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**TE TINI ROTO
TE TINI ORA**

**Health Promotion: Purchasing
Health Gains for Maori**

**R.J.T. NIA NIA
2000**

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TE TINi ORA

**Health Promotion: Purchasing Health Gains
for Maori**

A thesis submitted in fulfilment of the
requirements for the degree
of
Masters of Philosophy
in Maori Studies
at
Massey University

by

**RIKI JEVON THEODORE NIA NIA
2000**

ABSTRACT

The health reforms of the 1990's were in part implemented to develop a more effective, efficient and responsive health system. The reforms were to see major changes introduced into public sector management with a growing emphasis on accountability and responsibility. Competition at all levels of the health sector was to produce more effective purchasing of services, better delivery, and quality health services. More proactive emphasis was to be placed on the Governments goal for Maori health to achieve more equitable health standards for Maori. The reforms saw a greater emphasis being placed on public health strategies including health promotion as an effective means to prevent poor health outcomes, thus improving standards of health including those for Maori.

The primary focus of this thesis is an evaluation of the health sectors ability to effect positive changes in Maori health outcomes. Health promotion activities implemented by mainstream public health units are used as a focus point, and to provide some useful detail around the relevant issues. The view presented is that health promotion as an approach at both a provider and policy level - when implemented following effective principles of community development - provides a useful framework for progressing better health outcomes for Maori.

The main finding of this study is that health promotion has potential for improving Maori health but needs to focus more on actual outcomes, and community development, with greater local control over priorities.

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DEDICATION

Ki oku matua me o raua mokopuna.

This thesis is dedicated to Mum, Dad and their
grand children

Tevita, Sela, Kahungunu and Awhiora

To Mum and Dad for their unconditional support,
and to Tevita, Sela, Kahungunu and Awhiora
for making this thesis worthwhile.

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TE TINI ROTO, TE TINI ORA¹

HEALTH PROMOTION: PURCHASING HEALTH GAINS FOR MAORI

CHAPTER ONE

MOVING TOWARD A MORE EFFECTIVE, EFFICIENT, AND ACCOUNTABLE HEALTH SECTOR.

INTRODUCTION

For most of New Zealand's modern history, Maori have been over represented in numerous measures of poor health. When compared to non-Maori, history shows Maori have lived shorter lives, suffered more frequently from illness and disease, and have had a poorer quality of life (Durie, 1998a. Broughton, 1998. Pomare, 1996). In 1991 the National government proposed and began several radical changes to the New Zealand health sector. This thesis attempts to determine the degree to which the changes to the New Zealand Health sector have effected positive changes in Maori health. The primary question of this thesis therefore, is, whether the New Zealand health sector has been able to bring about positive changes in Maori health.

To provide this study with a focus the provision of health promotion services by public health units in New Zealand is used as the central focal point, particularly in relation to how they are shaped by policy, how public health services are purchased and how they are delivered.

THE HEALTH SECTOR REFORMS

In 1991 the Rt. Hon, Simon Upton (Minister of health) released the National Governments proposed plans for the health sector in the document 'Your health, and the public health'. Within this document Upton identified three key factors that

¹ Tiniroto is the home of my grandparents. Unique to this small East Coast village are several lakes, each significant to the local tribe for distinct reasons e.g. fishing, eeling, traditional rituals, sport and recreation. Each activity is important to well-being. The lakes are therefore symbolic of the widely accepted Maori view

underpinned the proposed health sector reforms. The key factors were:

1. the need for changes to the health sector that would effect greater financial efficiencies
2. the importance of effective public health strategies (including health promotion), as a means to prevent negative health, produce better health outcomes and reduce unnecessary treatment costs absorbed by the health sector.
3. to move away from a social democratic approach to government toward a neo liberal government, based on the principles of the free market and minimal state intervention.

These three issues are illustrated in the following extract from *'Your health and the public health'*.

"Reform of our health system is worth doing only if the outcome is a better system with benefits for all New Zealanders. We must be quite clear about the goals we set ourselves and realistic about what in fact can be achieved. The primary objective of this reform process must be to secure, for everyone, access to an effective level of health care. Low income should not create a barrier to quality care ... sufficient resources must be set aside for effective health promotion and disease prevention campaigns. Public Health² programmes are essential long-term investments in health for the whole population ... The time has come for action. We must start building a revitalised system, which is both strong and flexible enough to serve all New Zealanders better in the future (Upton, 1991. 8-9)."

The overall goal of the 1991 health reforms was to produce a more cost effective

that good health results from an interaction of many factors.

2 Public health services are activities designed to promote, improve the health status of populations and reduce inequalities in population health status (as opposed to personal health care services which meet the needs of individuals)

health sector that would be better able to produce positive health outcomes for all New Zealanders within clear financial boundaries.

Neo Liberalism

The dominant underlying theoretical perspective driving the public sector reforms during the 1980's and 1990's was neo liberalism, more commonly known in New Zealand as the 'new right' (Jesson, 1988. Sharp, 1994. Spoonley, 1990. Kelsey, 1997. Boston, 1998). Neo liberalism represents a revitalisation of Libertarianism and prescribes as part of public sector reforms, a clear distinction and separation of key public sector roles, for example, the role of provider from purchaser. This action is believed to remove to some degree the opportunity for decision making based on self-interest (supposedly a characteristic of a social democratic public sector). Competition is another key feature of neo liberalism; competition is thought to create a greater opportunity for both efficiency gains and more effective health outcomes. The question remains, however, as to whether the reforms have effected both efficiency gains and improved health outcomes, including positive changes in Maori health. The reforms were a new approach to public sector management, best summed up by Durie (1998a) when he describes the 1991 reforms as;

"A move towards greater accountability for expenditure of public funds and a refocusing of health priorities towards earlier forms of intervention, quality care and a reduction of unacceptable disparities (Durie, 1998a. 95)."

Central to the reforms was a greater level of accountability placed on the health sector, that is accountability in terms of implementing outputs that would positively contribute to desired outcomes of Government. Government would clearly detail its expectations of the health sector, through a set key result areas (KRA's) and strategic result areas (SRA's), that were shaped to make positive contributions to the Governments overall goals for health.

This thesis examines both the goals set by the Government for Maori the health sector's response.

Public Health

A strong emphasis on public health services was proposed by the National Government as its primary strategy for reducing unnecessary preventable negative health states and more particularly the unnecessary cost of preventable illness and disease. It was proposed that funds for public health strategies were to be ring-fenced, and the Public Health Commission was to be responsible for both purchasing and co-ordinating the provision of public health services. Public health services would have three specific components, health protection, health promotion and disease prevention, each component more clearly outlined in '*Your health and the public health*' in 1991:

"1. Health Protection

Health protection activities are designed to ensure a healthy and safe food supply, clean air, soil, water, and safe disposal of chemical waste. Such services are largely invisible to the public, coming into attention only in a crisis, as when food supplies or food are contaminated.

2. Health Promotion

Health promotion activities are designed to reduce disease and the number of deaths related to lifestyle, for example the effects of smoking, poor diet or drinking and driving. Past major Health promotion programmes in New Zealand have been directed at reducing injuries from motor vehicle crashes, heart disease and lung cancer.

3. Disease prevention

Disease prevention activities aim to reduce the incidence of preventable diseases and therefore to lower the costs of disease to the health sector and society (Upton, 1991. 108)."

The Government proposed to foster the development of effective public health services in order to ensure a safer environment and better health outcomes for all New Zealanders.

METHODOLOGY

The process for developing this thesis has involved:

- 1. scoping key documents and other written information pertaining to the health reforms
- 2. interviewing key people within the health sector
- 3. analysing from both sources

Scoping key documents and written information

Pivotal to understanding the issues has been the scoping and collation of information derived from key documents associated to the New Zealand health reforms and the resulting structure and operations of the health sector. Information has been aggregated in three parts. First, literature that assists explanations of the health reforms (reasons and intent), second, literature that describes the health reforms in practical terms and third, literature in relation to the evaluation of the health reforms. This has included the review of relevant, legislation, health policy, health theory, strategic plans, operational plans, business plans, policy guidelines and public management theory.

Table 1: Interview participants

Department	Role	Number
Ministry of Health	Management	1
Health Funding Authority	Group Management	2
Health Funding Authority	Contract Management	2
Public Health Unit	Manager	2
Public Health Unit	Team Leaders/Supervisors	2
Public Health Unit	Health Promoter	2
Maori Provider	Manager	4

Key Participant Interviews

In order to obtain a first hand and practical perception of the health reforms a number of key participant interviews were undertaken. Interviewees were selected from all levels of the health sector, including, the Ministry of Health, the Health Funding Authority, three Public Health units within the central region and a number of Maori providers (see table 1).

The Interview Process

The Process for key participant interviews was:

1. contact key people by phone to set up interviews.
2. hold verbal interviews with all participants in a location of their choice.
3. record information either in writing or by audio recording
4. transcribe information and present information where relevant

The Survey Tool

The survey tool was developed to derive the following information.

1. To identify those strategies being progressed by the organisation to improve responsiveness to Maori
2. To identify how Health Promotion was defined, implemented, evaluated and reviewed.

THE ANALYSIS

The final part of the development process was the analysis of the and the presentation of findings, using theory pertaining to social policy and public sector management, health promotion, Maori health perspectives and Maori aspirations.

The data collected is analysed against three significant themes:

1. effective health promotion service delivery
2. public sector management

3. health gains for Maori

The aim of the analysis was to determine the effectiveness of the health sectors approach to improving Maori health using health promotion service delivery as the focus point. Central to this task has been the analysis of public sector management using theories developed to better understand how the public sector operates, including universal theories that inform social and economic policy.

The analysis has therefore been informed by a wide range of theory and feedback and documentation collected from various sources e.g. health sector agencies, public health unit documentation and staff.

Research Considerations

For the most part this has been a qualitative study. Qualitative approaches are thought to be especially useful in the analysis of social policy and its intended outcomes:

"Public policy interventions are invariably affected by the ebb and flow of political agendas and events. Interpretative methods, generally based on qualitative techniques, are well suited to studying such complex situations and offer much to the study of public health (Baum (1995) as cited in Goodwin, 1997.51)."

CHAPTER OVERVIEW

Each chapter in this thesis is considered to be a logical progression toward an understanding of how effective the Health sector has been in using Health promotion as a tool to improve Maori health. The following issues have been progressively examined:

- defining Maori Health
- bench marking the state of Maori health and well-being
- determining the rights of Maori to good health
- understanding the intent and focus of health promotion
- understanding the universal theories that shape social policy

- gaining an overview of the 1993 health sector reforms
- determining the effectiveness of mainstream approaches to health promotion services delivery
- critical analysis and discussion of the findings.

Chapter Two: - Defining Maori Health.

This chapter has two functions. First, to overview historical approaches to the definition of being 'Maori', and, second, to provide an overview of traditional perspectives of Maori health. It will demonstrate that being Maori is constantly changing, Maori health is multi dimensional in nature and that any strategy to advance the current position of Maori health must address multiple factors at all levels.

Chapter Three - The State of Maori Health and Well-being.

This chapter has two primary functions. First, to overview the increasing support for views pertaining to the importance of external influences of health such as the social, cultural and economic determinants of health; second, to provide a snapshot of Maori health in relation to Maori well-being. The primary purpose of chapter three is to illustrate the complex and high level of needs Maori have in terms of their health. This chapter is central to this thesis because it shows that despite improved health services, Maori disparities in health have not improved and in some instances have widened.

Chapter Four - Maori Expectations of Good Health.

Chapter Four emphasises the right of Maori to experience good health. It attempts first to show how the Treaty of Waitangi has relevance to social Policy, including health, thus according Maori the expectation for equitable health status with non-Maori. Second, it provides an overview of international treaties that assert the right of indigenous people (including Maori) to a certain standard of good health and well being. The purpose of this chapter in contrast to the last chapter(which was about need) is to advance good health as a right.

Chapter Five - Health Promotion

This chapter has two functions, first, to overview the key issues surrounding the definition and delivery of health promotion and second, to outline, the focus, the intent and the most effective methods of health promotion practice. It attempts to show that Health Promotion has a multi-dimensional health focus (not dissimilar to Maori perspectives of health), and provides a useful framework for addressing the multi-dimensional issues relating to the status of Maori health. Health promotion is defined and key principles for effective health promotion practice are identified.

Chapter Six - Universal Theories that shape Social Policy in New Zealand

The purpose of this chapter is to provide background information useful for interpreting the underlying political perspectives inherent in the health reforms of the 1990's. It provides an overview of those universal theories that underlie dominant political perspectives in New Zealand. It therefore has two functions, first, to provide an overview of those theories that predominantly have shaped social policy in New Zealand and second, to determine what the implication of each of these universal theories for the delivery of health in relationship to Maori in New Zealand.

Chapter Seven - Health Reforms and the Health Sector

This chapter presents reasons for the health reforms started in the 1980's by the fourth Labour Government and continued in the 1990's by the current National Government Coalition. Second, it scans the structure of the health sector with particular reference to the function of key purchasing and policy organisations and how they fulfil their roles. The demise of the Public Health Commission is also discussed.

Chapter Eight - Health Sector Responsiveness

Central to this chapter is an overview of the Governments objective and proposed strategies for Maori health. The purpose of this chapter is to determine to what degree the strategies implemented at the policy level for Maori health are being

achieved at the provider level, using health promotion service delivery in Public Health Units as an example

Chapter Nine – Public Health Delivery

This chapter is an examination of the public health purchasing process in New Zealand and an evaluation of three public health services in their provision of health promotion to effect positive changes in Maori health.

Chapter Ten - Discussion

This chapter amplifies the key findings. It attempts to evaluate to what degree the health reforms and the current approach of the health sector have made a positive difference for Maori.

