareholders. The core business of TTOH is delivering Treaty based services which means that TTOH delivers health, education, and social services. In addition, it provides services on resource management issues and Treaty of Waitangi claims and partnerships. The organisation is led by the community, and has four divisions (Rangatiratanga, Business and Corporate Services, Hauora, and Tautoko Whanau and Matauranga).

Alayna Watene, the TTOH General Manager, commented on how TTOH functions by stating that:

> TTOH represents nga Marae o Heretaunga and urban Maori. The organisation is committed to the Treaty of Waitangi, which affects all aspects of our business from governance, management and training, to policy procedures, and in our relationships with others. As a Manawhenua organisation, the delivery of culturally relevant services is important, and cultural diversity is respected. The organisation delivers to

> both Maori and Pacific Island (PI) people, and others. The TTOH governance and management structures provide strong leadership and rigorous management. Effective quality planning and assurance control systems are in place. All staff undertake professional development and upgrade qualifications to equip them to carry out their roles in the most effective manner. Holistic care is provided to all TTOH hauora clients.

The organisation's central kaupapa is "Kanohi ki te kanohi, pokohiwi ki pokohiwi, ka whawhai tonu atu." Translated it means, "face to face, shoulder to shoulder, fight without end." In carrying this out, the plan is to work with Maori well-being, effective leadership, whanau development, holistic Services, all with a whanau focus (Te Taiwhenua o Heretaunga, 2001-2002, pp. 1, 3).

TTOH's interpretation of their commitment to the Treaty of Waitangi is taiwhenua wide and not just expressed for their hauora component. TTOH demonstrates commitment to the Treaty of Waitangi though its goal of achieving tino rangatiratanga by asserting hapu right to be in charge of their own affairs and working with taiwhenua populations to defend and develop Maori benefits. For instance, it delivers Kaupapa Maori services to reduce disparities, in line with government obligation to equality for Maori, it acts as a conduit for Maori to access government funded services, and it undertakes action with government to strengthen their obligation to protect tino rangatiratanga (Taiwhenua o Heretaunga, 2001-2002). Through its commitment to the Treaty of Waitangi, TTOH recognises and delivers health care within the context of whanau, hapu, tribal development and the Maori concepts of health as articulated in Te Whare Tapa Wha, and Te Wheke Maori models of health (see Appendix B).

Alayna Watene

Alayna Watene has long been involved with TTOH and has been a staff member since its conception in 1988. She was first employed as the Taiwhenua Business Development Manager. In December 2002 when the interviews occurred, Alayna was the General Manager of TTOH reporting directly to Te Haaro, the TTOH Board of Trustees. In her words, Alayna was "responsible for practically all the operational aspects of the Taiwhenua, that is its finances, its assets, its service

contracts, and its staff." In 1994, when the TTOH wing began to provide services Alayna was the Finance and Investment Manager. Alayna retained that position when she became Manager in 1994. As of February 2002 an appointed Manager now reports to Alayna. A point to note is that Alayna was the only informant from the three Maori health providers in this study to have business management expertise, when the organisation moved into health. She was interviewed in December 2002 along with her other two colleagues.

Angeline Tangiora

Angeline Tangiora completed her Comprehensive Nurse training at the EIT in 1993. Prior to this, she had worked extensively in Australia with Northern Indigenous people. Angeline learned 'tika' - the correct way of caring for herself and others in a Maori context – from her grandmother and the idea of being able to deliver services "by Maori for Maori" is dear to her heart. When interviewed, Angeline was working as Clinical Manager at Te Roopu Huihuinga, a Maori Development organisation in Hawke's Bay. At that time, she also worked part-time for TTOH, in the role of Registered Nurse for the Mobile Disease Management service. That service visited targeted people in their homes who had medical conditions such as diabetes, respiratory, and heart problems. When the health component of TTOH was established in 1995 Angeline was the only registered nurse and in that capacity, she actively assisted to establish the operation for TTOH. She stated, "My role as an Iwi nurse was very broad...the main focus being health education and health promotion to Maori by Maori." The only other employee for that first contract was a community health worker. Angeline remained working as a full-time registered nurse for TTOH until she moved to Te Roopu Huihuinga in 2000. However, Angeline continued to work part-time for TTOH.

Rose Whenuaroa

When I interviewed Rose Whenuaroa in 2002, she had not associated with TTOH since 2000. With growth and the introduction of strategic planning practices in 2000, management had changed the structure of the TTOH. This

combination led to dissolution of the health committee of which Rose had been a member since 1995, after which she retired. Rose also acted as kuia for TTOH at hui they attended from 1995 to 2000.

The health services provided by TTOH and to whom

TTOH provides health services funded by the Ministry of Health from ten contracts. The services are whanau-based and, as with Choices and TKH, focus on healthy lifestyles. In 2001, the services were delivered in four different venues, these being: from a General Practitioner's clinic, in people's homes, in a home especially for inpatient Whaiora, and at marae. The health component of TTOH was set up in 1994, when TTOH hauora acquired their first contract. In 1995, TTOH hauora set up a health committee, Te Wairatahi – originally a name for the Community Health service which was discontinued when more health contracts were acquired by TTOH. The committee had six members and their role, according to Rose, was to "drive the kaupapa out to the community, to try and help them understand what the government was supposed to be providing to Maori...taking care of their own health." From the beginning, TTOH services have thus been delivered 'by Maori for Maori', which Angeline described as "delivering the service to them in a way that made them feel accepted and comfortable, and you weren't talking at them. You were talking with them." By 2001, what are today known as Maori models of health had been developed and incorporated into the care provided by TTOH.

TTOH have incorporated the use of the Te Whare Tapa Wha model with the Te Wheke model (see Appendix B) as a guiding structure for all the health services that they provide. In addition, a whanau health plan developed by TTOH staff is also now used at every new client assessment. In this TTOH developed plan, progress is made forwards or backwards, along the continuum of Maori health elements, as care changes during interactions between TTOH staff and the client. A simple example illustrates the whanau element: a person may not have much or any whanau connections, as the health of the client improves so might the interaction of that client with the whanau. There is movement along that continuum. As some whanau may not be aware of some of the elements that

make up the Maori models of health, staff actively explain how the models work with the health care they receive through TTOH.

Overview of Ministry of Health contracted services

An overview of the TTOH MoH contracted services can be found in Appendix G. As with Choices and Te Kupenga Hauora, transport may be provided with some contracts, but this is not a contractual requirement. Of the three Maori health providers in this study, TTOH has the largest number of contracts. The key contracts are Tamariki Ora/Well Child service, School-based nursing, and Oranga Niho/Dental health educator. Exclusive TTOH contracts are the Maori disability support service, Maori mobile disease state management service, General Practitioner service, and the provision of a dentist. They also have two contracts in common with TKH and these are Whanau Ora, Nga Oranga o te Rae (similar to TKH Kaupapa Maori Mental health, but with no age definition), and Kia Piki Te Ora o Te Taitamariki. The Car seat service is similar to that held by Choices.

TTOH's first contract was one of the "ten sustainable Maori health initiatives" that Rongo Wirepa, the first Maori manager for the CRHA, set up in a "strategic point throughout the region and to increase Iwi involvement in primary health care, older people, and psychiatric and mental disability" (Durie, 1994, p. 192). It was specified that the target population was to live in Flaxmere, a Hastings suburb in the West of the city which is located near to the TTOH offices. The first contract was a community health contract and the operational staff engaged were Angeline, a registered nurse, and a community health worker who was a male Maori, conversant in te reo. Since then, TTOH has expanded its work to include groups across its territorial region. However, most contracts are still delivered in the Western suburbs of Hastings.

Issues facing TTOH

While the most problematic issues facing TTOH occurred within the first three years of operation a number of these had not changed by 2001. The issues were

reflective of the interviewees' positions in the TTOH organisation, and their understanding of how the funder and the TTOH organisation worked.

The contracting model and reporting to the funder

The first contract TTOH acquired was the Whanau Ora/Community health contract, one of the ten sustainable contracts distributed by the CRHA Maori group, as reported in the TKH chapter. Alayna recalls:

> I don't think we negotiated, they just told us – in those days there was very little negotiation – you just got what you were given. A modest contract of $86,000 to do Whanau Ora/Community Health, in Hastings. They didn't stipulate what your inputs were. They did set targets as to how many Whanau Ora plans (units) they wanted you to achieve in a year.

Thereafter, requests for proposals (RFPs) were used for applying for other contracts. Some were based on gaps providers recognized in their area, others were based on gaps identified by MoH. One of the key problems TTOH staff found in working in an environment characterised by the provision of services by providers who must 'win' contracts from purchasers, such as those that arose with government changes since the Central Regional Health Authority (CRHA) and in 2000 the District Health Boards, was the inability of these contracts to cater for tikanga Maori – or the Maori way of doing things.