CHAPTER TWO

DEFINING MAORI AND MAORI HEALTH

INTRODUCTION

Three themes are explored in this chapter: statistical and official definitions of Maori, Maori models of health and wellbeing and Maori development.

DEFINING MAORI

There are several issues that require clarity in defining being 'Maori' and who potentially can and can not be included when collecting data which is 'Maori specific' (i.e. data directly linked to the Maori population). Some issues that need consideration are:

- who decides who is Maori (i.e. sets the criteria for being Maori)
- how has defining Maori occurred in the past
- what contemporary realities need to be considered when defining Maori

A practical issue that requires consideration directly related to defining Maori is consistency in utilisation, particularly when pertaining to collection of data (Pomare 1995). The need for consistent utilisation when defining Maori is also progressed.

It should be noted from the outset, that the purpose of this section is not to make a decision about the most appropriate definition of Maori, or how that should be achieved, but to provide an outline of historical approaches, current definitions and issues pertaining to consistency in utilisation.

Historical Approaches to defining Maori

Several approaches have historically been used to define Maori (i.e. determinants of being Maori) often with political motivation. In recent times, for example, when determining the number of Maori is directly linked to funding and resource allocation by the State.

Therefore for interested observers (e.g. Iwi, Hapu, Government), the definition of Maori becomes extremely important because the result can either be too exclusive or too inclusive (depending on perspective).

Approaches to defining Maori therefore take on a new importance, as the definition ultimately determines the size and nature of any particular issue pertaining to Maori. This task is made challenging given the fact that the Maori population is not static but dynamic and ever changing. The evolving nature of Maori people further complicates the process of identifying the Maori population. (Durie, 1998a. Pomare, 1995).

Durie (1998a) has described the various historical approaches to determining what constitutes being Maori. Approaches to the definition of Maori include having sole Maori ancestry, being half or more Maori in origin, or having (among other lines of descent) Maori ancestry. Table 2 outlines the various approaches and their origins as described by Durie. Initially, what constituted being Maori was based on the biological concept of race. However over time this has changed and it is determined by self-identification and ethnic rather than race affiliations.

Both Durie (1998a) and Pomare (1995) regard the 1991 census as significant in terms of advancing the definition of being Maori, as it proved to be most responsive to the changing realities associated with being Maori. The 1991 census offered Maori participants two distinct response categories descent from a Maori and ethnic identification.

Table 2: Approaches to defining being Maori

Year	Origin	Definition
Prior to 1840	Maori Tribes	Maori seen as normal, therefore, no need to define
1840 onwards	Non-Maori Settlers (Eurocentralism)	Maori seen as different, issues around definition begin
1926	Government	Half or more Maori blood (biologically determined)
1953	Maori Affairs Act	a person belonging to the aboriginal race of New Zealand, including half-castes and those intermediate to being half-caste or pure bloods (descendants).
1974	Maori Affairs Amendment Act	A person of the Maori race and any descendants of a Maori person (descendants)
1975	Electoral Act	A person of pure Maori blood or a person of less than pure Maori blood who wished to be considered as a Maori (self identification)
1986	Census	Self identification regardless of Maori blood percentage
1991	Census	Self identification regardless of Maori blood percentage

(Source: adapted from Durie, 1998a)

There was some debate whether the Maori population was best determined from the Maori descent category or from ethnic identification and by 1996 the debate was extended because, there were options for mixed ethnic identifications; As a result the sole Maori category was correspondingly much lower. The census was restructured to better estimate population and resulted in a number specific categories (see table 3).

Table 3: 1991/1996 Census - number of Maori

Category	Total Number per category	
	1991	1996
Those who have Maori ancestry	511,278	579,714
Those who self identify as being ethnically Maori or Maori plus other ethnic group	434, 847	523, 371
Those who self identify as being solely Maori	323, 998	273,693

(Source: Statistics NZ.,1997)

The reduction in the sole Maori category may well be an artifact of the question asked. However, it is now difficult to compare data over time. Whereas the sole Maori category more or less equated with the biological definition of half caste or more, by 1996 it was clear that the sole Maori category had lost much of its significance and could no longer be used as a useful denominator.

Diverse Realities of Maori

An issue that needs consideration when attempting to define the Maori population is the issue of diverse Maori realities(nga matatini). Given the changing nature of Maori society, fuelled by such processes as the urban migration of Maori in the 1960's, Maori realities have changed. For example all Maori no longer have an affiliation to ancestral marae, or have a command of the Maori language. Contemporary Maori live in many different realities, some of which bear little

resemblance to traditional Maori society (Durie, 1998b).

"Maori are as diverse and complex as other sections of the population, even though they may have certain characteristics and features in common. There is no one Maori reality nor is there any longer a single description that will encompass the range of Maori lifestyles (Durie, 1998b. 92)."

One issue surrounding what constitutes being Maori gaining prominence, particularly in the media when there was debate between tribal and urban Maori. is the issue of 'Urban Maori'. The issue rose as a result of the Government predominantly dealing with Iwi when attempting to allocate resources (such as the fisheries) and settlement of other Maori grievances. A group of urban Maori authorities questioned whether the historical definition of Iwi Maori (tribal groups determined by genealogy) was relevant, given modern demographic characteristics.

In their view, a reliance on tribal measures would mean that some twenty percent of Maori would be ineligible for benefits because they no longer knew, or cared not to exercise, tribal affiliations. Yet they were still Maori.

Henare (1999) proclaims " the Maori humanist view argues it is Maori people who define Maori culture, and not the other way around. According to this view, the kinship and descent systems of whanau, hapu, and Iwi all engender a sense of belonging and solidarity. Iwi while important, is not the sole source of identity and being. It is in tikanga and ritenga-world view, customs, ethics, and values- that identity and personhood are primarily defined. It is argued that 'Iwi' can therefore refer to a group of people who have formed a social organisation and called it an Iwi, and that the evolution of this form of social organisation is appropriate to the modern age of Maori urbanisation and social mobility. Iwi is thus a means to an end and the end is authentic Maori development (Henare, 1999. 57)."

Mahuika (1999), O'Regan (1999), have rejected this view and have made strong statements, that being Maori is primarily determined through association with tribal ancestry.

While this debate has largely been centred around the redistribution of fishing resources, it highlights two important features of the Maori population. First, Maori realities continue to change and second, Maori can have multiple affiliations. The question of multiple affiliations raises the issue of which body best represents Maori and should be dealt with as the Treaty partner to the Crown.

Durie (1998b) perhaps advances the logical conclusion pertaining to changing and diverse Maori realities when concluding that;

"While there is an obvious and enduring place for iwi and hapu structures especially in relation to Treaty-based political negotiations and possibly the ownership and management of physical resources, social policies and programs must relate primarily to Maori whanau and individuals across a range of social and cultural conditions. An exclusive focus on tribal structures will bypass many Maori who, for reasons of their own are not active participants in Maori society (Durie, 1998b. 96)."

Consistent Utilisation

In terms of definition, one ongoing issue has been the inconsistent utilisation of one particular approach (used to define Maori), and the impact this has on the ability to compare Maori health data between sectors and time frames. This is a particularly important issue when attempting to determine changes in Maori health status. A key performance issue in assessing the Crowns Treaty of Waitangi obligations (to be discussed in the next chapter), as changes in health status and well-being can only be achieved through an analysis of current and past information across sectors. Therefore from a general perspective consistency is

also an issue for resource allocation, monitoring future trends and in terms of determining the size and nature of a particular issue (Pomare, 1998).

Pomare (1995) presents a practical difficulty that existed prior to 1995 due to the variation in approaches being used to define the Maori statistic." If you take as the numerator, death rates from asthma in Maori as coded by the Ministry of Health. If you then take as the denominator, the number of Maori in New Zealand as collected by the 1991 census to determine the proportion of Maori who have died from asthma you would divide the numerator by the denominator. However this would give you an inadequate reading because the two figures have been derived from different sources that have a different basis for defining Maori. Thus, the information is not totally accurate (Pomare(modified), 1995. 43)."

To address this issue, the Ministry of Health has changed their approach to determining ethnicity by aligning their definition of Maori with the ethnicity question posed by Statistics New Zealand in the collection of census data (Ministry of Health, 1998a.8).

The Ministry of Health (1998a) reports this has the following advantage:

"... the new ethnicity concept for ethnic specific information the numerator (number of deaths) and denominator (total number at risk) now correspond (From 1996 onwards) with information collected from other sources (Ministry of Health, 1998a. 7-8)"

The disadvantage being that due to the changes in the ethnicity question, ethnic specific data is not directly comparable prior to and after 1995. Hospitalisation data has also been modified to align itself with 1996 methods and categories of collecting ethnicity data. This change has also lead to a change in targeted outcomes for Maori health monitored by the Ministry of Health as a key component

of its 'progress on health outcomes' project. These examples and recent changes demonstrate the importance of consistent utilisation, both for determining the size of an issue, shaping strategic interventions and setting achievable targets with regards to addressing any particular issue.

The approach to defining Maori specific data that has become most commonly used by official sources of data is ethnic self - identification (Statistics NZ, 1998: Ministry of Health, 1998a, National Health committee, 1998). This as with every approach (depending on perspective) can be seen as being too inclusive or not exclusive enough. An interesting example pertaining to resource allocation currently presents itself in the American State of Hawaii. Native Hawaiians have the opportunity to lease land (@ us\$1 per year for 99 years) within the native Hawaiian homesteads. To be eligible one must be able to demonstrate native Hawaiian bloodlines of fifty percent or greater (Kamaki, 1999).

Summary

In summary, defining Maori has historically seen a number of approaches. Three predominant approaches have become apparent, namely, definition by biological determination, definition by ethnic affiliation and definition by ancestry. The most commonly used approach to determining Maori at present is ethnic self - identification. While there has been a discussion over which resulting source of data is most appropriate. Pomare (1995) suggests that the selection of one source of Maori specific data or one definition, is perhaps not the issue and instead the issue should be in determining which source to use and when.

An issue that has gained prominence in recent times among urban Maori groups is the 'Humanist' approach to defining Maori. The Humanist view states, that being Maori is determined by Maori people, not by traditional views of Maori culture and association with traditional iwi. This debate will need to be resolved before allocation of resources can be progressed. The outcome either way will have great

significance in determining who is and isn't Maori (at least from a legal perspective).

One practical issue with regard to the variation in the collection of Maori specific data has been attempts to use/compare the data collected from various sources to determine statistical rates (e.g. death rates from asthma in Maori). The differing methods of which Maori have been defined makes this process inaccurate. In response to this issue Statistics New Zealand has modified the way it collects ethnic data. The new method being used has two advantages. The first being an alignment with other key data collection sources (in particular the department of Justice, in terms of birth/death registers) and secondly, ethnicity is now self determined and not limited to those of half or more Maori blood.

DEFINING THE SCOPE OF MAORI HEALTH

Obtaining a truly clear picture of Maori health status and well-being requires more than just looking at data pertaining to hospital admissions and disease registers specific to Maori. This section provides justification for the assessment of Maori health and well-being from a multidimensional viewpoint (that is including a number of variables besides those derived from the health sector, for example, employment, education, income, housing, social cohesion and cultural identity).

Durie (1998) surmises "that no single measure can give an accurate indication of the state of Maori health (1998a. 123). "

Pomare (1995), Durie (1998a), Love (1998), Te Puni Kokiri (1998), National Health Committee (1998), Ministry of Health (1998) have all concluded that Maori health is much more complex in nature than just physical illness and diagnostic categories (as adhered to by Western models of medicine) Mackay (1995). Any review in the status of Maori health needs to have particular regard to the wider social, economic and cultural determinants. A similar view has been advanced in

recent times within mainstream health circles (e.g. National Health Committee, Ministry of Health. 1998, Ministry of Health. 1997, World Health Organisation. 1948) and is advocated by both traditional and contemporary models of Maori health. This view is represented in such Maori models of health as Te Whare Tapa Wha (Durie. 1998), Te Wheke (Pere), Nga Pou Mana (RCSP³).

Models of Maori Health

While the mainstream health circles are beginning to promote the need to view health as a multi-dimensional concept, both in nature and in terms of determining health status, this is not a new ground for Maori. Maori traditionally have had a multi-dimensional conceptualisation of health. This view was perhaps best summed up at a recent Healthy Community meeting held in Wanganui in September 1999. The meeting was organised by the local Healthy Communities network as an opportunity to bring Maori up to speed with the multidimensional nature of health, both in terms its nature and determinants. After the presentation had been completed, a Kaumatua from up the Wanganui River stood to respond. His words were:

" You have not brought us up to speed as these ideas you bring are not new. They are the Maori view of health. We have been pushing these ideas for many years. Maybe now you're saying them, someone will listen. It is good however that you guys have finally caught up (Pouro quoted in Wanganui Healthy Community Group meeting minutes, 16/9/99)."

Fundamental to understanding the scope of health are models of Maori health. The most recognised and commonly acknowledged models are:

1. te whare tapa wha
2. te wheke

³ Royal Commission on Social Policy

3. nga pou mana

Common to all models is the shared view that health is multi-dimensional and is determined by several factors both internal and external to the individual. As previously stated the acknowledgement of these dimensions is the first step in defining the level of Maori health status, the extent of the Maori health issue, and consequently the development and progression of meaningful strategies for change. They are important because they demonstrate the broad view of health adopted by Maori (Durie, 1998a. Henare, 1999).

Te Whare Tapa Wha - four corner stones of health

Te Whare Tapa Wha (also known as the four corner stones of Maori health) symbolises a strong house of four equally significant parts, each interrelated and important in terms of maintaining well - being. This model presents health in terms of four key components:

1. Taha Tinana - which refers to the physical dimension of health
2. Taha Wairua - which refers to the spiritual dimension of health
3. Taha Whanau - which refers to the importance of the extended family to health
4. Taha Hinengaro - which refers to the mental health dimension of health

If each dimension is nurtured and developed to be stable the symbolic house will be strong, thus enhancing well being. The *Rapuora* report stated that:

“A study of Maori health must follow more than two strands (physical and mental). Tinana is the physical element of the individual and Hinengaro the mental state, but these do not make up the whole. Wairua the spirit and Whanau the wider family, complete the shimmering depths of the health pounamu. The precious touchstone of Maoridom (as cited in Durie, 1998a.127).”

Te Wheke - The Octopus

Te Wheke is another model of Maori health, proposed by Rose Pere. The model symbolises an octopus and again portrays health as being multidimensional in nature. The symbolism extends to the intertwined nature of the tentacles, which depicts the close interrelated and interconnectedness of each dimension. This model encompasses Te Whare Tapa Wha and in addition has four more key components. The additional features are:

5. Mana ake - which refers to the individual uniqueness we all have
6. Mauri - which states the life ethos within all things
7. Ha - which refers to the breath of life and importance of ancestry to Maori.
8. Whatumanawa - which refers to emotions and the importance of expressing ones emotions.

As a model Te Wheke stresses not only the importance of the mind, body, spirit and family to health, but also the significance of the past to the present and ultimately the future. It builds upon the key features of Te Whare Tapa Wha by associating the importance of having knowledge of the past in terms of the present (Ha). The implication is similar to the Hawaiian concept of progression in the depiction of a fish, the central principle being that in order to move progressively into the future one must know the significance of the past, that is a fish can not swim without its tail. (Burns, 1999).

Nga Pou Mana

The Royal Commission on social policy also progressed a model to better portray the multi dimensional nature of Maori health. Nga Pou Mana has four key features that strongly express the external factors that determine health than the first two models discussed. This is related to the primary purpose of this model being to progress supportive social policy

Durie, (1998a). Hence, (1999) have described Nga Pou Mana and the importance

of the four Pou (supportive structures) to well being. These external features are closely aligned to what has become more commonly termed in recent times as the social determinants of health

The four components of Nga Pou Mana are:

1. whanaunatanga - stating the importance of the extended family to well being
2. taonga tuku iho - stating the importance of those treasures both material and non-material handed down from ancestors. (Cultural heritage)
3. te ao turao - stating the importance of protecting and respecting the physical environment
4. turangawaewae - stating the importance of belonging to the land

Durie (1998a) surmises that the model brings together the importance of external factors to health in a way Maori can understand. Similar views about the importance of social determinants have also been progressed by the National Health Committee (1998) in their report on the social, economic and cultural determinants of health.

Summary

In summary the three Maori models of health show that Maori health is:

- more than physical in nature
- multi-dimensional in nature
- determined by both internal and external factors
- closely aligned with current mainstream advances in social, cultural and economic determinants of Health

The implication for assessment of Maori health is that it must take into consideration data pertaining to (1) taha tinana (the physical dimension), (2) taha wairua (the spiritual dimension), (3) taha whanau (the extended family dimension)

and (4) taha hinengaro (the Mental health dimension) (5) mana ake (individual uniqueness), (6) mauri (life ethos), (7) ha (breath and knowledge of Maori ancestry), (8) whatumanawa (emotions) (9) whanaunatanga (the family), (10) taonga tuku iho (cultural heritage), (11) te ao turoa (physical environment), (12) turangawaewae (land base).

MAORI HEALTH DEVELOPMENT

Relevant to discussions pertaining to Maori health definitions are Maori health aspirations in terms of the Maori development paradigm. The concept of Maori development is not a new one. The issue of Maori development in modern times was initiated at the Hui Taumata in 1984. This concept is not dissimilar to Maori self-determination or control over resources, services and other issues pertaining to the self-determined destiny of Maori. However, one issue that differentiates Maori self-determination from Maori development is that the Government has had and can continue to have an active role in implementing and advancing Maori development strategies. In any event a key component of the decade of Maori development in a broad sense was the advancement of Maori health.

Maori health developments have been progressed in the 1990's with increased opportunities for Maori service providers being provided by the Government⁴ Relevant to the concept of Maori health developments is the views of contemporary Maori leaders. Tangihaere (1999) the Chief Executive Officer of Te Runanga o Turanganui a kiwa (Tribal authority) argues that Maori should not be in the business of health service provision, but solely in the position of 'Purchaser' This way Maori can choose providers, monitor performance and regulate provision. This view is supported by Gibson (1999) the Chief Executive Officer of Ngati Porou Hauora (Tribally mandated Health services) who while currently entwined in the development of Health service provision on the East Coast, argues that the logical

⁴ In the 1990's the Governments policy direction for Maori has been to increase the number of Maori providers within the health sector

progression for Maori is control of the total spectrum of health services, from top to bottom. An Iwi summit health held in Wanganui in August 1999, also confirmed the notion of total Maori control, but concluded that control needed to be expanded to cover all sectors, for example, health, education, welfare, economic development (Taumata Hauora, 1999 Iwi summit findings, 1999).

Three common themes exist in terms of Maori health development. Common to all themes is the notion of Maori self-determination.

1. Developing and implementing Maori health services, including work force development.
2. Maori taking control of health resources by performing a purchasing role
3. Developing social policy that encourages Maori health development

However, a significant distinction can be made at this point. It is important not to confuse the issue of Maori development with the goal of Maori health. While the overall goal for Maori development is the development of Maori across all sectors in terms of ownership, control and leadership, the goal for Maori health is to improve Maori health outcomes. While these two goals often coincide, sometimes the political goals of Maori development can appear to over-ride the central goal for Maori health.

SUMMARY

Maori society is constantly changing. Maori live in various realities, some of which bear little resemblance to traditional Maori society. The changing realities of Maori society present a challenge in attempting to define the Maori population. Whatever the approach used to perform this task it is important that it is used consistently, and takes into account the dynamic and changing nature of the Maori population. Consistency in defining Maori will also ensure comparisons to determine changes and trends can be made between sectors. One further challenge for the Government is to align the way it interacts with the Maori population in a way that

responds to the changing realities of Maori society.

An aim of this chapter has been to illustrate the scope and nature of Maori perceptions of health. It can be concluded that Maori have a multidimensional view of health, both in terms of the concept of health and the determinants of health. Maori have also reflected this notion in traditional and contemporary approaches to health. The multidimensional view of health has gained prominence in mainstream New Zealand society with the inception of such enterprises as the practice of health promotion (post 1970's). The National Health Committee have also progressed this perspective of health and its wider determinants, in their report entitled '*The social, cultural and economic determinants of health*', 1998.

The multidimensional views of health by Maori, which are now shared and can be closely aligned to mainstream views of health, would suggest that the assessment of health status and well-being should not be confined to merely traditional health related statistics and data, but should also include an analysis of wider social determinants.

Finally, while the goal of Maori development is an important issue for all Maori, it should not be confused with the goal for Maori health which is to produce better Maori health outcomes. Sometimes the two conflict.

CHAPTER THREE

THE STATE OF MAORI HEALTH AND WELL-BEING

INTRODUCTION

The purpose of this chapter is to discuss Maori health status. But for any such discussion to be meaningful it needs to be approached from a multidimensional perspective. It must look beyond health data and statistics and include an analysis of Maori well being that considers the wider determinants of Maori health. Thus, the chapter begins, by looking objectively at the social, cultural and economic determinants of health. These wider social determinants will be used as a framework for considering the current well being of Maori. Not only do they provide a useful context within which Maori health status can be pictured, but they also make more sense to Maori people as a measure of wellness.

THE SOCIAL CULTURAL AND ECONOMIC DETERMINANTS OF HEALTH.

Obtaining a truly clear picture of Maori health status requires more than an examination of hospital admissions and intervention rates. This section provides support for the assessment of Maori health status from a multidimensional viewpoint that includes several key variables such as employment, education, income, housing, social cohesion and cultural identity).

Like other commentators Potter concludes that:

" Socio-economic status is the single most important determinant of an individuals health, In countries all over the world, people with high socio-economic status are healthier and generally live longer. But there is another dimension to this picture. When we look at the overall health of a whole population, the distribution of income and social status is, in fact, a more important factor than per capita income that a country spends on health care... Other major determinants of health include social support, education, employment and working conditions, physical

environments, biology, health practices and coping skills healthy child development, health services, gender and culture (Potter, 1997. 274)."

The above view has been progressed within mainstream New Zealand, in particular by the National Health Committees and the Ministry of Health⁵. It has also been advanced internationally by the World Health Organisation (WHO⁷). And as discussed in chapter two, a multidimensional perspective of health is also shared by Maori, perhaps best represented in such Maori models of health as, Te Whare Tapa Wha (Durie. 1998), Te Wheke (Pere), Nga Pou Mana (RCSP).

The National Health Committee Report on Social, Cultural and Economic determinants of health.

In June 1998 the National Health Committee published a report on the social, cultural and economic determinants of health in New Zealand. The principal findings of the report were:

- social, cultural and economic factors are the main determinants of health
- there are persisting health inequalities as a result of socio-economic factors in new Zealand and evidence that some may be worsening
- current trends in many socio-economic factors in New Zealand are likely to widen health inequalities further
- there are good reasons for intervening to reduce socio-economic inequalities in health
- there are evidence-based interventions for reducing health inequalities

The National Health Committee (1998) identified the following seven factors as being determinant of health status in New Zealand: income, employment,

⁵ Has the legislative function of advising the Minister of Health on the kinds and relative priorities of personal health, disability support and public health services that should, in the committees opinion, be publicly funded

⁶ Chief policy advisor to government on issues pertaining to health

education, housing, culture and ethnicity, population-based services and facilities and social cohesion. They concluded that ultimately, the ability:

" ... to deliver effective and high quality services in an equitable way is highly dependent on addressing adequately the social, cultural and economic context in which ill health and disability arise (National Health Committee, 1998. 3)."

Summary

The findings of National Health Committee (1998) suggest that any accurate review of Maori health status must look beyond just health statistics and include an assessment of Maori well-being that encompasses an analysis of data pertaining to the social, cultural and economic status of Maori. This multidimensional analysis in turn gives perspective to Maori health status.

MAORI WELL-BEING - A MULTIDIMENSIONAL SNAPSHOT

A multidimensional snapshot of Maori well being is important because the way we perceive Maori health issues is critical in developing and shaping effective solutions.

To determine the well being of Maori a number of reports have been consistently referred to in this section:

1. National Health Committee - *The social, cultural, and economic determinants of health in New Zealand*, 1998
2. Ministry of Health - *Progress on Health outcomes*, 1998
1. Ministry of Health - *Taking the pulse*, 1998
2. Ministry of Health - *Child Health Review*, 1998
5. Ngai Tahu Maori Health Research Unit - *Does it really have to be this way?*, 1999
6. Te Puni Kokiri - *Progress towards closing the gaps between Maori and Non-*

7 Set up after WWII to encourage, foster and maintain world peace

Maori, 1998

7. Ministry of Health - *NZ food, NZ people*, 1999

It is well documented that Maori health in comparison to non-Maori (in some instances on a world-wide scale) is poor. (Pomare, 1995. Durie, 1998. Love, 1998. Broughton, 1999). The status of Maori health has been the topic of many reports (see above) and is the result of poor performance by Maori across a number of interconnected sectors. Spoonley (1990) made a pertinent observation with regards the risks of being Maori in New Zealand when he stated that:

"If working in a lower class job, being poorer and less educated already significantly increases the risk of death, the social consequences of being Maori adds further to that risk (Spoonley, 1990. 149)."

Maori Educational Status.

Maori have historically been poor achievers in terms of the mainstream educational performance indicators, such as, participation in the education sector, levels of forced non-participation in the education sector, retention and academic achievement within the education sector. Overall the performance of Maori in education has improved. However, Maori still do not perform (attaining qualifications) or participate (enrolment) to the same level of non-Maori.

Education is an important issue in determining well being, because it is directly linked to income and employment, both central to determining health (Potter, 1995). Without a good education and the acquisition of academic or other recognised qualifications the opportunity for employment and getting well paid jobs is almost impossible. Wadsworth (1997) states that,

"Educational attainment is strongly related to subsequent occupation and income level, and poor social consequences in early life are associated with significant

chances of low education achievement (as cited in National Health Committee, 1998. 28).“

Participation and Retention

Compared to non-Maori, Maori are less likely to:

- participate in early childhood education
- progress into senior secondary school classes
- undertake formal tertiary training
- participate in university programmes

Since 1992 Maori enrolment in early childhood education has increased by 26.1%. Tertiary enrolments have increased by 29.8% (In 1997, some 195,193 Maori were formally enrolled in formal education programmes compared to 168,718 in 1992). However while numerically participation has increased, so too have levels of disparity between Maori and non-Maori. Non-Maori participation has increased at a greater rate. Within the early childhood sector between 1991 and 1997 non-Maori were twice as likely to participate as Maori. The disparity in terms of participation in formal education has almost doubled, non-participation ensures low academic achievements of Maori will be maintained, thus leading to low incomes and unemployment.

Both suspension and expulsion of Maori have doubled, from 1694 in 1992 to 4772 in 1997. The most concerning observation is that while Maori represent only 19.8% of those students participating within New Zealand schools, they accounted for 41.7% of all students who were suspended or expelled in 1997 (see table 4).

Maori participation in formal school examinations is low. Maori are both less likely to participate at senior secondary school levels (6th and 7th form) and less likely to be involved in formal examination at this level (see table 5). In terms of student retention at secondary school Maori students on average still stay for shorter

periods (4.1 years) than non-Maori (4.5 years).