Angeline thus recounted working 'out of' the contract specifications at times so she could practice Maori kawa in relation to caring for her clients. She recalls this happening frequently because "the contracting model was based purely on Western health model expectations." This led to feelings of inadequacy according to Angeline: "[I] knew that the contract specifications were inappropriate for the type of health care that as a Maori health practitioner, [I] felt needed to be provided to the Maori community." However, her instinct was strongly Maori, so she continued to work that in with the Western health model of the contracts.

The women interviewed from TTOH felt that the reporting and compliance costs of the accountability models used by the health purchasing organisations for which they provided health services, weighed heavily on the limited organisational capacity of TTOH. This was particularly the case in the early years of the organisation's shift into the provision of health services. One of the major problems experienced by TTOH in the early years of its operations was the necessity of reconciling the different compliance needs of the various contracts they were delivering and the different times in which they would be paid for the various contracts. Alayna recounts "you got paid after you completed the work. They pay you in twelfths instead of one lump sum per year." This issue made accounting practice within the organization more complicated than needed and meant valuable time had to be spent working on compliance issues rather than on delivering health services.

Inadequate funding

A recurring problem confronted by TTOH has been the inadequacy of the funding they receive to supply health services. Alayna, Angeline and Rose all commented on this aspect of inadequate funding. In Alayna's opinion:

> We were all given crumbs...the contracts were not enough to support a manager and I existed on my Taiwhenua manager's salary and some money from a small investment fund the Taiwhenua had until three years into the first contract, when we were offered $18,000 for an 0.5 manager, which we took. Basically the health component existed on the back of Taiwhenua Education and Training...we didn't use their money, but we shared their office, their phones, their computers, and I was already being paid a managers wage.

Similarly, Angeline remarked in her interview that the "employment of staff was limited to the amount of funding you received. In the first two years only two staff were employed and yet they were expected to deliver the entire Whanau Ora contract." In discussing contracts, Rose remarked "You never got sufficient funding for it...there was never what I thought it should be."

Relative to the contracts, the numbers of people you could employ, and the amount of money available, Alayna made pertinent remarks when she articulated:

> There was never any FTEs [full time equivalents] and for the scale and size of our organisation, for example, in dental education a 0.5 position and that is because if they give you $36,000 that is for their overheads and employment and training, you can't pay a 1FTE, so you give them a 20 hour week...and they all do a bit of Whanau Ora to top them up to a 1FTE.

Alayna described how later, as their position as a Maori health provider strengthened, they dealt with these problems:

> So yeah, it is just through economy of scale that those contracts can now actually support, and then we grew...And where you have got FTEs then across them we have charged against them the cost of administration and manager...So through that we have been able to grow the management side which has been really light, very light.

Next, in referring to herself, Alayna added that, "then the general manager has to manage the rest of the organisation as well as worry about that!" The problem stemmed in part from the fact that in order to win contracts, a health provider basically had to underbid its competitors. However, all interviewees felt that despite these problems they needed to maintain bidding into the process as otherwise local Maori may not receive the care they needed.

Professional intolerance

In her interview Angeline, as the only trained health practitioner amongst the TTOH interviewees, did not perceive any professional intolerance. This may have stemmed from the fact that she had only just recently completed her comprehensive Nurse Training at EIT where she had contact with a wide population of health professionals.

Alayna did not comment on direct professional intolerance as such but she did relate how when doctors began forming groups, such as the Independent Practitioners Association (IPA), the funding they received was not comparable to

that received by Maori health providers. Alayna argues that, "They got millions and millions of dollars, and they were formed the same time as Maori health providers, but theirs was management money...and here we are struggling away."

Further to the above, Alayna commented on whether the issues have changed in 2001 as compared to the early 1990s when Maori health providers and IPAs evolved. Alayna replied strongly when she said:

> They still remain, I think. When you look at...It is funny you know, 10 years ago...they set up IPAs and doctors were paid management fees for their IPAs and they got millions and millions of dollars. You hear about Pegasus in Christchurch sitting on a surplus of $20 million, and you have got Pinnacle, and you have got all these IPAs and they were formed the same time as MHPs got in the sector. But theirs was management money and they set up great Information Technology systems, they had a full time CEO, they set up technical support and here we are struggling away, and now it has come to a new phase.

Rose remarked on how she felt when attending a meeting with other health professionals – it seemed that doctors at the same meeting appeared to be ignoring her presence as if to say "What are you doing here?"

On the whole, the women interviewed at TTOH did not feel that there was explicit professional intolerance of their work although as these examples raised by Alayna and Rose indicate, professional intolerance may have been present in a more implicit manner.

Competition for resources

The common resources the Maori health providers compete for are funding and people. As discussed above in terms of the problem of inadequate funding, Maori health providers compete with each other and other health providers for the monetary resource allocated by the MoH for Maori health provision. Personal knowledge gained in conversation with managers from TKH and TTOH and the

manager of the Hawke's Bay DHB Maori health unit (Hawke's Bay District Health Board, 2003) indicates that the Ministry of Health allocates a certain amount of money yearly, particularly for Maori health provider contracts. The allocation method, however, is not public knowledge. Clearly then, funding continued to be centrally controlled and even with the shift of funder to the DHB, the MoH still centrally control the amount of money devolved to DHBs. In addition, in her interview, Alayna was disturbed that a group of four marae continue to be funded for health. The marae belong to Te Taiwhenua o Heretaunga, and Alayna has stated she, as TTOH, had offered to supply health services to those marae. However, as recently as 2006, they were still being funded for health service provision. This strategy of group competition was seen by all three interviewees as being problematic in terms of providing the best possible health care to local Maori. The competition was not healthy and led to the various health providers being allocated an ever smaller piece of the funding.

The other key issue raised by the interviewees was the problem of employing well-trained staff. This shortage of Maori health professional and health workers is perennial however and not just an issue in Hawke's Bay. In some cases whanau affiliation is an indicator of where one will work. However, Alayna states the employment process followed by TTOH is professional. By this she means that a job is advertised followed by a process of elimination and interviews to choose the right person as per the job specifications. Alayna does not have a special pool of people to call on but relies on the good reputation of TTOH and the quality employment TTOH offers to obtain staff. TTOH has a low turnover of staff with most employees having been with TTOH since being employed on the respective contracts for which they were hired. Angeline is perhaps the most recent person to leave the TTOH employment after eight years of service to go to a more senior position in health.

Alayna felt Maori health providers were exploited. In her interview she said that:

> We were all given crumbs and I knew they were crumbs but we wanted to be in the action...so we were prepared to accept exploitation just to be a part of it. They had a proliferation of providers as opposed to really

> establishing and strengthening one or two providers...they were trying to plant as many providers as they could with the limited resource.
> *Health system restructuring resulting in short term policies*

The problem of short term policies and their impact on planning was a key issue for the women interviewed at TTOH. Alayna argued that part of this problem can be traced back to the issue that there is no long term plan for the Maori. An example she provided was being asked to have a strategy but the difficulties of planning when there is no guarantee beyond either one or three year contracts for health services. Alayna would have preferred there to be sustainability and quality reflected in the contracts they now have. Alayna thus argued that:

> Early on, I didn't want to hire people and then say there is nothing here. But that hasn't happened, so I guess we have got more confidence throughout the Maori provider sector that we are here for the long haul and that we can offer stability. It has got out in the Maori health workforce that Maori providers are OK to work for...It used to be like, you could be here today and gone tomorrow. In fact, all the providers are largely still here.

On a different note, while Angeline thought the short term policies were unfair to management, she herself did not worry unduly about it. She was busy doing her work as a registered nurse and felt confident that Maori health provision would continue.

Tino rangatiratanga

As with other Maori health providers, TTOH were not in control of their contracts. For example, in 2001, Alayna had employed a person specifically to manage TTOH. This manager would have preferred more clinically focused contracts to be acquired, so the nurses could work more in clinically focused environments. Alayna stated that only four contracts had clinical components. Of those that were not clinically focused, she believed the reason was that the purchasing unit (amount) between $25,000 and $30,000 a year would only support the wage of a community support worker. You would have to pay a

nurse from $28,000 to $40,000. In fact, wages were controlled wholly by the funder, and thus once again, Maori health providers are not able to exhibit tino rangatiratanga.

Additionally, unlike TKH, TTOH did not appear to have the close relationship with the CRHA Maori team. Alayna recounts, "Whanau Ora was presented to the Taiwhenua through the CRHA Maori team and...they just told us. In those days there was very little negotiation, you just got what you were given...they set targets as to how many Whanau Ora plans (a plan equals one person) they wanted you to achieve."

Alayna recalled, "It is not a long term plan for the Maori sector...they asked you to have a strategy but it is really hard to plan when there is no guarantee of funding into the future...it is like you could be here today and gone tomorrow." This indicates all the planning came from the MoH with no input from Maori health providers. However, despite this, Alayna still sees Maori participation in health as being "an extremely positive and powerful development for whanau."

Devolution was another major theme for TTOH. Alayna did not think it had happened as Maori society had originally envisioned it happening. She stated she was part of the devolution process in Hawke's Bay in the 1980s when governments set up agencies to deal with the things Maori Affairs had previously dealt with. The people thought that with devolution they would be able to set up well resourced, robust, Maori organisations that were going to take over from the State and the Department of Maori Affairs. But in actual fact and to use Alayna's words, what Maori were getting were "crumbs."

Alayna dreams of a future where TTOH is able to "offer a meaningful option or alternative to families in Heretaunga...we would like to have the capacity to service half the Taiwhenua population...and to work collaboratively with Maori providers and non Maori providers...so that we are really supporting the patient." With the maturation of Maori health providers and acceptance over time by other health providers, in 2006, it appears that Alayna has had most of her objectives met. The unmet portion is to service half the Taiwhenua population. Angeline's

future dream was to "see the Taiwhenua become quite an effective health service – really effective". In 2006, if not achieved already, TTOH is most of the way towards this goal. Rose saw the future for TTOH as "providing real health and welfare" which in 2006 is largely accomplished.

Conclusion

This chapter has discussed the experiences of TTOH, which in 2007, is the largest Maori health provider offering health services to the Heretaunga Maori population. As this chapter has shown, the creation of TTOH and the establishment of their health services arm is a direct result of the broad changes in New Zealand government policy of the 1980s of devolution – of Maori solutions to Maori problems. As demonstrated in this chapter, this did not necessarily equate with Maori health providers having the requisite resources or power to do so. The voices of the women interviewed echo frustrations at not being able to put into practice tino rangatiratanga. Despite the problems, all three interviewees were positive about the future of both Maori health provision and TTOH.

The next chapter expands on the notion of tino rangatiratanga for the three Maori health providers through a comparison and analysis of their experiences drawing on the themes discussed in this chapter and the two preceding it.

Chapter Seven
Weaving the Threads Together

Maori have called for the provision of health care 'by Maori and for Maori' for many years. Broad shifts in the social policies of successive governments over the past few decades have seen some movement towards this kind of service provision within New Zealand. When these forms of devolution were first considered some Maori saw it as a way to bring tino rangatiratanga into practice. However, as the case studies have shown this does not appear to be the case. While devolution of service delivery to Maori providers has provided a space for Maori to bring about tino rangatiratanga, it has not been without effort.

The data presented in the earlier case study chapters has shown that the three Maori health providers studied in this research experienced a number of problems which they felt prevented them from operating at an optimal level. This chapter looks at these issues in a more focused way, drawing from all three case studies. After briefly discussing the idea of devolution of service delivery, this chapter then uses the framework developed in Chapter Three (which was then used in the three case study chapters), to group the issues that the Maori health providers that took part in this study felt, held back their work. The chapter then ends by looking at how tino rangatiratanga does not appear to be being delivered through this process of devolution.

Devolution

As chapter two demonstrated the programme of reforms in New Zealand that began in the 1980s set about disassembling the welfare state and the associated mechanisms that maintained it. The massive restructuring that followed in the wake of those reforms led to both Pakeha and Maori suffering, but Maori bore a disproportionate brunt of the reforms (Barcham 2004). During the 1980s the Maori unemployment rate rose to as high as 20% (Durie, 2005). One of the key planks to this programme of reform was devolution. This process of devolution

was seen by some as a positive step for Maori self-determination. Durie has thus noted that in the shift towards the new neo-liberal policy agenda while:

> state retrenchment and the devolution of state activities to the private sector, communities, and Maori was the new goal...[this process of] devolution coincided with Maori aspirations for greater autonomy and greater freedom from the shackles of the state...the devolution policies...suited Maori ambitions for Maori service delivery, tribal self management, and a greater say in policy making (p. 170).

Devolution thus allowed providers to deal directly with funders instead of having to go through parties such as Maori Affairs. This shift towards an ethic of 'by Maori for Maori' was the window of opportunity that allowed Maori health providers like the three discussed in this thesis to be created. As the case studies have shown all three organizations were created by local Maori women setting up organisations that employed Maori workers and delivered services to the local Maori community in a culturally safe and appropriate manner.

As was shown in Chapter six Angeline and Rose saw devolution as a chance for Maori to deliver "by Maori for Maori" health services. They both believed this to be a positive move, and were enthusiastic for Maori to be "looking after their own." In the same chapter Alayna argued that Maori participation in health was "an extremely positive and powerful development for whanau." However, later in the chapter Alayna did not think devolution happened exactly how Maori society (in Hawkes Bay at least) had envisioned it. She argued that she was part of the devolution process in Hawke's Bay from the very beginning and that people thought that with devolution, they would be able to set up "well resourced, robust, Maori organisations that were going to take over from the State, the Department of Maori Affairs. But in actual fact what we were getting were crumbs." This disappointment with the early promise of reforms was something common throughout all the interviews.

Major Topics of Analysis

As was discussed in Chapter two the initial analysis of the data collected from the semi-formal interview process led to the emergence of some key themes.

These key themes, based around issues to do with the contracting model, the types of reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short-term policies are now used to provide a structure for analyzing the data presented in the previous chapters.

The contracting model and reporting to the funder

The contracting model used when the CRHA began distributing funds to Maori health providers in the early 1990s was governed by the philosophies of the government of the day (Te Puni Kokiri, 2000). The funders based their contract amounts on the units of service they bought from the Maori health providers. For example, one provider might be paid to deliver a service to 200 children, the price and particular services paid for being specified against the number of children to be seen. This model has continued through changes of governments to the present day.

One of the issues discussed by the interviewees was that the contracting model only paid for services rendered, so that in the beginning many providers found lack of money a huge problem when starting up. The process of not paying for services before the service was rendered and instead paying retrospectively, three monthly, was and still is a feature of the contracts to Maori health providers. Further to that, the Maori health providers reported a lack of funding for the numbers of staff they were able to employ for their contracts. This particular phenomenon was a feature of the health reforms in the early 1990s. The problem as seen by the interviewees in this study was that they did not get enough money to employ the number of staff they perceived as being required to deliver the contracts. Neither could they, in some cases, afford the right mix. For example, Alayna describes how she employed two registered nurses for the first mental health contract she acquired whereas if she had better knowledge at that time, she would perhaps have only employed one Registered Nurse and one community worker. However, this problem was solved in the late 1990s by the funders prescribing the mix and qualifications of required staff, for specific contracts, during the funding proposal process.

The fact that the three providers reported delivering some services over and above those contracted for may be related to the above phenomenon. They did this in order to fulfill their obligations of 'by Maori for Maori' service and their dedication to the holistic models of Maori health care recognised when using Te Whare Tapa Wha whanau principles (and in the case of TTOH the Te Wheke model). Choices and TKH, more than TTOH, reported providing practical support (for example transport, assistance with obtaining formula and prescriptions) and information and advice about non-health matters to their clients (for example advice about benefits, clothing sources, budgeting, food bank referrals, training opportunities, and relationship or family problems). The Hawke's Bay experience is not unfamiliar as Crengle (1997) also reports instances of Maori providers working outside the contracts in this manner.

All three providers offer services to any member of the whanau that requires assistance and this may be at a time when the context of the care involves a different matter for a different whanau member. These unfunded activities (provision of care to other whanau members, undertaking support, health promotion and education activities over and above those specified in current contracts) are undertaken for a number of reasons. The whanau and whanaungatanga concept requires that the needs of all whanau members be met regardless of the contractual arrangements a Maori health provider has with the funder. The argument from funders that these services fall outside the contracts provided is untenable for Maori health providers who base their approach to service delivery in kaupapa Maori of which whanau and whanaungatanga are a core element of their philosophy. The problem as Durie (2005) argues is that:

> the sectoral nature of the state runs counter to Maori preferences for a holistic approach...Performance measures contained in contracts have also been difficult to reconcile with Maori perspectives and expectations...indicators have failed to reflect Maori worldviews, and have seldom been able to endorse Maori aspirations for an integrated approach to social, cultural, and economic development...Part of the rationale for Maori services is the inclusion of Maori concepts, cultural paradigms and distinctive methods of communication (p. 177).

Despite these negative issues some good things were identified by the interviewees. For instance, Jean and Erin from Choices, Marj and Audrey from TKH and Alayna from TTOH all reported that in 1999 the contracts being offered became better integrated, so that more of the whanau and tamariki programmes were evenly distributed throughout the Maori health providers.