Table 4: Number of Maori and non-Maori suspensions and expulsions (1992 - 1997)

Year	Maori	Non-Maori	Percentage of Maori in total school population	Maori percentage of all suspensions and expulsions
1992	1,694	3,388	19.6	33.3
1993	2,352	3,930	20.1	37.4
1994	3,059	4,432	20.3	40.8
1995	3,516	5,334	20.2	39.7
1996	3,932	5,874	19.8	40.1
1997	4,772	6,682	19.8	41.7
% growth 1992 - 1997	182%	97%		

(Source: Ministry of Education as cited in Te Puni Kokiri, 1998)

Table 5: Percentage of Maori and non-Maori students assessed in formal school qualifications.

Formal Examination	Maori	Non-Maori	Disparity
School Certificate	64.0	92.3	28.3
Sixth form Certificate	37.9	74.4	36.5
UE/Bursary/Scholarship	24.1	58.3	34.2

(Source: Ministry Of Education as cited in Te Puni Kokiri, 1998)

Maori participation at tertiary level has increased from 18,200 in 1992 to 23,617 in 1997; however, there remains a considerable disparity in representation of Maori at this level. In 1997 while there were five times more Maori involved in 'Training Opportunities Programmes (TOPs)' than non-Maori, Maori representation at University was only two thirds the number of non-Maori participation at this level. In 1997 however, Maori participation in polytechnic courses and teachers training was very similar to that of non-Maori.

In summary while Maori participation in formal education is improving, particularly at early childhood and tertiary levels, the disparity between non-Maori and Maori participation at all levels remains the same or has increased in size.

Educational Achievement.

The most significant indicator in terms of achievements at an early childhood and primary school level is participation; however, at a secondary and tertiary level of education, the number of people achieving a certain formal national qualification best determines achievement.

Literacy skills are critical for effectively coping in our society. Over 60% of Maori, Pacific people and members of other minority groups are functioning below the level of literacy required to effectively meet the demands of everyday life. (National Health Committee, 1998).

At the secondary school level Maori success in achieving a sixth or seventh form qualification has trebled in percentage from 14.4% in 1977 to 40.2% in 1997. However, two factors in particular put this positive result into context (in terms of the historical poor academic achievements of Maori), first, the disparity between Maori and non-Maori remains constant and, second, since 1992 the proportion of Maori leaving school without a qualification remains the same.

Since 1990 the growth of Maori University graduates has increased from 409 new graduates to 1571 new graduates in 1996. Compared to non-Maori growth in this area Maori growth can be considered slow, as Maori make up only 7.7% of total graduates (1996). Interestingly, Maori are more likely to graduate from the social sciences and law than non-Maori, who are more likely to graduate from the natural and applied sciences, business, commerce, health and medicine.

Summary

While Maori are achieving at a much higher rate than ever before the disparity between Maori and non-Maori (in terms of educational attainment) remains. Maori are under represented in certain fields of study, specifically, the physical and applied sciences business, health and medicine. Low educational attainment, is directly associated to employment and income levels, both of which are key determinants of health. Thus, if Maori health status is to improve, Maori must do better within the educational sector. At present they struggle to compete for highly paid employment.

The Socio-economic status of Maori

Employment status and Income have a major bearing on the social and economic well being of Maori families. Again both issues are key determinants of health status. The lower levels of labour force participation, and under representation in higher paying occupations coupled with higher rates of unemployment have significantly contributed to disparities between Maori and non-Maori economic status (Te Puni Kokiri, 1998.17).

Two specific indicators reflect economic status. Namely, the level of employment participation, and income levels.

Employment

The relative low level of academic achievement by Maori and the disproportionately high younger population of Maori both have had an effect on

Maori employment status, which has been considered to be the main factor in determining adequate income (Dept of Statistics, 1991).

With regards the participation of Maori in paid employment, the changes in economic conditions during the 1980's in New Zealand saw Maori unemployment levels grow rapidly. In 1992, 27.3% of Maori were unemployed, this figure being more than three times the rate of non-Maori. Maori youth (15 - 19 yrs) are twice as likely to be unemployed than non-Maori youth.

However, with the more favourable economic conditions of the early 1990's some 150,000 new people were employed, 20,000 of these being Maori. But, this has not been sustained. The Maori unemployment figures have again increased to 18.3%. (1996) compared to around 5% for non-Maori.

The disparity between Maori and non-Maori with regard to employment status remains constant and again continues to grow, a crucial factor determining the status of Maori health.

Income

It is not surprising that, given the low level of Maori academic achievement and resulting low level of Maori participation in the workforce that disparity in income with non-Maori continue to grow. The National Health Committee reported in 1997 that,

"Income is the single most important determinant of health. There is a persistent correlation world wide between low income and poor health (National Health Committee, 1997.23)."

Between 1987 and 1997 the average Maori household income rose from \$26000 to \$37000 (an increase of 40%). Non-Maori income increased by 48%. However

in dollar terms the disparity has widened. In 1987, the non-Maori average income was \$5500 higher than for Maori. However, in 1999 this has increased to \$10,000.

In 1997, only 11.95% of Maori earn more than \$68,200 compared to 20.9% of non-Maori and Maori are over represented in lower income groups. (Earning less than \$28k per annum). Although hard to measure, Maori self-employment (i.e. business ownership) has doubled between 1981 and 1996, from 5.4% to 9.9%.

With regards the source of Maori income, in 1996, 36.3% relied on government provided benefits compared to 14.3% of non-Maori. For those Maori in paid employment, the majority of revenue comes from salaries and wages, as opposed to sources such as investments.

Summary

While Maori income levels have increased, the disparity in income between Maori and non-Maori has widened. Maori continue to rely heavily on Government provided benefits. Lower incomes are the result of non-participation in the workforce, which in part is also related to the low educational attainment of Maori, which in turn reduces their ability to compete for jobs. Income is considered the most significant determinant of health status, because it is directly related to lifestyle choices, access to health services, housing and educational and learning opportunities.

Housing

Good housing is important for health. Good housing conditions prevent disease and illness. Good housing also provides positive environments for learning and improves self-esteem. The National Health Committee reports that:

"Housing tenure is linked directly to cardiovascular and all-cause mortality, with people in rented accommodation having higher death rates than owner-occupiers,

even after other socio-economic variables are considered. In some area the health impact of poor quality housing is combined with neighbourhood problems such as substandard community services, high levels of unemployment, inadequate public transport and recreational facilities, environmental hazards and violence (1998.30)."

An interesting observation pertaining to poor housing and its impact on health can be made when considering the small religious settlement of Ratana, located east of Wanganui. In a needs assessment of the total population (n=700), it was found that housing in this area was poor and few houses had been maintained over the past decade. Houses had therefore become characteristically damp and dusty. The findings showed that the incidence of asthma and other respiratory disease was extremely high compared to other Wanganui settlements. Good Health Wanganui hospital admission data showed 1251 admissions for the period 1997 - 1998, domiciled back to the Ratana locality. On average almost one admission per person per year. The Ratana population is almost totally Maori. To worsen matters there is one car for every ten people living at Ratana (Gardiner, 1999).

In 1996, 50% of Maori as opposed to 72% of non-Maori owned their own home. In terms of home ownership with a mortgage the 1996 census figure shows the gap between Maori and non-Maori is decreasing. However, this is more a reflection of non-Maori freehold ownership decreasing. The disparity continues to grow with regard to freehold ownership (i.e. ownership without a mortgage). This is due to Maori freehold home ownership remaining constant while non-Maori ownership continues to grow. In 1996, 46.4% of Maori were in rental dwellings as opposed to 25.9% of non-Maori. The gap in this area remains constant also.

Summary

In relationship to home ownership and living in rental accommodation the disparity between Maori and non-Maori continues to grow. Maori continue to be less likely

to own their own home and more likely to be in rental accommodation. Both issues are considered significant in terms morbidity and mortality, as poor housing has been shown to have a direct correlation, to income, environment, services, transport and ultimately health and well-being.

Cultural Identity

While the significance of a strong cultural identity to health status is still to be determined (National Health Committee, 1998), the over representation of some ethnic groups in low socio-economic surroundings suggests culture has some correlation to health outcomes. Pomare identified the significance of cultural practices to health in his role as the first Maori medical officer of health in the early 1900's. He advocated against the traditional cultural practices of Tohunga, which he believed were directly detrimental to Maori health and well being.

In recent times a longitudinal research project - entitled Te Hoe Nuku Roa - is being undertaken by the School of Maori studies at Massey University. This study is partially an attempt to better understand the diverse realities Maori experience and to determine how cultural identity relates to well-being. More specifically cultural Identity refers to, self identification, knowledge of whakapapa, participation in customary social and cultural centres, involvement with whanau, access to ancestral lands, use of the Maori language and interaction with other Maori (Durie, 1998b. 58).

While the study is still progressing Durie (1998b) notes from early findings,

"What is suggestive, however, is that a secure identity may have advantages beyond cultural affirmation. It may for example afford some protection against poor health (in that) it is more likely to be associated with active educational participation, and with positive employment profiles (p. 59)"

The results of the study so far show that (analysis of 200 participants of 700):

- 35% have a secure identity
- 53% a positive identity
- 6% a notional identity
- 6% a compromised identity

Summary

Other than the above information generated from Te Hoe Nuku Roa, limited data exists in terms of determining the cultural identity status of Maori and the impact of culture on health. Early suggestions are however, that culture, cultural identity and cultural practices can impact on health and well being. To what level of significance this occurs is yet to be determined. Early indications are that cultural identity has an interconnected relationship with health outcomes.

Summarising Maori Well-being

The Well-being of Maori has been analysed against social, cultural and economic factors. The analysis shows that disparities continue to exist between Maori and non-Maori in New Zealand. In some instances they continue to grow. For example, Maori are more lowly educated, are more likely to be unemployed, earn low incomes and are less likely to own their own homes than non-Maori. The poor performance of Maori in education and employment has resulted in low incomes and poor housing conditions. Research shows that these factors are significant determinants of health status. Therefore strategies to improve health status can not just focus on improving the ability of hospitals to deal with illness and disease, they must be multi-dimensional, cut across sectors and have a common preventative element.

MAORI HEALTH STATUS

Pomare (1995) found that since 1860 Maori health status has historically been very poor in comparison to non-Maori. A number of recent reports confirm the

trend. For example, National Health Committee - *The social, cultural, and economic determinants of health in New Zealand*, 1998; Ministry of Health - *Progress on Health outcomes*, 1998; Ministry of Health - *Taking the pulse*, 1998; Ngai Tahu Maori Health Research Unit - *Does it really have to be this way*, 1999; Te Puni Kokiri - *Progress towards closing the gaps between Maori and non-Maori*, 1998; Ministry of Health - *NZ food, NZ people*, 1999.

Key indicators that can be used to determine health status, are longevity (length of life), mortality (death rates) and morbidity (illness rates). Hospital admission data, disease registers and mortality data are the most common source of health specific information Pomare (1995). One issue that clouds analysis of changes in Maori health status, has been the change in the way data pertaining to this matter is formally collected (Durie, 1998. Pomare, 1995. Te Puni Kokiri, 1998. Statistics NZ, 1999), given the various approaches to defining Maori. This issue has already been discussed in the previous chapter.

Longevity

Durie, (1998), Pomare (1995), Te Puni Kokiri (1998), National Health Committee (1998) all report that the gap in longevity between Maori and non-Maori closed significantly between 1950 and 1990. During this time life expectancy for Maori males increased by 14 years and Maori females by 17 years. The largest contributing factor to improvements in longevity is the decline in Maori infant mortality. However in terms of longevity, the disparity between Maori and non-Maori remains, for example a new born non-Maori male has a life expectancy 5.4 years longer than the Maori male, and the non-Maori female baby has a life expectancy 6.2 years greater than the Maori female.

While there has been significant improvements in Maori life expectancy, the gap persists in comparison to non-Maori. The lack of movement in this area by Maori since 1990 and continued improvements in non-Maori amplify this. Thus the gap

in longevity again begins to widen.

Hospitalisation Rates of Maori

Because there has been a change in the way Maori data has been collected, data from 1995 and onwards is not directly comparable with data collected prior to this date. Even so, analysis of data with this in mind still shows that the Maori are far more likely to be hospitalised than non-Maori. The disparity between 1987 and 1997 has increased four folds. In 1997 37,689 (per 100,000) Maori, were hospitalised, compared to 16,179 (per 100,000) non-Maori.

Maori Child Health Status (0 - 14)

In terms of sudden infant death syndrome (SIDS) Maori rates continue to be higher than non-Maori. In 1994 the Maori rate was 5 times higher than the non-Maori rate, that is, 6.9 (per 1000) Maori compared to 1.4 (per 1000) non-Maori died from cot death.

Since 1993 Maori rates for hospitalisation have decreased, however, the Maori rate remains far greater than for non-Maori. Glue ear is particularly damaging to the life chances of children because it effects their ability to hear and if not detected early on, results in an inability to participate effectively within formal learning environment, which in turn effects educational attainment and ultimately results in poor life chances. Dickson (1999) states that poor hearing at childhood is a characteristic of many prison inmates.

Maori children are more frequently hospitalised for asthma than non-Maori. In 1994 the figure for Maori was approximately 500 (per 100,000) as opposed to 200 (per 100,00) for non-Maori.

Some general observations are that Maori infant deaths are twice that for non-Maori. Maori infants are at greater risk of death from most major causes of death. For example, Maori are 83% more likely to die before the age of 15 than non-Maori

(Ministry of Health, 1998).

Maori Youth (14 - 25)

Disparities also exist between Maori youth and non-Maori youth. For example the disparity (between Maori and non-Maori) continues to widen in terms of Maori youth pregnancies. Maori youth are also more likely to, commit suicide be hospitalised for mental health disorders, and for self-injury or injury obtained as the result of motor vehicle accidents (Broughton, 1999). A further alarming point is that although the rates for suicide are similar, the Maori rate is increasing more sharply than non-Maori.