Inadequate funding

Another key concern of interviewees from all three organisations was that there was no perceived guarantee of funding continuing. This conclusion was reached due to comments by the interviewees on the problems they encountered in fulfilling one-year contracts since inception of the Maori health providers in the mid-1990s. One of the key results of a Te Puni Kokiri evaluation (International Research Institute, 2002) of Maori service provision was that, "...the short term nature of contracts hindered positive Maori development" (p. 36). Comments also related to the change of governments and the changing 'goal posts' brought about by this change in government. Inevitably, new governments bring their own political orientation with them to policies which means that "consistency of health policy may only be achievable for the length of time a minister holds office" (Gauld, 2001, p. 77).

Alayna recalled that it appeared that there was no long term plan for the Maori sector, "they asked you to have a strategy but it is really hard to plan when there is no guarantee of funding into the future...it is like you could be here today and gone tomorrow." It appeared to the interviewees that all the planning came from the Ministry of Health with no real input being sought from Maori health providers. This looked like a very strange form of devolution. Alayna would like there to be sustainability and quality reflected in the contracts they now have. She argued that "it is like you could be here today and gone tomorrow."

The managers of the three Maori health providers believe they were exploited by government through the funders when they were first given health contracts. Alayna in particular strongly thought so:

> We were all given crumbs and I knew they were crumbs but we wanted to be in the action...so we were prepared to accept exploitation just to be a part of it. They had a proliferation of providers as opposed to really establishing and strengthening one or two providers...they were trying to plant as many providers as they could with the limited resource.

In the previous two chapters, Jean and Erin, and Marj and Audrey, all made similar comments regarding the lack of funds. Jean and Erin recalled putting in proposals and getting the contracts but not for the amount of money applied for by them. "It had nothing to do with the numbers of people you thought you could care for," according to Jean. All interviewees described being affected in similar ways when they first acquired their contracts. To some degree, they all worked without pay until the first payment came from the funder, three months into the contracts. Choices and TKH relied on whanau/hapu/iwi kindness for a starting point. Choices began working out of Jean's brother-in-law's premises and TKH began working out of the Taiwhenua o Whanganui a Orutu building in Napier. Securing cars and tools with which to work were a problem. Alayna was the fortunate exception. Despite enduring hardships when TTOH began, their experience was different. They were fortunate to have the backing of the Education component of TTOH services to assist them. Alayna recalls using their phones, some of their office space, and their computers. Alayna was already working as a manager for TTOH and one of the contracts they had was able to pay Alayna a part time manager's wage. This situation lasted for about three years. All again is not negative though as Alayna later went on to argue that despite all of this Maori health providers in Hawke's Bay are largely still here." Interviewees from Choices and TKH echoed this sentiment.

Professional intolerance

Professional intolerance was reported by all three Maori health providers in this study. As with other issues, there were varying degrees to which the providers identified the intolerance. However, while the professional intolerance identified by the interviewees was not bad enough that ethical lines were crossed, or that professional misconduct could be proved, or professional misconduct cases taken

against the other parties, it was something with which almost all of the interviewees felt that they had to contend.

In chapter four Jean from Choices recalled instances of suffering professional intolerance by other midwives, Plunket nurses, public health nurses, and doctors. Jean also recalled that the other midwives did not pay her, even when she referred patients to them and helped with the work.

So too the Plunket nurses were somewhat "distant" when Choices acquired a Tamariki Ora contract. The contract covered some of the area the nurses were already covering. This professional intolerance could thus be identified as a form of professional fear by other health providers that the Maori health providers would 'steal' their clients. And so a draft HBDHB Maori Health Plan (2003) discussed the case in Wairoa where once upon a time Plunket referrals were 90% but since a Tamariki Ora contract was established in that region the Maori health provider nurse now saw 90% of the babies in that area. Similar problems occurred with public health nurses when Choices acquired a School based nurse contract. Both problems were resolved without intervention after a time when the other parties realised Choices staff were working with a totally different clientele than their own.

A problem arose with a doctor who had been working part time for Choices. His manager from another practice indicated to him that he would have to stop working at Choices and they altered his contract with an inclusion that forbade him from working within a 2 mile city limit. This meant Choices was excluded from the area the doctor could work, but not any of the other Maori health providers.

Marj and Audrey from TKH experienced some form of professional intolerance from some staff at the then Napier hospital. In chapter five they reported incidents where a door leading from the ward in which they were located was chained and locked from the hospital side, to prevent TKH from using their facilities. The speculation was that hospital staff acted in the way they did because TKH was a Maori organisation, and because TKH were working out in

the community and perhaps the hospital staff did not think they were qualified to do that job.

In a separate but related thread Alayna related how when the doctors began forming Independent Practitioner Associations, the funding they received was much more than what TTOH received for any of their contracts.

Tully and Mortlock (1999) help us understand these issues more clearly when they highlight, "the importance of recognizing the context in which professional claims are made and how it influences both the form and the outcome of struggles between occupational groups for control over areas of work" (p. 179). These forms of professional intolerance may have been a reaction to insecurity brought on by the massive changes being introduced to the New Zealand health system and a fear of people that they would lose their clients.

Competition for resources

One theme that appeared to be common across all the interviews was the recurrent problem of a competition for resources. The reforms of the New Zealand health system in the 1980s and 1990s had created a system based on struggle, and rivalry where Maori health providers compete amongst themselves and with other health providers for the scarce resources of funding and people.

One of the concerns raised by interviewees such as Jean at Choices, in chapter four, was the problems of uncertainty that followed from the variability in the levels of funding available for health providers from year to year. Problems of uncertainty in funding were also raised by Alayna in chapter six. The key issue for Alayna though was uncertainty on how funding decisions were made. The other issue was over how the funding was allocated. Alayna talked about her concern that some organisations (in this case four separate marae) were being funded for services that Te Taiwhenua o Heretaunga could more efficiently provide. The key issue here was that the competition model seemed to undermine the operation of economies of scale.

The issue of funding was in turn linked to the other concern raised by the interviewees in the competition for resources that being a lack of trained staff. This shortage of Maori health professional and health workers for the number of jobs available placed increased pressure on organizations like Choices to deliver the services they were contracted to deliver. The three Maori health providers discussed in this thesis had all come up with various ways to overcome this shortfall. In chapter four we saw how a lack of qualified Maori midwives and Registered Nurses led members of Choices to obtain these qualifications. In chapter five we saw how Marj and Audrey actively work with EIT to recruit from their nursing students. We also saw how members of MWWL continue to do voluntary work in order to support Te Kupenga Hauora. Something common across all the providers was the use of whanau connections to support the operation of the organizations with whanau working sometimes for free to provide necessary services.

There has been a general recognition of this problem. In an effort to recruit more entrants into the health field, New Zealand presently has a Health Workforce Advisory Committee (HWAC) working on preparing a strategy for New Zealand and there is a subcommittee for Maori workforce development (Ministry of Health, 2006). More work still probably needs to be done though to ensure that Maori health providers are able to attract the staff they require to deliver the services they are contracted to provide.

Health system restructuring resulting in short-term policies

Gauld (2001) compared services at the beginning of the health reforms around 1993 with developments in health in circa 1999/2000[5]. This comparison shows

[5] Gauld (2001) has adapted Health Funding Authority (HFA) information that identifies the issue of Contracting under Regional Health Authorities (RHAs) circa 1993, as being individualized with lack of output definition, is provider-focused, and sustains adversarial relationships. Under Purchasing Framework issue, the description is fragmented, inconsistent, with poor information systems. Priorotisation informs there is no common framework, and few agreed principles. This is the environment into which Maori health providers were introduced. There were 23 Maori health providers at that time, and they adapted Maori health goals. By 1999/2000, Contracting had changed to become national frameworks. Contracting was for outputs, and funding was patient-focused and integrated. The purchasing framework had become a national collaborative, with equity and consistency as goals and sector wide information gathering occurring. Priorotisation

unprepared health reforms in place in 1993. An extension of this information could correlate to the funders not knowing how much to fund a new initiative, such as Maori health provision. By 1999/2000 more control is demonstrated which is in line with the three MHPs studied, who commented on how in 1999 their contracts were more integrated, and common contracts were shared such as the Tamariki Ora and Whanau Ora contracts.

Although all three MHPs complained about one year contracts, Alayna in chapter six was the most vociferous when she described there being no long term plan for Maori health. Although funders asked for long term plans, this was impossible for the Maori health providers discussed in this thesis to produce, having experienced one year contracts from 1994 to 1999. In 1999, some contracts were renewed for three years but by 2002 with a new government, the contracts reverted to a one-year rollover. While this was problematic at a managerial level, at an operation level, Maori health provider staff like Angeline at Te Taiwhenua o Heretaunga, found no issue with one-year contracts from her work perspective.