Maori Adults (25 years plus)

Maori are more likely to die from cancer. While the non-Maori rate is stable, the Maori rate continues to grow, hence the gap between Maori and non-Maori widens. Maori are also more likely to be hospitalised for diabetes, stroke, pneumonia, and influenza than non-Maori. Maori adults are also over-represented in mental health admissions to hospital (Ministry of Health, 1998).

1999 National Health Survey of New Zealand

The Ministry of Health has presented the most recent health self-assessment of New Zealanders and Maori - in a report entitled '*Taking the pulse*', (1999). The report details the findings of the national health survey undertaken by the Ministry of Health (as part of their population health monitoring function). The survey was aimed at determining association with health-related risk factors, utilisation of health services and health status (Ministry of Health. 1999).

The findings of the report pertaining to Maori were,

Health related risk factors - those factors related to poor health;

- Maori were more likely to smoke than non-Maori. (Around half of the Maori adults surveyed reported to be smokers)
- Maori were more likely to have high blood pressure
- Maori, younger people and men and those in a lower socioeconomic group were most likely to have drinking patterns that put them at risk of future physical or mental negative effects of alcohol.
- Maori adults were most likely to indicate hazardous patterns of drinking i.e. to drink five or more drinks on a typical day drinking and to drink six or more drinks at least once a week.

Health Status

- Maori and Pacific Island people were twice as likely to be diagnosed with diabetes
- Women and Maori were more likely to fulfil the criteria for probable asthma
 - European/pakeha and Maori reported higher rates of injury than Pacific people.
- European/pakeha rated their health higher than non-Maori

Health Service utilisation (previous twelve months)

- Maori and low income families were more likely to have visited the GP six or more times
- Rates of hospital admission did not differ across ethnicity
- European/Pakeha were more likely to have visited health professionals covered in the survey.

What is interesting about the findings is that they do not in all instances line up with information derived from such sources as New Zealand hospital data and disease registers. This would suggest that Maori in some instances have a better perception of their health status than the statistics would suggest and may be the result of poor health experience being seen as normal and becoming more

accepted, than by non-Maori.

However, although the responses do not totally match statistical findings, what is clear is that, there is high Maori representation of at risk behaviours, Maori have an interesting perception of their health status and a high utilisation rate of health services.

Injury to Maori

A recent report prepared by John Broughton (1999) on injury to Maori showed that injury to Maori is a major concern. Maori suffer from more injury-related accidents and fatalities than non-Maori.

Broughton (1999) reports that, for Maori in the 5 - 14 year old age group, 26% of all hospital admissions are due to injury. For Maori in the 1 - 4 year age group, 59% of all deaths are a result of an injury. For Maori in the 5 - 14 year age group 56% of all deaths is the result of an injury. 78% of Maori in the 15 - 24 year's age group dies as a result of an injury (26% of which is the result of self inflicted injuries). Motor vehicle accidents are the major cause of death. 61% of all Maori deaths in 15 - 24 year age group are the result of a motor vehicle crash.

Maori Mental Health

The Mason Report (1996), concluded that "In terms of poor mental health Maori now face an appalling situation (Mason, 1996.137)." Mental health is considered by many to be the number one health issue facing Maori today. Maori mental health admissions are now two to three times that of non-Maori. Readmission rates are estimated to be 40% higher than non-Maori (Kingi, 1998).

"Current evidence also suggests that Maori tend to access mental health services at a later stage than non-Maori. This implies that treatment will often be sought at an acute stage of illness, requiring ongoing, and often expensive, treatment. The

resulting health outcomes are therefore likely to be less effective and may in part explain high rates of admission (Kingi, 1998. 11)".

Another recent report pertaining to the health status of Maori is the Health Funding Authorities 'Kia Tu Kia Puawai', which presents to some degree, the risk of Maori to developing serious mental health disorders. While the report does not present actual rates, it confirms earlier arguments in this chapter relating to multiple determinants of health, by clearly stating that the presence of certain factors contribute to mental health disorders.

The report states that in terms of mental disorder Maori children have a number of identifiable risks. Child abuse, early substance abuse and educational underachievement as well as suicide are a real concern for Rangatahi along with alcohol and drug abuse. (Confirmed by Broughton, 1999) Maori are more likely to rate their mental health status as poorer than non-Maori (particularly Maori women). Maori do not access services early enough and are disadvantaged by co-existing drug and alcohol disorders with mental illness. (Health Funding Authority, 1999).

One apparent statistical observation is that for Maori adults, Maori mental health admissions in 1993 are twice that for non-Maori (see table 6).

Table 6: Maori and non-Maori mental health admissions (per 100,000)

	1960	1990	1991	1992	1993
Maori	88	205	185	203	191
Non - Maori	119	127	107	109	104

(Source: Te Puni Kokiri, 1998)

Progress on Health Outcomes

The Ministry of Health has been tasked with progressing the monitoring of Health Outcome targets, set by the now defunct Public Health Commission in 1996. One of the key target areas is improving the health of Maori across five broad categories, social and physical environment, health of children, health of young people, health of adults, health of older peoples. The public health goal for Maori is:

“To improve, promote and protect Maori health status, so that in the future Maori will the opportunity to enjoy at least the same level of health as non-Maori. The objectives are: (1) To ensure that services funded are appropriate and compatible with gains in Maori health (2) To show and understanding of and commitment to the Treaty of Waitangi (Ministry of Health, 1998. 62).”

The 1998 progress report on health outcomes prepared by the Ministry of Health show that for most issues that are monitored a trend cannot be established either way. However, for tobacco consumption, drowning, road traffic injuries, ischaemic heart disease, cervical cancer and influenza the trend is positive (see table 7). Some trends identified in table 7 were not assessable because data was not available or comparable.

Interestingly, where there has been no progress on Maori targets, the Ministry of Health (1998) has attributed this in part to ineffective interventions and macro-economic performance, thus confirming the role social determinants play in determining health status. Those aside, perhaps the most significant point in terms of the Ministry of Health in its monitoring of the health outcomes of Maori, are the apparent limitations in developing practical measures. It continues to struggle in its attempts to develop and progress an effective mechanism for measuring Maori health.

Table 7: Trends in Health goals and objectives, Maori population, over the past five years for which comparable data is available

Goal	Objective			
	Tracking toward health	Static	Tracking away from health	Trend not assessable.
Social and Physical Environment		Breast feeding Hazardous substances (poisonings)		Foods and nutrients obesity Physical activity Oral health
Health of children	Tobacco consumption Drowning	SIDS Burns Hearing loss		Immunisation Child abuse
Health of young people	road traffic injuries	Alcohol consumption		STD's (except AIDS) Cannabis consumption Youth suicide
Health of adults	Ischaemic heart disease Cervical screening	Rheumatic fever		Stroke Breast cancer Diabetes
Health of older people	Influenza			Falls

(Source: Ministry of Health, 1998. 62)

Summary

The information derived from recently released health reports clearly show that the health of Maori is poor and on most counts worse than for non-Maori living in New Zealand. Maori are more likely to be hospitalised, die younger and suffer from

such illnesses as diabetes and asthma, than non-Maori. Maori also are more likely to smoke, display patterns of alcohol use that is likely to lead to poor health results, and die from accidental and self inflicted injury. They also have serious mental health issues unparalleled among non-Maori.

While these findings are not unexpected, given the preceding analysis of well being, they are alarming. They suggest that Maori live shorter lives than non-Maori and these lives are more likely to be associated with disease, illness, injury and admission to hospitals and other health services.

SUMMARY

Health is determined by more than physical determinants. Social, cultural and economic conditions are major determinants of health. The aim of this chapter has been to illustrate the status of Maori health. The findings are that Maori have high levels of health need. Furthermore the disparity between Maori and non-Maori Health status remains constant or continues to grow.

An analysis of Maori well being shows that Maori are by far worse off than non-Maori. While there have been improvements in Maori well-being, the disparity with non-Maori remains constant or continues to grow. Maori continue to be lowly educated, are more likely to be unemployed and earn low incomes and are less likely to own their own homes. The poor performance of Maori in education and employment has resulted in low incomes and poor housing conditions. Research shows that these factors are significant determinants of health status. In light of research that strongly suggests the association between the wider social factors and health, the prospect for Maori health to improve without multifaceted interventions are minor.

What this chapter has demonstrated is that, Maori health remains poor and the

health needs of Maori are far greater than non-Maori. This is significantly impacted upon by the poor performance of Maori in indicators of well being, such as, employment, education, income and housing and the high level of risk behaviour by Maori. Strategies to improve Maori health cannot solely focus on health services, they must be multi-dimensional and operate across all sectors.

CHAPTER FOUR

MAORI EXPECTATIONS OF GOOD HEALTH

INTRODUCTION

The previous chapter concluded that Maori have a multitude of health needs. It also showed that the disparity between Maori and non-Maori standards of health in most areas either continues to grow or remains constant. As a result Maori are over represented on most measures of poor health. The relationship between Maori well-being and Maori health status suggest that the opportunity for Maori health to positively progress will remain minimal, unless strategies to improve health are effective in addressing the adverse social, cultural and economic determinants of health.

The primary purpose of this chapter is to overview the guarantees and rights of Maori to good health. Several rights based documents identify the rights of indigenous people and people in general. Some of these documents either clearly state or infer the right of people to good health and a certain standard of well being. For example, the 1840 Treaty of Waitangi, 1948 Universal declaration of human rights, 1978 Alma Ata, 1989.the International Labour Organisation convention No 169, 1993 Human Rights Act, and the 1993 Draft Declaration on the Rights of Indigenous People all have implications for health.

Central to demonstrating the guarantees and expectations of Maori to good health will be the task of showing the relevance of the Treaty of Waitangi to health. While the Treaty is not necessarily seen as a rights based document, from its principles and provisions some basic rights can be deduced in the form of guarantees and expectations. Furthermore taking into account the spirit of the Treaty, guidelines for progressing Maori health can be developed.

THE TREATY OF WAITANGI AND HEALTH

A convenient starting point for considering a rights based approach to Maori health

is with the Treaty of Waitangi. Many people (including Maori) see the Treaty as the primary source of their rights to good health. While the Treaty has not historically been considered a rights based document for health, it can provide guidance in terms of the application of rights for good health. In the past the 1840 Treaty of Waitangi has mostly provided guidance in the settlement of Maori grievances pertaining to land and physical resources, but as the Royal Commission on Social policy has demonstrated its principles are highly relevant to social policy and to health (Durie, 1994).

'How' and 'Why' the Treaty of Waitangi is associated with health can be understood by considering the principles of the Treaty and to a lesser extent, the historical contraventions of the state towards the Treaty.

Reasons for the Treaty of Waitangi

The most significant evidence to suggest that the Treaty should be considered relevant to social policy (including health), and not just land and other physical properties can be found within the reasons for the development of the Treaty, at least from British perspectives. First, the need for a more systematic and controlled colonisation process (including the protection of already settled British citizens in New Zealand) through the establishment of government (law and order) was deemed unimportant by Britain. Second, the threat of annexation by non-British powers was a challenge to the British Crown. Third, the humanitarian ethic had emerged in Britain and there was a germ of concern about the plight of indigenous peoples in lands colonised by Britain.

While external threats of annexation are hard to prove as a motivating factor, it had earlier been a significant motivation for the 1835 Declaration of Independence. There was speculation that both the French, and the Americans (with increase American whalers in New Zealand and the appointment of James Cledon as the consul to the Bay of Islands) posed threats to Maori sovereignty and challenges

to British pretensions to New Zealand (Orange, 1988).

Private colonisation schemes such as that proposed by the New Zealand Association (1837) were used to rationalise Colonial intervention. The New Zealand Company had failed to come to an agreement with the British Parliament and hastily left for New Zealand with the liberal notion of buying land cheaply and selling it for lucrative profits. The missionaries in New Zealand opposed these schemes and made their opposition known to their political contacts in Britain.

A third justification for the Treaty was from a humanitarian viewpoint. Maori were suffering from haphazard British settlement, the influx of disease and the implication of new lifestyles, and were seen as unable to effectively establish a central government that would intervene with any effectiveness in dealing with the modern issues. This view (i.e. the inability to establish central government by Maori) was largely based upon the political divisions into tribes and the lack of a confederating capacity (Orange, 1998).

With colonisation came infectious disease, land alienation, the introduction of arms, and political oppression. It was to quickly undermine traditional Maori public health systems. Even before the Treaty was signed, the Maori population had reduced by a quarter and in 1837 Busby reported to the colonial office that without British intervention Maori would surely perish. Houghton (1980) describes the dire situation of Maori when making the following observation:

"Apparently, the Maori had not suffered from such ailments as measles, rubella, chicken pox, influenza, and scarlet fever. The absence of these contagious diseases meant that Maori had no immunity to them. (Houghton, 1980.146)."

The authorities in Britain believed they could only provide meaningful protection for Maori, by formally annexing New Zealand and introducing British rule. Of

course, British motivation for formal intervention was not confined to concern for Maori health; it was also based on economic interests, a need to expand in order to sustain a growing home population, and New Zealand's strategic location (Durie, 1998a).

Orange (1988) states that:

"All parties that shared an interest in New Zealand in 1838 shared the conviction that British intervention was both necessary and desirable. Opinion differed only on the extent of that intervention and the role the Maori people should play. It was now a question of whose interests should come first - British or Maori (P.26)."

Summary

Among the reasons for the Treaty of Waitangi was a concern for Maori health based on fashionable humanitarian principles and goals. While not the primary reason for British intervention, it is widely supposed that the health and well being of Maori was nevertheless an important motivator leading to formal British intervention. The Treaty was developed in part to 'protect' Maori interests, from the negative impact of colonisation, external threats and illness and disease. The British Crown felt that they could not address these issues without formal intervention, and annexation.

What can therefore be concluded is that the Treaty was intended to encompass Maori social well being. Furthermore article three of the Treaty extends to Maori the right to enjoy the benefits of society, and to expect some equity of outcome.

The texts of the Treaty and the derived principles

The most significant association of the Treaty of Waitangi to health stems from within its articles, and subsequent principles and provisions that have been derived in more recent times.

The two texts of the Treaty of Waitangi

Within article one the key differences between the English and Maori texts is the Maori translation of sovereignty. In article one of the English version, sovereignty (i.e. total power and control) is ceded to the Crown. However, the Maori version is less comprehensive in terms of ceding power and instead 'gives' the Crown the right to establish government (Kawangatanga katoa). Durie (1998) argues that a closer translation for the word 'sovereignty' might have been Kingitanga or te mana, given they had appeared in an earlier translation of the word sovereignty in the 1835 Declaration of Independence. The key issue therefore, is whether sovereignty or the right to govern was ceded/given to the Crown.

In article two further discrepancies exist. The Maori version is broader in implication. Within the English version Maori sovereignty (guaranteed control) is acknowledged over tribal physical resources, while the Crown receives the right of pre-emption i.e. exclusive right of purchase of Maori lands. The Maori version however is more expansive guaranteeing Maori 'tino rangatiratanga' (absolute control) over 'taonga katoa', (cultural, social as well as material properties, even good health and welfare perhaps). The most significant question is whether the Maori translation of 'taonga katoa' includes the good health of Maori. If it did then the Crown would have a clear obligation to actively protect Maori health.

Article three however, is more obviously linked to health. The English version stated:

"In consideration thereof, her Majesty the queen of England extends to the natives of New Zealand her royal protection, and imparts to them all the rights and privileges of British citizens."

The English translation of the Maori version states:

"This (the third clause) is in consideration of the acknowledgements of the Queens

governance. The Queen of England will protect all the Maori people of New Zealand. They will be given all the rights equal to those of the people of England.”

Durie (1998) explains that "Article three of the Treaty of Waitangi, has more obvious and direct implications for Maori health ... By promising all rights and privileges of British subjects Maori individuals acquired new citizenship rights (It was as much about equity as citizenship. Its significance for health is particularly evident in light of continuing disparities in standards of health between Maori and non-Maori (1998.83).”

Article three therefore is of critical significance to health and well being. Maori have a right to the same levels of health as other citizens of New Zealand. It is the role of the Crown to ensure and protect these rights.

Linking the Treaty of Waitangi to Health

As a result of the discrepancies that exist in the translation of the Treaty of Waitangi, and to associate practical guidelines with the Treaty for future action, Treaty principles have been derived from its articles.

Perhaps the most useful in terms the Treaty of Waitangi and health are those principles derived by the Royal Commission of Social Policy in 1988 and the ‘provisions’ derived by Durie (1998a). Combined, these principles and provisions reflect the Treaty’s implications for Maori Health, and provide some guidance for future health action including progression of Maori ‘rights’ to good health (see table 8).

Table eight clearly shows how the spirit of the Treaty has relevance with health.

The principles and provisions also provide guidance in terms of advancing the rights of Maori to good health.

Table 8: Treaty principles / provisions and health

Provision / Principle	Implication for Health
Kawanatanga (Article one)	This represents the right of the Crown to govern and legislate and ensures the adequate provision of services for all. It also applies to government departments and the way in which policies are formulated.
Tino Rangatiratanga (Article two)	The right of Maori to control their resources and self-determine their own destiny. Maori have the right to shape and provide health services.
Oritetanga (Article three)	The guarantee of equality and equity with other new Zealand citizens. Maori therefore have the right to experience similar health outcomes to non-Maori.
Partnerships (RCSP)	The notion that the government has an obligation to work together with Maori to advance health and well being. i.e. to equally share power and decision making in this area
Protection (RCSP)	The obligation of the Crown to actively protect Maori interests (including protection against adverse determinants of health) i.e. proactive measures to promote health and prevent illness.
Participation (RCSP)	In relation to health this principle accords Maori the right to participate at all levels of the health sector. From policy making to provision.

Based on the principles and provisions the following processes are suggested for advancing the health of Maori:

1. any advancement in Maori health by the Crown should be performed in partnership with Maori
2. any strategies developed for the advancement of Maori health must aim to protect the interests of Maori
3. any advancement of Maori health developed by the Crown should have active Maori representation at all levels
4. the advancement of Maori health must be supported by good governance

- practices and the implementation of supportive legislation and social policy
5. in the advancement of Maori health, Maori have the right to self determine necessary strategies and interventions for progress, that are within the law
 6. any advancement of Maori health should aim at the very least to ensure Maori have equal health status and well being with non-Maori.

Historical Treaty contravention's

One further issue that relates the Treaty to health albeit indirectly stems from those events initiated by the Crown after the Treaty was signed that contravene its intent, both in terms of Lord Normanby's instructions and Maori expectations. Again while this does not directly associate the Treaty to health, the contravening events post 1840, suggest the Crown has a moral obligation to right past wrongs, given the Treaty was developed to protect Maori interests, not undermine them by creating adverse conditions pertaining to Maori health status.

Historical Attitude of the Crown

Despite the Treaty of Waitangi and its intentions, history shows that until recently there was a complete disregard of the Treaty by the State. Three features characterised the intervention of the British post 1840: assimilation of Maori, alienation of land and increased British settlement. Historically there has been a range of Government policies and legislation achieved those goals, all of which have either directly or indirectly contravened the Treaty of Waitangi. Some attention is given here to selected examples.

Expanding British settlement and the alienation of land

In 1862 the Native Lands Act destroyed Maori communal ownership of land. A land Court was established to individualise titles, Maori were also now able to sell to anyone. It was a response by the State to the fact that while Maori land was collectively owned it was difficult to alienate. The New Zealand Settlements Act and The Suppression of Rebellion Act, allowed for the confiscation of Maori land

as a measure to deal with rebellion, or defiance towards the Crown. Some three million acres of Maori land was confiscated (Walker 1990). By 1975 Maori owned a mere 3 000 000 acres of land in New Zealand. Orange (1998) argues,

“The New Zealand Settlements Act did grievous damage to Maori -Pakeha relations for it left the Maori people with a deeply felt sense of injustice that still rankles (p.167).”

This type of legislation was preceded and proceeded by a variety of laws designed to alienate Maori land. (1894 Maori Land settlement Act, 1894 Validation of invalid Land sales Act, 1864 Native reserves Act, 1865 Native Land court). Ultimately, the alienation of land from Maori while in direct violation of the Treaty has left Maori without an economic base, which is seen as the single most important determinant of health. (Bedggood, 1980. Naidoo et al., 1994. Durie, 1998. Best 1999). Thus, the loss of land was detrimental to Maori. First, because of the spiritual significance of land to Maori, there was a spiritual decline. Second, a loss of land meant lost opportunity to generate economic activity on a sustainable economic base.

Assimilating Maori and Eroding Maori culture

With the erosion of the Maori land base came the erosion of the Maori culture. Moves were being made to use the education system to assimilate Maori. In 1871 it became policy that native schools would provide instruction in English. This had been preceded in 1847 by the Education Ordinance Act that insisted missionary schools be taught in English. In 1905 teachers were instructed to allow only English to be spoken in the playgrounds. Physical punishment was accorded any violation for some five decades.

Walker (1990) surmises that:

“Schooling demanded cultural surrender or at the very least suppression of ones language and identity. Instead of education being embraced as a place of development and growth, it became an arena of cultural conflict (p.147).”

Also eroding cultural belief systems was the 1907 Tohunga suppression Act, which resulted in Maori healers being forced underground along with their ability to share their expert health cultural knowledge

Such assimilative policy and legislation resulted in the near total loss of the Maori language, Maori health knowledge, cultural identity and self-esteem. Coupled with this has been the historical poor educational achievements of Maori students. As with income, both education and cultural identity are shown to have a direct association with health outcomes (Wadsworth, 1997).

Using legislation, the Crown has historically contravened the Treaty on two grounds, the alienation of land and the assimilation of Maori culture. Given the negative impact of these events on the social, cultural and economic base of Maori, there is a direct association with health. Given that these events contradict the Treaty and rights of Maori to the protection of their health interests, the Crown has a responsibility to advance strategies that will address the adverse determinants of Maori health. This view continues to gain acceptance. Durie (1998a) observes that:

“Some Maori groups concerned about poor standards of Maori health in comparison with other New Zealanders have threatened to take a claim to the Waitangi Tribunal, fully realising the difficulties in proving Crown negligence ... it would not be an easy task to untangle the multi causal factors which underlie illness or disease. (However), unsatisfactory social conditions might be considered more relevant than inadequate hospital care or delays in gaining access to treatment (1998a. 93-94).”

Growing recognition by the Crown

However, despite the frank disregard in the past, in more recent years, since 1975, the Crown has recognised the Treaty in both law and policy.

Up until 1975 the legal application of the Treaty of Waitangi was largely diminished by the alignment of the Crown and its judicial system with two particular legal orthodoxies. First, that the significance of the Treaty was ultimately for the Crown to determine in term of its interaction with Maori. The premise for this approach is based upon English law relating to protectorates and the interaction of the Crown with indigenous peoples. Second, while the Treaty may be enforceable as part of international law. It is not recognised in local courts unless it is supported by legislation that incorporates it into domestic law (Williams, 1990).

Apart from two or three exceptions, the Treaty of Waitangi is therefore only legally significant if it incorporated into legislation while it a useful tool for guidance, its legal significance to social policy (including health), is legally dependent on the presence of its principles in relevant legislation. In practice however there are other ways in which Maori interests can be protected in law, without a Treaty clause. And, quite apart from legislation, the Treaty can be recognised within policy - as it is in health policy.

Developing modern application of the Treaty

In 1985 the Standing Committee on Maori Health recommended that the Treaty of Waitangi be regarded as the foundation for good health. Its parent body the New Zealand Board of health recommended that all legislation relating to health should include recognition of the Treaty. In 1986 the Fourth Labour government stated that all legislation should be examined to determine any implication for Maori in terms of the Treaty, both form a financial and resource perspective. Departments were also directed to consult with Maori on all-important issues (Ministry of Health, 1999). The Director General of Health Dr Salmond responded

by recommending that the Treaty be integrated to all health services. However, application of these positive assertions was hampered by a lack of clear guidelines pertaining to the Treaty and social policy. (Durie, 1998a. Durie, 1998b). The Waitangi Tribunal had previously developed treaty principles however, these principles were mainly used to guide the settlement of land grievances.

To progress the positive intentions of the Crown and its departments principles were developed to provide guidance in terms of the Treaty and social policy. The development of Treaty principles (for social policy purposes) has been progressed by the Royal Commission on Social Policy and there was a greater awareness and recognition the Treaty. Most Government departments for example refer to the Treaty with some positive strategic significance in key documents. The Health Funding Authority in its recently release plan for mental health (*Kia Tu, Kia Puawai*), made the following positive statements concerning the Treaty:

"The Treaty of Waitangi is the first point of reference in the development of social policy and strategies that will impact on Tangata Whenua populations. As the founding document of New Zealand the Treaty predicates the relationship between the Crown and Tangata Whenua and the way in which the partnership might influence the health sector to protect the interests of Maori (HFA,1999.8)."

This assertion by the HFA of the Treaty is a good example of the growing relevance the Treaty has gained in recent times in social policy in New Zealand. The Minister of Health in 1992 confirmed that although there was no reference to the Treaty in the Health and Disability Services Act 1993, the Treaty has a major role to play in social policy, and was to be considered as the 'founding document of New Zealand'. The Governments objective for Maori health had already shown the importance of the Treaty to health. It states that the government aims:

"To improve Maori health so that at the very least they may enjoy the same level

of health as non-Maori (Ministry of Health, 1998. 66)"

Despite this significant movement forward by the Crown, there remains a degree of uncertainty about the Treaty in relationship to health.

"The claim that the protection of the health of Maori has a special claim on New Zealanders as a whole, over and above the responsibility of the Crown to secure the health of all citizens is not one the government accepts (Department of Health, 1993. 23)."

While there have been many positive developments, there still appears to be a reluctance by the state. This is best evidenced in terms by a reluctance to include the Treaty of Waitangi into social policy legislation.

Despite early assertions that the Treaty was New Zealand's 'founding document', in 1993, the Minister of Health felt New Zealand had not yet decided what the significance of the Treaty to social policy was, thus refraining from incorporating the Treaty in legislation for the health reforms. Maori were disappointed by the decision not to incorporate the Treaty within the Act (Henare, 1999. Durie, 1998). To date the Treaty is yet to appear in legislation relevant to social policy including health.

After the development of the Coalition government in 1996, four Maori focused Commissions, were established one of which has Maori health as its primary focus. The Maori Health Commission was established in 1997 and its role in terms of Maori health:

"To make sure what needs to be done is identified and, in fact, done. We can do this by exerting influence, providing advice and focusing on resource allocation (Maori Health Commission, 1998. 4)"

The Commission has developed four strategic goals:

1. to create effective Maori participation in the development, management and control of health resources and services in the mainstream.
2. to create and promote effective Maori health development
3. to influence the development of Maori health research priorities controlled by Maori.
4. to develop an organisational capacity to meet the goals and objectives identified in the Maori Commissions strategic plan.

In relationship to the Treaty and health, and the rights the Treaty ascribes for health the Maori Health Commission has stated that:

"The Maori Health Commission recognises that the Treaty of Waitangi is central to Maori health development and therefore upholds the understanding that the Treaty guarantees to Maori a basic right to good health and enhanced quality of life (Maori Health Commission,1998.8)."