The key issue for all interviewees at all three Maori health providers was the lack of certainty that the apparent short-term focus on New Zealand health policy caused them. This lack of certainty made it hard for them to plan ahead as organisations.

Tino rangatiratanga

An analysis of the data presented in the three case study chapters that the shift towards Maori health provision for Maori has not resulted in the increase in tino rangatiratanga that early supporters thought it would bring about. Tino rangatiratanga is broadly defined in this thesis to mean Maori sovereignty, or being in charge of one's own destiny. Durie (1992) discusses tino rangatiratanga as it appeared during the decade of Maori development which foresaw a

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showed access to be on a needs basis, and a Priorotisation framework was developed. By then, there were over 200 Maori health providers delivering Maori Public Health programmes that included requirements for mainstream providers (p.154).

framework of Maori self-sufficiency and Maori control. As outlined in chapter two the government of the day was introducing policies that would reduce reliance on the State, turn spending in to positive funding and instill confidence in tribal delivery systems by encouraging Maori social and economic advancement. These policies were directed at Maori development and Durie (1992) argues that Maori were not only ready for this change but also wanted it. This led amongst other things to a proliferation of iwi provider services throughout New Zealand, mainly in the field of social service provision. However, some of the iwi providers also delivered some form of health services to their communities. What Durie saw emerge out of this was a dilemma for Maori. Durie states that "Tino Rangatiratanga and its promise of greater Maori autonomy could be construed as offering implicit support for privatisation or at least for reduced state provision of services" (1992, p. 3). However, what iwi providers received instead were "meagre resources from the state...while were they forced to use some of their own money, to provide the economic, social and cultural programmes" (1992, pp. 3-4). This was not the tino rangatiratanga that Maori thought they would receive when they began to create Maori service providers.

This lack of tino rangatiratanga is clearly perceived in the issues that were identified by the three Maori health providers studied in this thesis. In chapter four one of the key problems identified by Choices in the devolution of service delivery of Maori for Maori was a lack of control over the contracts they acquired. Instead of control being devolved to them as a Maori service provider final control still remained with government at the Ministry of Health. The interviewees at TKH and TTOH felt that health contracts were similarly still controlled by the government with no real power being devolved to communities as represented by Maori health providers.

Another issue raised by the interviewees was the inability of the contracts to take Maori worldviews seriously. Marj at TKH related how at the early stage of contracting the contract did not specify using any type of Maori care. Any change to health care provision was to ensure they delivered appropriate care by the Maori health providers themselves. In order to ensure that their work was

appropriate to the needs of the Maori community that they served, TKH began using the Whare Tapa Wha Maori model of health. However, more than the other two providers, TKH appears to have more so, adapted their services to their clients. The key reason for this may have been the closer relationship they had with the CRHA Maori team through Marj's historical connections with the manager. Even though the delivery of services had to be within the constraints of the contracts, Audrey and Marj interpreted this was at least a partial concession to tino rangatiratanga and, therefore, that was acceptable to Maori.

The story was somewhat different with the other providers. By the late 1990s, Maori models of health had become increasingly popular amongst Maori service providers. Using TTOH as an example, as discussed in chapter six, they chose to use a combination of the Whare Tapa Wha and the Te Wheke models of care when working with their clients. However, the client choice was always the deciding factor. If clients were unaware of the Maori models of health and how their health and knowledge care could be worked, the kaupapa was always explained.

The first contract TTOH received from CRHA was a Whanau Ora contract that involved caring for a specified number of families in the Flaxmere and Hastings West areas. As Alayna recounted, the funder specified everything about the contract with no Maori-specific care input being specified:

> Whanau Ora was presented to the Taiwhenua through the CRHA Maori team and...they just told us [how things were going to be delivered]. In those days there was very little negotiation, you just got what you were given...they set targets as to how many Whanau Ora plans they wanted you to achieve.

Given their kaupapa of Maori service delivery TTOH therefore had to work around the contracts to deliver the more holistic Maori health service delivery they thought their clients deserved. As Angeline recounted in her interview, "I worked out of the contract at times in order to practice my Maori kawa, because there was nothing written in the contracts that allowed you to do that...the contracting model was based on purely western concepts." As with the other two Maori health providers tino rangatiratanga was only visible in the actual work

carried out to complete the contracts. This finding ties into the discussion of authors, such as Durie, who have argued that while successive New Zealand governments have been seen to be connecting with Maori, contract wording has done little to encourage Maori sovereignty or purpose (Durie, 1997 pp. 150-1). This has meant that while Maori were delivering services, they had no input into policy design.

In a sense, tino rangatiratanga was not something directly achieved in the devolution process. Instead, the Maori health providers introduced in this thesis had to work outside their contracts to deliver the more holistic health care they felt was appropriate to their clients. Devolution had thus led to an increase in tino rangatiratanga for Maori, but in many respects, this was despite the changes made to the system. It seems then that the devolution programme undertaken by government has merely "pushed responsibility for service delivery on to Maori providers...with limited scope for Maori involvement in determining the shape of Maori development" (Durie, 1997, pp. 150-1). While the process of devolution had opened the possibility for tino rangatiratanga, it was still something the Maori health providers in this thesis had to fight for, to practice.

Conclusion

As this chapter has shown, the process of devolution has not delivered the extent of tino rangatiratanga that some hoped would be delivered through the devolution of service delivery to Maori. The framework developed in chapter three was used in the three case study chapters to group the issues of the Maori health providers. This chapter has shown that the three Maori health providers studied in this research, faced a number of problems which prevented them from operating as well as they could. In the final section of the chapter, while devolution of service delivery to Maori providers has provided a degree of space for Maori to practice tino rangatiratanga, it has not been without effort. Issues such as uncertainty in funding and other tensions, such as the inability of health funders to take seriously the broader health view of hauora espoused by many Maori health providers, have hampered the ability of Maori health providers to provide the appropriate care they want to provide to Maori communities. Despite

broad shifts in the social policies of successive governments over the past few decades Maori still feel constrained and not empowered by the New Zealand health system.

Chapter Eight
Conclusion

This thesis has considered how government policies of devolution and the associated creation of appropriate health care organisations for Maori, affected the operation of the three Maori health providers that were the subject of this study. This final chapter looks at the arguments and evidence discussed in this thesis before discussing how, despite the relatively bleak picture that this thesis has painted of the experiences of these Maori health providers, their experiences should still be seen as an example of success.

A space for tino rangatiratanga?

As chapter two showed, Maori have called for the provision of health care 'by Maori and for Maori' for many years. In the last decades of the twentieth century some movement towards this kind of service provision within New Zealand did occur. As that chapter showed this shift in New Zealand government policy was contextualized within a broader shift towards neo-liberal forms of government in the 1980s. This shift opened up the possibilities for increased devolution of service delivery to Maori – something that Maori increasingly argued for at key events such as the Hui Whakaoranga in March 1984 and the Hui Taumata in October 1984. This shift thus opened up for a space for increased tino rangatiratanga for Maori. However, as later chapters showed, the devolution of health care authority to Maori has not delivered the extent of tino rangatiratanga that the initial Maori supporters of these policies (including the women interviewed for this thesis) thought that it would.

In gathering the data utilised in this study, the thesis drew on a number of important methodological principles and guiding frameworks which were laid out in chapter three. Utilising a Maori-centred research paradigm much of the primary data for this thesis was obtained through semi-structured interviews. Issues such as case study selection, interviewing techniques and appropriate methods for data collection and analysis were also discussed in chapter three.

Chapters four, five and six then presented the experiences of the women interviewed who worked for the three organisations that took part in the study. Chapter seven then discussed and analysed the data from the previous chapters. As chapter seven showed, the process of devolution had not delivered the extent of tino rangatiratanga that some hoped would be delivered through the devolution of service delivery to Maori. While devolution of service delivery to Maori providers has provided a degree of space for Maori to practice tino rangatiratanga, it has not been without effort. Issues such as uncertainty in funding and other tensions, such as the inability of health funders to take seriously the broader health view of hauora espoused by many Maori health providers, have hampered the ability of Maori health providers to provide the appropriate care they want to provide to Maori communities.

This thesis utilised a framework for analysis based on major topics of analysis as identified by Durie (1994) and outlined in chapter three. Once again, those topics were: the contracting model used, the types of reporting required by the funders, inadequate funding, professional intolerance, competition for resources, and health system restructuring resulting in short term policies. This section considers those topics once more in considering the question originally posed in this thesis: whether or not this new policy environment has actually led to increased tino rangatiratanga for Maori health providers.

The contracting model and reporting to the funder

One of the key issues discussed by the interviewees was that the contracting model only paid for services rendered, so that in the beginning many providers found lack of money a huge problem when starting up. Another problem was that they did not get enough money to employ the number of staff they perceived as being required to deliver the contracts. In addition the three providers all reported providing services over and above those contracted for by the funder, such as transport and assistance purchasing prescriptions for their clients. They did this in order to fulfil their obligations of 'by Maori for Maori' service and their dedication to holistic models of Maori health care. All three providers thus offered services to any member of the whanau that wished assistance, even when

the matter involved was different from the original or involved a different whanau member. Despite these negative issues some the women interviewees remained positive and told of improved reporting ability due to being able to attend training with the result that all the interviewees reported that in 1999 the contracts being offered became better integrated.

Inadequate funding

Interviewees from all three organisations spoke of how there was no perceived guarantee of funding continuing. Another concern was how a change of governments often meant a change in the 'goal posts' they had to work within. It appeared to the women interviewed that there was no long-term plan for the Maori sector. The managers of the three Maori health providers also thought they were exploited by government, through the funders. Despite all these problems, the women believed not everything was necessarily negative, since all three organisations were still operating and reasonably meeting their targets.

Professional intolerance

All three Maori health providers in this study reported feeling some professional intolerance in their work. The cases studied all provided examples of what the women thought were examples of professional intolerance, such as a reluctance of mainstream health professionals to recognise their work or to work with them. One possible explanation for this intolerance may have insecurity brought on by the massive changes being introduced to the New Zealand health system and a fear by other health practitioners that they would lose their clients.

Competition for resources

One theme that appeared to be common across all the interviews was the recurrent problem of competition for resources. One of the key concerns raised by the women interviewed, was the uncertainty that followed from the variability in the levels of funding available for health providers from year to year. Another key issue was over how the funding was allocated. The point here was that some

of the women interviewed felt that the competition model seemed to undermine the operation of economies of scale. The other key concern was the lack of trained Maori health professional and health workers for the number of jobs available. These factors all combined to increase pressure on organisations like the three Maori health providers discussed in this thesis, to deliver the services they were contracted to deliver. They ended up in competition for resources with each other, and an uncertain existence which made it difficult to plan for the future.

Health system restructuring resulting in short-term policies

The key issue for all interviewees was the lack of certainty that the apparent short-term focus in New Zealand health policy caused them. This lack of certainty made it hard for them to plan ahead as organisations. Alayna in chapter six, was the most vociferous when she described there being no long term plan for Maori health. Although funders requested long term plans, this was impossible for the health providers discussed in this thesis to produce, having experienced mainly one year contracts from 1994 to 1999.

Overall this data provides a relatively negative picture of the first years of existence of the Maori health providers. From looking at the data it would appear that the shift towards Maori health provision for Maori has not resulted in the increase in tino rangatiratanga that early supporters expected. The thesis showed that the women working in these three Maori health providers felt that despite government rhetoric of Maori control over Maori service delivery, there was a general lack of power over the contracts they acquired. Instead of control being devolved to them as Maori service providers, final decisions and power remained with government at the Ministry of Health. According to the women who took part in this study, initially, the contracts used failed to take Maori worldviews seriously. Any change to health care provision to ensure that the care they delivered was appropriate, was done by the Maori health providers themselves. While this changed as time went on, and as Maori views of health began to be taken more seriously by funders, the organisations still continued to provide services over and above those contracted for by the funders, in order to fulfil

their obligations of 'by Maori for Maori' service. This highlights the Maori health provider's dedication to providing holistic models of Maori health care to their clients. In sum then, it would appear that tino rangatiratanga was not something directly achieved in the devolution process. Instead, while the process of devolution had opened the possibility for tino rangatiratanga to be practiced, it was still something that had to be fought for by the Maori health providers discussed in this thesis. And so, despite broad shifts in the social policies of successive governments over the past few decades, the women interviewed in this thesis, still felt relatively constrained and powerless within the New Zealand health system.

This should not be seen as a purely negative picture. As the various interviews showed, the women who worked in these organisations thought that the new system was an improvement over the old system. At least in the new system, a space was available for tino rangatiratanga to be practiced, even if it was not to the extent that these women had first hoped. While they may have disagreed with the particular ways in which the process of devolution had occurred, they nonetheless felt they had more freedom in the new system – even if it was still relatively constrained by the broader system. The women interviewed in this thesis were all pragmatic realists and have made the most of the opportunities that the contracting out of former government services have provided for both their own organisations, and the broader Maori communities that they service.

I want to return now to the original quote by Durie (1994) which provided the initial idea for the use of this structuring framework for the writing of this thesis. He argued that:

> Tino rangatiratanga (Maori control and determination) had become part of the new Maori health movement and Maori health initiatives were claimed by Maori as their own. Often they were, but seldom was it that clear. Instead, inadequate funding, professional intolerance, health system restructuring, and short-term policies combined to marginalize many initiatives and force them into narrow roles prescribed by area health boards and at odds with Maori aspirations and priorities. Sometimes ownership of an initiative had never been clearly established and conflict

> followed when it was discovered that the institution retained control, not Maori. What had not been lost, however, was a new awareness that Maori could, and should, play decisive roles in addressing Maori health needs (1994, p. 57).

The final thought of this quote regarding a new Maori awareness, warrants closer focus. In this context it means that despite the bleak picture that emerges from the experiences of these Maori women working in Maori health providers, their experiences should still be seen as an example of success. The first and most important point to make is that all three organisations are still operating and this ultimately makes this thesis a story of success. This success though, appears to be in large part a story of how these women have managed to keep their organisations afloat, despite the various impediments to success that they have had to fight against.

Despite all the problems they have had to face, the change in policy environment which allowed for the establishment of Maori health providers has in due course been fruitful. While some of the policies, structures and processes which they have to work through at points seem to impede the operation of their organisations, their efforts have created a space in which they are able to assert their tino rangatiratanga through their mana wahine.

Where are they now, in 2007?

As noted above Kahungunu Health Services, or Choices, Te Kupenga Hauora, and Te Taiwhenua O Heretaunga, continue to provide health services to the Maori population in Heretaunga. All are accredited health organisations. But where are they now?

Kahungunu Health Services, (Choices)

Choices have continued to obtain new contracts. Over time as they have gained more experience and increased their capacity the value of their contracts has

continued to increase. And, as part of their new contracts they have begun a number of novel initiatives including the establishment of mobile nurse clinics.

Te Kupenga Hauora

TKH has managed to acquire a number of new contracts from a variety of agencies including becoming the lead provider for workforce development for the Hawke's Bay District Health Board. On the organisational level they have won a number of awards including the award for being the 'Most Professional Maori Business' in the Ikaroa district. They have also recently purchased their own building in downtown Napier.

Te Taiwhenua O Heretaunga

TTOH are piloting a number of contracts for the Hawke's Bay District Health Board and have managed to recruit a very experienced Maori doctor to work full time at their General Practice clinic. They have also begun working with other central government ministries such as their work with the Ministry of Social Development in the creation of a position for a teenage parent support coordinator. While they still have problems recruiting qualified staff they are in a more secure position as an organisation.

The point to note is that all three Maori Health Providers continue to provide appropriate health services to their clients. Despite the problems that they have come up against, they continue to operate successfully. In a similar vein, changes at the national level are occurring which should ensure that Maori Health Providers do not have to face the same issues and problems that the three organisations discussed in this thesis, had to face. One small example is that in an effort to recruit more entrants into the health field, New Zealand presently has a Health Workforce Advisory Committee (HWAC) working on preparing a strategy for New Zealand. As part of this a subcommittee for Maori workforce development has been established (Ministry of Health, 2006). In the past three years, more scholarships for training in various health fields have been made

available, for amounts large enough to ensure the training received is worthwhile.

Lessons Learnt

At the outset of this thesis I wrote that this research should be useful to a range of readers including policy analysts at the Ministry of Health, Maori health providers and other social service providers. There are a number of lessons that can be usefully taken from the findings of this thesis for that audience. First would be, that despite issues with how the new policy environment has played out in terms of delivering all that the women interviewed for this thesis thought that it would deliver, it has still produced a space for the practice of their tino rangatiratanga. Second, is that the small size of this space for the practice of tino rangatiratanga appears to be due to central government and associated key agencies like District Health Boards, a) not being willing to give up control to Maori health providers and/or support them adequately and, b) not being able to provide funding and policy certainty. Following on from these two issues the third point would be that for increased tino rangatiratanga to occur for Maori health providers, (and other Maori providers) then government agencies need to be prepared to hand over greater control to these providers and support them in their endeavours. If this occurs, both in terms of the creation of new policy as well as in practice, then Maori health providers may finally be able to achieve the tino rangatiratanga that they hoped for when they embarked on their journey of health service delivery for Maori in the mid-1990s.