The objective of this section was to link the Treaty to health and draw attention to the differing attitudes towards physical resource rights and social policy rights. By and large the application of the Treaty to resources such as lands, forests, fisheries is more readily accepted than the application to health, education and employment. Although policy formulation incorporates a Treaty perspective, no social policy legislation includes a Treaty clause, despite the fact that the Treaty's evolution was quite clearly linked to concerns about Maori health and depopulation.

Summary - The Treaty of Waitangi and Health

The Treaty of Waitangi is relevant to health. It is relevant because one evidenced reason for its development was the protection of Maori interests on humanitarian

grounds. Any promises accorded to Maori within the Treaty (that have largely been associated to land grievances) must therefore also be considered to be relevant to health. At the very least the Treaty accords Maori the right to expect equality and equity of health status with non-Maori.

Using the principles and provisions of the Treaty, the Treaty can also be shown to have practical relevance to the advancement of Maori health. Maori have the right to make decisions conceding the future progression of their health.

Government legislation all too often contravened the Treaty creating adverse social, economic and cultural determinants of Maori health. Thus Maori have a moral right to expect the Crown to promote interventions that can reverse the adverse effects of the social, cultural and economic determinants of health in much the same way as the return of land for previous confiscation goes some way to reversing economic disadvantage.

TREATIES AND CONVENTIONS THAT ACCORD MAORI THE RIGHT TO GOOD HEALTH

While for most Maori the Treaty of Waitangi would accord them the protection of the health interest and therefore the right to expect good health it is not the only document that does so. Rights to good health are also found in the 1948 Universal Declaration of Human Rights, the landmark 1978 Alma Ata Declaration, 1989 International Labour Organisation convention No 169 - concerning indigenous and tribal people, 1993 Draft Declaration on the Rights of Indigenous People and the 1993 Human Rights Act. .

The United Nations

The United Nations was established after World War II. It was based on the premise that for peace to be experienced/maintained the protection of human rights was one of the essential conditions. To progress this a number of treaties

directed at the establishment and progression of human rights have been developed. The human rights treaties drawn up by the United Nations, however, are binding only for those states, which formally accept them. Declarations developed by the United Nations are not legally binding. However, whether treaties are accepted or not, or whether Declarations are legally binding or not, what these documents do provide is great moral authority in setting human rights standards for indigenous people of the world, including Maori.

1948 The Universal Declaration of Human Rights

When the United Nations was first established, one of its primary aims was the development of an international system for the universal observance of human rights. To progress this aim, the general assembly adopted the Universal Declaration of Human Rights (UDHR) on the 10th of August 1948. The Declaration states that everyone is entitled to the rights outlined within the its document and proclaims that:

"All Human beings are born free and equal in dignity and rights. They are and should act towards one another in a spirit of brotherhood (United Nations, 1948)."

The UDHR also accords people certain rights to health and well being e.g. accessing free and effective education (A.26), having social security (A.22), access to employment/paid work and both favourable enumeration and work conditions (A.23), being appointed to govern (A.26), expressing cultural beliefs (A.27), life and liberty (A.3). But perhaps the most relevant article to health is Article 25, which states that:

"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood

in circumstances beyond his control. (UDOHR, 1948. Article 25)."

Thus within the UDOHR both the right to favourable social, cultural and economic conditions are accorded to all people, including specific rights to health and wellbeing.

1978 Alma Ata Declaration

The Alma Ata is a name that has become synonymous with one of the great public health movements of history aimed at the quest for equity in health. It has been expressed by the WHO goal, 'health for all by the year 2000'. The Alma Ata conference held in September 1978 was primarily initiated to address the issue of 'wide spread inequalities in health and health services that formed an appalling presence of neglect and deprivation. The result of the conference was the declaration of Alma Ata, which set out a challenge to WHO, the member states and the entire world to ensure all people of the world had a level of health that would enable them to live socially and economically productive lives (World Health Organisation, 1988). The Alma Ata declaration stated that

"The existing gross inequality in the health status of people particularly between developed and non-developing countries and as well as within countries is politically, socially, and economically unacceptable and is therefore, of common concern to all countries (Alma Ata Declaration, 1978)."

The Alma Ata declaration stated that all people had rights to:

1. the highest possible level of health
2. protection from social and economic hardship
3. participation in the planning and implementation of health services.
4. a responsible government proactively committed to attaining good health for all.
5. effective primary health care services and strategies.

The Alma Ata concluded by challenging all governments to attain an acceptable level of health care for all by the year 2000, through the implementation of effective primary health care, services, strategies and supporting social policy.

The Alma Ata is more specific to health than the Universal Declaration of Human Rights. Its primary focus is stating the rights of all people to good health, and subsequently challenging those governments where disparities continue to exist in order to attain an equitable level of health for all by the year 2000.

1989 International Labour Organisation Convention No 169 - concerning indigenous and tribal people

The International Labour Organisation convention No 169 (ILO) was adopted by the general conference of the International Labour Organisation in June 1989. The main aim of the convention was to advance the protection of indigenous people by their governments. It states that:

‘Governments shall have the responsibility for developing, with the participation of the peoples concerned, co-ordinated and systematic action to protect the rights of these people (indigenous people) and to guarantee respect for their integrity by ...Promoting the full realisation of the social, economic and cultural rights of these peoples with respect for their social and cultural identity, their customs and traditions and their institutions (ILO No 169, 1989. Article 2).’

The Covenant goes on to both support and progress the key components of the Universal Declaration of Human Rights and other human rights based document. In terms of those conditions relevant to determining health status the International Labour Organisation Convention also specifically states that Governments have some responsibility for social well being:

"The improvement of .the conditions of life and work and levels of health and education of the peoples concerned, with their participation and co-operation, shall be a matter of priority in plans for the overall economic development of areas they inhabit. Special projects for the development of the areas in question shall also be so designed as to promote such improvement. (ILOCONO 169, 1989, Article 71)."

Furthermore the ILOCONO has a specific section relating to the rights of indigenous people to good health and good health care. These articles guide governments in terms of their responsibility to ensure that:

1. indigenous people are provided with resources to allow them the opportunity for the provision of their own services
2. that health services are provided in co-operation with indigenous people and are developed to ensure they take into consideration the social and economic conditions of indigenous people and show respect for their traditional health practices.
3. the health system proactively encourages indigenous people to increase participation at all levels of the health workforce.
4. health services are co-ordinated and take into consideration other social, cultural and economic when being measured.

This ILOCONO convention is particularly significant because it outlines the responsibility of government to the advancement of indigenous health within a social, cultural and economic framework. It recognises the interconnected relationship, but importantly the role of and importance of government in advancing health in accordance with the wider social determinants of health. It again asserts (as with pre-mentioned documents) but this time specifically in relationship to indigenous people, the right to good health.

1993 Draft Declaration on the Rights of Indigenous People.

While not yet in final form the 1993 Draft Declaration on the Rights of Indigenous People (DDHRIP) again asserts that indigenous people have a right to good health and to live within favourable social and economic conditions associated with good health.

The DDHRIP again relates both to those essential conditions associated with health and specifically to health also. It encompasses and proclaims the right of indigenous people to full and effective employment (A1), self determination (A3, A31-34), to either develop their own systems for social, cultural or economic advancement (A4), protection and security from aggressors (A11), to practice and revitalise cultural traditions and customs (A9).

One interesting feature of the DDHRIP is the notion that:

“Indigenous people have the right to the recognition, observance and enforcement of treaties, agreements and other constructive arrangements concluded with States or their successors, according to their original spirit and intent, and to have states honour and respect such treaties and other constructive arrangements ... (DDHRIP, 1993. Article 36.).”

This is interesting because, if enforced, and taken into consideration along with the Treaty of Waitangi the DDHRIP would suggest that the government would need to both protect and advance Maori interests with regards their health in a more positive way than at present.

With regards to health the DDHRIP also suggests that indigenous people have the right to:

“Maintain and develop their political, economic and social systems, to be secure in the enjoyment of their own means of subsistence and development, and to engage freely in all their traditional and other economic activities. Indigenous

peoples who have been deprived of their means of subsistence and development are entitled to just and fair compensation (DDHRIP, Article 22.1993).”

The DDHRIP goes on to accord indigenous people the right to develop their health priorities, health services and to practice traditional methods of medicine (A22-23), within a self determination framework.

The Covenant on Civil and Political Rights of Indigenous People and The International Covenant on Economic, Social and Cultural Rights.

New Zealand has adopted both of the above Treaties, which means they are both binding and the New Zealand Government has the responsibility of reporting to the United Nations on their compliance with human rights.

The Covenant on Civil and Political Rights of Indigenous People, 1966

The Covenant on Civil and Political rights of Indigenous People (1996) is one of the major treaties adopted by the United Nations. It gives legal effect to the articles outlined in the 1948 UDHP. New Zealand signed this covenant in 1968 and is required to report to the United Nations systematically on the work it has done to progress human rights.

The Covenant on Civil and Political rights of Indigenous People asserts those issues found within the Universal Declaration of Human Rights and previously discussed documents, for example the right to education, employment, to embrace traditional cultural practices, freedom, social security and protection by the government from unjustified aggression. In short it is an adoption of the UDHR's document of 1948.

As part of the New Zealand Governments commitment of this document there have been several developments including, the Privacy Act and the Human Rights Act of 1993. The Human Rights Act has seen the implementation of a Human

Rights Commission and the appointment of a race relation's conciliator. While not directly related to health or indigenous people the Act is able to apply pressure on employers and the public at large, to create better opportunities in employment for those historically disadvantaged, including Maori.

The International Covenant on Economic, Social and Cultural rights.

The International Convent on Economic, Social and Cultural rights has also been adopted by New Zealand. Again the rights accorded within this document are in association with Universal Declaration of Human Rights. It states that:

"All people have the right to self determination. By virtue of the at right that freely determine their political status and freely pursue their economic, social and cultural development (ICESCR, 1978. Article 1)."

It is also specifically related to health and mirrors the Alma Ata Declaration by recognising that the State has the responsibility of ensuring the right of everyone to:

"the enjoyment of the highest attainable standard of physical and mental health. (ICESCR, 1978. Article 12)."

This is to be proactively achieved by governments through: (a) provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child, (b) improvement of all aspects of environmental and industrial hygiene, (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases, (d) creation of conditions which would ensure to all, medical service and medical attention in the event of sickness (ICESCR, 1978. Article 12).

Summary of Rights to Good Health

All people have a right to a certain level of health and to experience favourable

conditions that are associated with health e.g. social, economic and cultural. Treaties pertaining to the 'rights of humans' have mostly been advanced by the United Nations. The Alma Ata is a specific rights based document pertaining to health. It has been developed to challenge all governments to attain equitable health standards for all by the year 2000. Its development was motivated as a response to the ongoing disparities between certain groups in society in terms of health status. The key features of the rights based documents in terms of Maori health are:

1. indigenous people / Maori have a right to equitable health status
2. indigenous people/ Maori have a right to determine strategies, policies, goals, and services requires advancing their health and well being.
3. governments have a responsibility to protect Indigenous people from the adverse determinants of health.
4. indigenous people have right to participate in planning, development, provision and implementation of health services
5. indigenous people have the right to practice their traditional cultural health practices.
6. government has the responsibility of proactively advancing the health of indigenous people, particularly where a disparity exists.

While treaties and Declarations adopted by the United Nations are not binding by law (unless accepted by individual States in the case of treaties), they do provide moral authority in the setting of standards for all indigenous people, including Maori. That aside New Zealand has adopted both the Covenant on Civil and Political Rights of Indigenous People and the International Covenant on Economic, Social and Cultural Rights. A result of its commitment to these treaties, has been the development of the 1993 Human Rights Act, which while not directly specific to health of indigenous people, does attempt to legalise some of the important issues associated with the 1948 Universal Declaration of Human Rights.

SUMMARY

The key focus of this chapter has been assessing the right of Maori to good health. This chapter has shown that Maori have a right to good health, both in terms of the Treaty of Waitangi, and international rights based documents.

One of the key tasks associated with the focus of this chapter has been to relate the Treaty of Waitangi to health, thus linking its guarantees to social policy, and extending the expectations derived from its principles, to good health. Maori have an expectation of at least equitable health standards with non-Maori, and an expectation that Government will protect Maori interests by providing good governance.

While the significance of the Treaty to Social Policy continues to be explored, particularly among Government departments and their key strategic documentation, it has yet to appear in any social policy legislation. This is a significant issue for Maori as it is only when the Treaty is in legislation that it becomes enforceable in law. For Maori, however, the Treaty accords the right to good health, or at the very least to the same level of health as non-Maori.

Other international documents also impart to indigenous people including Maori the right to good health. For example the 1948 Universal Declaration of Human Rights, the landmark 1978 Alma Ata Declaration, 1989 International Labour Organisation convention No 169 - concerning indigenous and tribal people, 1993 Draft Declaration on the rights of indigenous people and the 1993 Human Rights Act.

This chapter concludes that in association with the Treaty of Waitangi, and the international human right documentation, Maori have a legal and moral right to expect a standard of health which is not significantly different from that of other New Zealanders.

CHAPTER FIVE

HEALTH PROMOTION

INTRODUCTION

Defining 'health promotion' is a central task within this thesis. The chapter is structured against the following key issues:

1. the conception of health promotion
2. defining health promotion and its functions
3. approaches to the implementation of health promotion

Two common themes run through this chapter. First, the intent of health promotion is to advance health and well-being through positive interventions that focus on changes to the social, cultural and economic determinants of health (that is health promotion has a multi-dimensional focus). Second health promotion provides a framework that can be used to progress gains in Maori health in the context of positive Maori development.

THE CONCEPTION OF HEALTH PROMOTION

Kemm et al (1995), Labonte (1999), Raeburn (1998) agree that historical evidence suggests health promotion is not new and has existed in different forms in ancient Greece, ancient Egypt and ancient China. There are a number of examples in these ancient societies of health promotion activity, including, the promotion of living healthy lifestyles, the importance of diet, the avoidance of disease and the relevance to health of hygiene and sanitation. Health promotion has been advanced as a central component of public health service delivery in contemporary New Zealand. There are however, a number of health promotion examples found within traditional Maori society.