Conclusion

I began this thesis with the question as to "how government policies of devolution and the associated creation of appropriate health care organisations for Maori affected the operation of these organisations, and whether or not this new policy environment has actually led to increased rangatiratanga for Maori – specifically Maori health provider organisations." The evidence provided in this thesis shows that in many respects this has not been the case. The process of devolution has not delivered the extent of tino rangatiratanga that some hoped

would be delivered through the devolution of service delivery to Maori. However, despite the relatively bleak picture that this thesis has painted of the experiences of these Maori health providers, their experiences should still be seen as an example of success. The policies, structures and processes, which they as Maori health practitioners and workers in Maori health provider organisations have had to work through, have at points, seemed to impede the operation of their organisations. However, their efforts have created a space in which they are able to assert their tino rangatiratanga through the practice of their mana wahine.

Glossary

Hauora	health
Hui	meeting
Hui Taumata	Māori Economic Development Summit Conference
Hui Whakaoranga	Māori Health Development Summit Conference
Iwi	tribe
Kahungunu Runanganui	great council of Kahungunu
Kaupapa	theme /vision
Kawa	protocol
Kuia	female elder
mana whahine	women's authority/power
Manawhenua	authority of the people of the Te Taiwhenua o Heretaunga district
Marae	ceremonial meeting place
Matauranga	knowledge
Noa	profane/free from constraint
Pakeha	non-Maori New Zealander of European descent
Pepi	baby

Powhiri	ceremonial greeting
Rongoa	medicine
Taiwhenua	district
Tamariki	children
Tapu	sacred
Tautoko Whanau programme)	supporting families (a government health
Te Reo	language
Tika	correct/true
Tikanga	customs
Tino Rangatiratanga	Maori sovereignty
Tohunga	expert/priest
Whakapapa	genealogy
Whakatau	to decide/greeting ceremony
Whanau	family
Whanaungatanga	family-like relationships
Whare Whanau	family house

Appendix A

Rangi Barcham
07051191
Masterate thesis research student
179.899

Interview Questions. Semi-Structured Interviews.

The Managers and the 4-6 key personnel will be asked the same questions.

1. Can you describe what your role is within Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga?
2. What role did you have when the organization was set up?
3. What role did you have when the health component of the organization was set up?
4. Why was Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga established?
5. When was Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga established?
6. What led to the health component of Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga being established?
7. Who do you see were the key players when the health component of Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga was being established?
8. In what way were these key players different from those who originally helped establish Te Kupenga Hauora/ Choices/ Te Taiwhenua o Heretaunga?
9. What issues arose with the health component during establishment?
10. How were the issues identified resolved?
11. In 2001 have the original issues changed or remained?
12. What was the initial plan for service provision?
    - What services were going to be provided
    - Where were you going to recruit staff from
    - To whom was the service to be provided
13. Has this plan changed in any way?
14. Can you tell me what contracts you now have with the Ministry of health?

15. Can you tell me the number and type of contracts the organization had when the health component was established?

16. Can you tell me of any plans for future contracts?

17. How have changing government policies affected the organization?

18. Where would you like to see this Maori health provider in the future?

19. Is there anything you wish to add?

2

Appendix B

COPY

MASSEY UNIVERSITY HUMAN ETHICS COMMITTEE

To: Secretary
Human Ethics Committee
Turitea, Palmerston North
Please send/deliver this original (1) application plus eleven (11) copies

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APPLICATION FOR APPROVAL OF PROPOSED TEACHING/RESEARCH PROCEDURES INVOLVING HUMAN SUBJECTS

APPLICANT: Name: Joan May Rangioue Barcham

Department: School of Sociology, Social Policy and Social Work

Contact Email/Number: rangib@ihug.co.nz

Status: Masterate Student

Name of Employer: Hawke's Bay District Health Board

PROJECT: Title: Enabled At Last: A history of three Maori Health Providers in Hawke's Bay.

Status: Masterate student research

Funding Source:

Clinical Trial Status: yes ☐ no x ☐

ATTACHMENTS: 1.Information Sheet.
2.Consent Form
3. Questionnaire.(to be submitted).

1

SUPERVISOR(S): Name:
Dr Jocelyn Quinnell, Dip Tchg; Dip Ed; MA (Hons); PhD, Auck,.
Ms Rachael Selby, JP, Dip Tchg; BA; M.Phil, Massey.

Department: School of Sociology, Social Policy and Social Work.

SIGNATURE(S): Applicant(s): .....

Supervisor(s): Jocelyn Quinnell R Selby

(required for all projects involving student research, implies satisfaction with application)

DATE: 6/8/02

OFFICE USE ONLY

Received: **Decision:**

Application Content

1. DESCRIPTION

1.1. Justification:

This research will be a study of three Maori Health Providers, which were established in Hawke's Bay between 1994 and 1995, to provide health services to local Maori. It will cover the years 1994 to December 2001. The research will record the history and development of these three providers. It will investigate why they were established; who the key players were initially and are now; what the startup issues were at the time and how these have changed over time; what changes have occurred in the provision of services; to whom services were provided; how government policies have impacted on the organizations.

1.2. Objectives:

The objective of this research is to record the experiences of three (3) Managers, and of four to six (4 – 6) key founding personnel.

1.3. Procedures for Recruiting Participants and Obtaining Informed Consent:

As this study will involve purposeful sampling, I will personally invite the 3 managers to participate. I will make a direct approach to 4-6 key founding personnel and invite their participation. Informed consent will be gained after an information sheet has been considered and a consent form read and signed prior to the interview.

1.4. Procedures in which Research Participants will be involved:

The participants will be involved in an in depth interview lasting up to two hours. Interviews will be undertaken at a time and place suitable to the participant. The researcher will mail copies of the edited transcripts to participants to check and make deletions or additions and then return the transcript to the researcher.

1.5. **Procedures for handling information and material produced in the course of the research including raw data and final research report(s):**

The interviews will be recorded using a dictaphone and hand written notes will be taken. The researcher will transcribe the interviews. The handwritten notes will support the audio recordings. Access to the data will be denied to anyone except the researcher and the supervisors.

1.6. **Procedures for sharing information with Research Participants:**

At completion of the study, the researcher will mail all participants a summary of the report. The final report will be available through the libraries at Massey University, the School of Sociology, Social Policy and Social Work, Massey University, and the researcher.

1.7. **Arrangements for storage and security, return, disposal or destruction of data:**

All data will be stored in a locked drawer at the home of the researcher. Tapes will be returned to the participants at completion of the study.

2. ETHICAL CONCERNS

2.1. Access to Participants:

The managers and the key founding personnel are all known to the researcher. They have all been involved in Maori health and the researcher has come to know them through her iwi networks.

2.2. **Informed Consent:**

The researcher will provide an information sheet to each of the participants. Formal informed consent will be gained prior to any interview

2.3. **Anonymity and Confidentiality:**

The Managers have approval from their organizations to participate in the study, and all three organizations:
Te Kupenga Hauora
Kahungunu Health Services/ Choices
Te Taiwhenua O Heretaunga
Have given written permission for their organizations to be identified in the study.

2.4. **Potential Harm to Participants:**

As the participants are providing their own views on the development of the organizations no harm is anticipated.

2.5. **Potential Harm to Researcher :**

No harm is anticipated.

2.6. **Potential Harm to the University:**

No harm is foreseen.

2.7. **Participant's Right to Decline to Take Part:**

Participation in the research is entirely voluntary and participants can withdraw at any stage in the project.

2.8. **Uses of the Information:**

The information will be used in order to complete a Masters thesis. In addition the results may be utilized to write further publications and/ or presentations at hue/ conferences.

2.9. **Conflict of Interest/Conflict of Roles:**

I will clarify and emphasize that during the interviews and subsequent writing up of the research, my primary role is as a student researcher.

2.10. **Other Ethical Concerns:**

The researcher is unaware of any other potential ethical concerns regarding this project.

3. LEGAL CONCERNS

3.1. Legislation

3.1.3. Privacy Act 1993

3.2. Other Legal Issues

4. CULTURAL CONCERNS:

None anticipated.

5. OTHER ETHICAL BODIES RELEVANT TO THIS RESEARCH

5.1. Ethics Committees

No other ethics committees have been applied to.

5.2. Professional Codes

This research does not come under any professional code.

6. OTHER RELEVANT ISSUES:

None.

Appendix C

Te Whare Tapa Wha and Te Wheke

Te Whare Tapa Wha

For Maori the concepts of health and well-being go beyond physical well-being. Good health is recognised as being dependent on a balance of factors. Mason Durie's Whare Tapa Wha model of health (1994) describes four components which represent the four walls of a house and the idea that if one of these walls falls, the entire house will fall. Reflecting a Maori perspective of health, whare tapa wha includes consideration of:

Te taha wairua: spiritual health, including the practice of tikanga Maori in general.

Te taha tinana: the physical aspects of health.

Te taha hinengaro: the emotional and psychological well-being of the whanau and of each individual within it.

Te taha whanau: the social environment in which individuals live, the whanau of family, the communities in which whanau live and act.

Te Wheke

Rose Pere uses the concept of Te Wheke, the octopus, to define family health. Pere describes the head of the octopus as te whanau, the eyes of the octopus as waiora (total wellbeing for the individual and family) and each of the eight tentacles as representing a specific dimension of health. The dimensions of health are as follows: wairuatanga (spirituality), taha tinana (physical wellbeing), hinengaro (the mind), the whanaungatanga (the extended family), mana ake (the

uniqueness of each individual and family), mauri (life force), ha a kore ma a kui ma (the breath of life from our forbears) and whatumanawa (the open and healthy expression of emotion). The tentacles are interwoven and this represents the close relationship of each of these dimensions.

Appendix D

Overview of services provided by Choices

Name of Service	Provided by whom	Provided to whom	Focus of the service
Tamariki Ora/Well Child Services	Registered Nurses and health support worker/ Enrolled Nurse as necessary	Maori 0-5 years and their whanau/care givers	Care and education around vision and hearing, Immunisation, Cot Death (SIDS), Nutrition, Breast feeding, smoke free homes, and support for mums at risk Assistance with positive parenting, maternity support, ante/post natal depression, homecare/safe environments, referral to other services as necessary, advocacy, transport to and from appointments Provision of well child checks 6 weeks-5 years age
Antenatal Postnatal and support for mothers and	Midwife/s and health support worker/ Enrolled Nurse as	Maori and other ethnicity women and pepi	Education and care with ante natal, post natal and delivery, normal baby milestones, breast

their pepi	necessary		feeding Full Maternity services, transport to and from Maternity unit as necessary Social needs assessment and referral to other services as needed, advocacy
School Based Nursing	Registered Nurse	Children between the ages of 5-12 years, who attend Decile 1 schools	Obtaining Memorandum of Understanding with the schools (Boards and Principals), Health Care Hawke's Bay Public Health Manager Informed consent of parents of children who attend the clinics, attendance of parent if they wish to be present during assessment Clinical and social assessment of children who attend the clinics, together with keeping of case notes Referral to other services and transport as necessary
Oranga Niho/ Dental Health	Registered Nurse/ or Enrolled	Maori children 2-5 years	Improving the oral health of tamariki.

Educator	Nurse/ or trained Health support worker		Staff work with whanau to give them an understanding of the importance of the school dental service, facilitating early enrolment into the school dental service, and monitoring dental service access Staff provide follow-up if appointments with Dental Nurse are not kept, transport to and from appointments as necessary, advocacy for the child and their whanau
Free contraceptive service	General Practioner (GP) as necessary/ maybe only a Registered Nurse	Maori women 16 – 25 years	Provide information to individuals and/or groups in appropriate venues, on sexually transmitted diseases, un planned pregnancies, the individuals rights and responsibilities, contraceptives and appropriate use of Referral to other services as necessary, GP

			consultation, provision of a prescription for free contraceptive, follow up service and monitoring
Car seat service/ Injury prevention	1 full time retail assistant,1x 12 hours per week person, 1 part time administration person	Pepi 0-5 years age resident in Hastings and Havelock North, and excluding Flaxmere (a Hastings suburb). Could be from Kohanga Reo in the areas.	Hiring car seats to parents of pepi and tamariki and giving injury prevention education to the young mothers (a different theme per week is highlighted and education is given at some Kohanga Reo within the area)
Smoke free/ Smoking cessation	1 midwife/ 1 male with a physical education background	Maori pregnant women and their whanau	Education around the benefits of a change in lifestyles to become smoke free, or raising awareness of the benefits for the whole whanau/family with being smoke free, offer smoking cessation service as appropriate

Appendix E

North Island, Aotearoa New Zealand.

This shows the Te Taiwhenua o Whanganui A Orutu area of Heretaunga. The Taiwhenua areas in total make up the Ngati Kahungunu Iwi.

Appendix F

Overview of Te Kupenga Hauora, Ministry of Health contracted services.

Name of Service	Provided by whom	Provided to whom	Focus of the service
Tamariki Ora/Well Child Services	Registered Nurses and Kaiawhina	Te Kohanga Reo tamariki, and whanau Tamariki not attending Te Kohanga Reo and whanau	Care and education around vision and hearing, Immunisation, Cot Death (SIDS), Nutrition, Breast feeding, smoke free homes, and support for mums at risk Assistance with positive parenting, maternity support, ante/post natal depression, homecare/safe environments
Whanau Ora – Kuia/ Koroua	Registered Nurses	Whanau, Kuia, and Koroua	Information and professional advice around healthcare, education and assessments regarding Heart disease, Asthma, strokes, cancer, diabetes, unintentional injuries, and nutrition.

			Free checks associated with this care on blood pressure, blood sugar, cholesterol levels, hearing tests, acuity eyesight tests.
School Health Services	Registered Nurses	Children between the ages of 5-12 years, who attend Decile 1 schools	Professional health care, education and support of the children who have health problems
Oranga Niho/ Dental Health	All Registered Nurses and Kaiawhina	Whanau and tamariki within the Napier defined area	Improving the oral health of tamariki. Staff work with whanau to give them an understanding of the importance of the school dental service, facilitating early enrolment into the school dental service, and monitoring dental service access.
Kaupapa Maori Mental Health- Rangatahi Ora/ Oranga Hinengaro	A Registered Nurse, a Councilor, and kaiawhina/kaitakawaenga	Those aged 19 years and under, who live in the Napier district and are at risk	Tamariki Maori and Rangatahi Day Activity programmes. Providing early detection and preventing escalation

Services		of developing mental illness	of mental health problems. Promoting mental wellness and assisting those who use the services to find strength in themselves so they are able to deal with personal issues that sometimes feel overwhelming for them.
Kia Piki Te Ora O Te Taitamariki – Maori Youth Suicide Prevention	A Councilor and kaiawhina/ kaitakawaenga	Maori youth residing in the Hawke's Bay District	A Youth suicide prevention programme. Youth are given appropriate information and are supported in improving their self-esteem and seeing their own self worth.

Appendix G

Overview of TTOH, Ministry of Health contracted services

Name of Service	Provided by whom	Provided to whom	Focus of the service
Tamariki Ora/Well Child Services	Registered Nurses and Kaiawhina	Te Kohanga Reo tamariki, and whanau Tamariki not attending Te Kohanga Reo and whanau	Care and education around vision and hearing, Immunisation, Cot Death (SIDS), Nutrition, Breast feeding, smoke free homes, and support for mums at risk Assistance with positive parenting, maternity support, ante/post natal depression, homecare/safe environments
Whanau Ora	Registered Nurses	Whanau, Kuia, and Koroua	Information and professional advice around healthcare, education and assessments regarding Heart disease, Asthma,

			strokes, cancer, diabetes, unintentional injuries, and nutrition. Free checks associated with this care on blood pressure, blood sugar, cholesterol levels, hearing tests, acuity eyesight tests.
School Based Nursing	Registered Nurses	Children between the ages of 5-12 years, who attend Decile 1 schools	Professional health care, education and support of the children who have health problems
Dental - Oranga Niho Service	All Registered Nurses and Kaiawhina	Whanau and tamariki within the Hastings defined area	Improving the oral health of tamariki. Staff work with whanau to give them an understanding of the importance of the school dental service, facilitating early enrolment into the school dental

			service, and monitoring dental service access.
Nga Oranga o te Rae	A Registered Nurse, a Councilor, and kaiäwhina/kaitakawaenga	Tangata Whaiora and their families	One on one support to Tangata Whaiora (mental health patients) and their whanau (family), to ensure they receive assistance with health and social issues.
Kia Piki Te Ora O Te Taitamariki – Maori Youth Suicide Prevention	A Councilor and kaiäwhina/ kaitakawaenga	Maori youth residing in the Hawke's Bay District	A Youth suicide prevention programme. Youth are given appropriate information and are supported in improving their self-esteem and seeing their own self worth.
Maori Disability Service	A RN or a well qualified specific person	People in Hastings area/Taiwhenua	An advocacy and support service for people with disabilities
Maori Mobile Disease state	RN or community health worker	The service is for people aged 20 years and older.	The aim is to identify and intervene early,

management service		TTOH have a van that this service is delivered from. Family homes or Marae are where the delivery occurs	with people who have heart disease, diabetes, and lung disease.
General Practitioner (doctor) service	Doctor/ nurses	General Practice for anyone and everyone	Works on a General Medical Subsidy (GMS) scheme, seeing patients. Fee is low or none.
Car seat service/ Road Safety	A health promoter plus 2 retail experience,	All people	Child injury prevention service includes promoting safety and preventing injury of tamariki. It involves the leasing out of car seats for children (at that time parents are taken through an injury prevention course.

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