Table 9: Core components of traditional Maori public health systems

Component	Description
Protection from disease	Strategies to protect people from disease are best seen in terms of two categories, protection from cross infection (e.g. avoidance of contaminated sites) and the enforcement of everyday hygiene standards (e.g. the location of latrines, location of rubbish dumps and the location of traditional Maori villages (pa sites).
Food security	Food security can be divided into three categories conservation of food sources, preparation of food and storage of food. Each category managed by a set of explicit regulations, controls, based on a collective value and belief system.
Protection from injury	For example, the use of rahui (no access zones) along coastlines where people had drowned, to avoid further drowning, or using the same principle to protect people from the dangers of construction sites, by not allowing people to access dwellings under construction.
Conservation	Maori also adhered to the principle of conservation, of food found in the bush and sea and water pending on environmental contusions.
Water security	The security of water as with food can be seen in terms of their processes, the conservation of water sources, preparation of water sources and storage of water. Water also has a spiritual significance and was categorised according to its source. e.g. rainwater (waiora) used in traditional rituals, drinking and cleansing.
Healing	Treatment of ailments and illness was also multi dimensional. Methods included using water, using massage, using medicine (rongoa), surgical interventions and spiritual interventions

(Source: Durie, 1998a)

Durie (1998a) has cited a number of examples of health promotion in traditional Maori society encompassed by a traditional public health system, "... based not on advances in medical technology, but on pure and reliable sources of water, efficient waste disposal, safe and comfortable accommodation, provision of food, environmental protection and attitudes that favour the future survival of generations (1998.7)." (See table 9). The effectiveness of these early systems was based on the collective integrity of the Maori community and made contributions to maintaining well-being, preventing unnecessary disease and growing the population. They were however, quickly undermined in the 1800's by the assumption of new lifestyles. When trading with settlers began the hilltop villages were abandoned for settlements in low-lying areas. A rapid decline in the Maori population followed (Walker, 1990. Durie, 1998a).

Maori Public Health systems that encompassed health promotion were managed by the use of a system of regulation and control, tapu and noa. Tapa items (food, places, people, water) demanded respect and a degree of caution. Noa items were in contrast generally regarded as safe and not likely to incur risk or injury. Within Main Communities then (and even now), leaders applied the tapu/noa distinctions to ensure maximum community safety and the reduction of hazardous behaviour. Over time, the notion of tapu has assumed 'spiritual' connotations. But its more practical use was as a public health measure. This practice based on cultural beliefs, set in place systems to protect the Maori population from potential disease and illness that may have played a part in the cause of death. It extended to those who had died at sea. A rahui (prohibited access or ban) was placed on relevant coastlines in the event of a life being lost at sea (and the body not being recovered), again to ensure protection from potential contamination from both those life forms coming into contact with the dead and the dead itself.

The practical implementation of these systems rested on common knowledge and an awareness of rebuke either, physical or mental if the restrictions were

compromised.

These traditional Maori public health systems clearly align themselves with modern perceptions of health promotion in that they modified behaviour in favour of a healthy lifestyle, they were managed through adherence to common values and beliefs, they protected the community from disease and avoidable injury, and were preventative in nature, in that they were strongly influenced by principles of conservation.

In the early years of the twentieth century Maori health promotion was seen as the most logical way to address the low health status. In his capacity as the Medical Officer of to the Maori's from 1901 - 1909. In this role Dr Maui Pomare was faced with a host of major health issues. Typhoid fever, miliary tuberculosis, rickets, childhood osteomyelitis, pneumonia and exceedingly high child mortality rates, were aggravated by poor housing conditions amongst Maori, abject poverty and open sewers close to daily activities of children. Pomare's approach to addressing the negative health status and its wider determinants has distinct parallels with what has commonly become known as community development, and which in modern times has been used as the guiding process for the application of health promotion (Labonte, 1999. Raeburn, 1998).

In the Newman lecture presented by Professor Mason Durie (1999a) at Auckland University, reference is made to the community development approach of Dr Pomare

"...he (Dr Pomare) was not trained in public health, but was a Maori physician and perhaps for that reason was able to see the clinical problems of the time within the broader context of social, cultural and economic conditions. Consistent with that philosophy Pomare committed his energies to Maori community development and worked to empower Maori community leaders. He had decided to make the best

of the Maori councils Act 1900, which had established Maori councils and recognised amongst the local councils a powerful army for health. This became his strategy, and I believe his single most important contribution to Maori development. Health was not something that could be prescribed by the doctor, but something which should arise from within communities: and the leaders of health were not doctors or nurses, but community leaders who could use their influence and wisdom to alter lifestyles and living conditions."

Dr Pomare recognised early in his time as the Maori Medical Officer that culture and the resulting cultural practices also impacted upon the health of Maori. This in part prompted his approach to the abolishment of the practices of Tohunga amongst Maori. Pomare wrote in his 1903 report "I have watched all these tohungas at work and have come to the conclusion that, unless parliament passes a stringent law prohibiting the practices of any kind of tohunga, we shall always have a great deal of Maori dying from the effects of tohungaism (Pomare, 1903)

What resulted was the Tohunga suppression Act of 1907. It was unpopular with Maori. The Act however, was created as much to deal with the emerging Maori leadership which was anti-British, especially Rua Kenana, a Maori prophet who had openly prophesied that New Zealand would not for much longer have Pakeha people living in it (Webster. 1979.221 -214). In any event, while the purpose of the Act was to improve health the unintentional result was the loss of traditional methodologies and health disciplines.

Despite his opposition to tohunga, Pomare recognised the implication of cultural values for health and was critical of Maori land tenure. He favoured individualisation of land title and openly spoke against collective ownership, which he saw to be detrimental to employment and economic opportunities of Maori. His 1904 report stated that "The individualisation of Maori land ought to be hastened with all possible speed. As long as we have communism so long shall we have

non-employed natives and long shall we have idleness (Pomare, 1904).

While his views were not widely accepted amongst Maori, he had in his own way recognised the links between culture and health. Durie (1999a) concludes that his record in the improvement of Maori health, better housing, vaccination and health education remains unparalleled.

Dr Pomare left his post within the Department of Public Health in 1909 and successfully entered politics. He later became the Minister of Health in the Coates government of 1923. In his short tenure he asserted political power to make positive changes in mental health.

Table 10: Themes advanced in practice by Dr Pomare

Theme	Description
Leadership	Pomare recognised that community leadership was vital for health advancement.
Social Adversity	Health was linked to socio-economic adversity - poor housing, poverty, limited access to education.
Culture as a determinant of health	Pomare linked cultural beliefs attitudes and practices to health, acknowledging that these factors had an important influence on lifestyle, day to day practices and ultimately health status.
Workforce development	Pomare recognised that importance of a trained work force, and the need to develop people with appropriate skills in health, and in relation to Maori.
The significance of political power	Political interventions are able to effect major changes in health status.

(Source: Durie, 1999)

Pomare’s contribution to Maori health was characterised by five broad strategies:

health leadership, reduction of social adversity, linking culture to health, workforce development and political intervention (see table 10).

The Maori Women's Welfare League (MWWL) has also practised forms of health promotion. The MWWL arose out of a desire to give Maori women a place and voice in New Zealand society. The League was developed in recognition of the importance of women in Maori society. It has some 3000 members today and is active throughout New Zealand. (Te Puni Kokiri, 1993.9)

In recent times the MWWL has provided leadership in health promotion with the successful progression of health promotion programmes based on the modification of lifestyles. Between 1981 -1984 a research programme was undertaken to determine the status and opportunities for Maori women in New Zealand. In the ensuing report, 'Rapuora: Health and Maori women' they declared 1985 - 1995 the decade of health. In 1987 the MWWL President developed a plan to improve Maori health. The president stated that:

"The MWWL proposes to initiate a preventative model which is based on positive values inherent in Maoridom, caring and sharing, and which provide a vehicle for promoting healthy lifestyle changes among a critical target group - young Maori women (Te Puni Kokiri, 1993. 10)."

The Healthy Lifestyles programme was the eventual outcome. It would take advantage of the netball setting in order to 'promote wellness and improve health amongst Maori women'. The objective was to reduce smoking by having smoke free players at all levels of the netball competition and all netball activities conducted in a smoke free environment. Healthy Lifestyles has since been endorsed by the netball association of New Zealand and is being proactively practised around the country. An evaluation of the programme by Te Puni Kokiri showed:

"The Health Lifestyles Programme of the MWWL is an approach that should be studied carefully by all those committed to Maori health development. Above all it is a programme that bustles with energy and shouts productivity...the programme has been an excellent avenue for the promulgation of health messages. The programme is also an initiative by Maori women for Maori women. It is also clear that involvement in the programme has also brought about significant increase in knowledge about health issues and the benefits of being healthy. For young Maori women the program has provided a negotiating tool for those wishing to quite smoking: a difficult challenge at school where peer pressure to smoke is sometimes intense (Te Puni Kokiri, 1993.5)."

The MWWL healthy lifestyles programme is based on the slogan '*Be Proud, Be fit, be Maori*'. It links health with a positive cultural and ethnic identity.

Another successful Maori health initiative has been the Tu Tangata program developed by Kara Puketapu out of Parkway College in Wainuiomata. The program has since spread to around 40 schools nation-wide. It has been advanced on Maori principles of community development and is an attempt to address some of the adverse social, cultural and economic determinants of health. This it does by encouraging parents from school communities (of any ethnicity) to be in the classroom with their children and to provide consistent support during the day, 'all day every day'. Central to the program is the role modeling of appropriate behaviour and improved learning techniques in the classroom, for example asking for clarification of issues where there is some confusion. The program has been particularly effective in changing classroom dynamics. Teachers no longer have the challenging task of facing students on their own or vice-versa, but are now supported by their community, who have taken responsibility for their children's education. The key to success of this program lies in community knowledge and local ownership. The children have respect for those

parents who support them because of their relationship in the community. Parents also know other parents of children in the classrooms and are able to contact them and discuss issues with them without the same anxious dynamics associated by a visit from a school counsellor or dean.

The program has had numerous positive outcomes. Using Parkway College as an example, truancy has dropped to zero percent in one year of operation. Suspensions have dropped to zero over three years and school certificate passes have increased by 25% since the inception of the program in 1996. Another positive has been seen in the community. The program has created 15 jobs. It has given the community an opportunity to participate positively in the school, experience many achievements, and meaningful work. This has resulted in the raising of the community self esteem, which has been in part reflected in a sharp decrease in youth crime statistics within the Wainuiomata region (Puketapu, 1999).

"The Tu Tangata programme brings adults alongside students. The non-government program was developed by the Maori community, but it is not only directed at Maori. The strength of Tu Tangata is drawn from the communities in which it operates; it is the whanau that gives it strength through its innate social capital (Robinson, 1999.18)."

One flaw of the programme lies in its success. Because it is a community initiative, and has been developed by the community using only their resources, that government has been reluctant to fund the program, given its self-sustainability to date. This has limited the growth and maintenance of the Tu Tangata program in some regions. It is a significant Maori community development example because it attempts to address a range of issues. e.g. educational issues, employment issues, self-esteem issues, health issues, relationship issues and so on.

Table 11: Common themes in Maori health promotion

Source	Themes
Traditional Maori public health systems	<p>importance of Healthy Lifestyles</p> <p>importance of protection from disease</p> <p>importance of collective adherence to rules and regulations</p> <p>importance of rules and regulations to health</p> <p>importance of public infrastructure to preventing illness</p> <p>importance of external factors to determining health</p>
Pomare	<p>the impact of cultural practices on health</p> <p>the importance of leadership to health</p> <p>the importance of a trained workforce to health</p> <p>the importance of legislation and political power to effecting changes in health</p> <p>the importance of social economic adversity to determining health status</p>
MWWL	<p>the importance of common and accessible settings</p> <p>the importance of self esteem to health</p> <p>the importance of healthy lifestyles</p> <p>the importance of interactive approaches to health</p>
Tu Tangata	<p>the importance of the community finding solutions to community problems</p> <p>the importance of community knowledge</p> <p>the importance of local ownership</p> <p>the importance of education to health</p> <p>the importance of positive community input</p> <p>the importance of socio-economic factors to health e.g. employment</p> <p>the importance of whanau and whanau support to well-being</p>

Summary

What is most interesting with regard to Maori and their approach to health promotion in the context of this chapter, is to note that Maori health promotion themes both historically and in recent times are aligned with modern perceptions of health promotion (See table 11).

Modern developments in Maori health promotion models

The most recent advancement of Maori health promotion is the conceptual model presented by Durie (1999b) entitled 'Te Pae Mahutonga', at the 1999 Health promotion forum of New Zealand Conference. Conference participants recommended to the Forum that it be adopted by the Health Promotion Forum as a model for Maori health promotion, and for health promotion in general.

Te Pae Mahutonga

Te Pae Mahutonga is the Maori name for the constellation of stars more commonly known as the Southern Cross. Durie uses the metaphor of Te Pae Mahutonga to illustrate the central importance of health promotion to Maori lives.

Te Pae Mahutonga consists of four central stars in the shape of a cross. Durie (1999b) uses these stars to describe the key tasks of health promotion. The stars are entitled (by Durie for the purposes of the model) as Mauriora, Waiora, Toiora, and Te Oranga. The Southern Cross also has two pointer stars that are arranged in a straight line. These two stars Durie has entitled, Nga Manu Kura and Te Mana Whakahaere. Each of stars are represents keys themes associated with Maori health promotion and have a range of key components attached to them (see table 12).

Te Pae Mahutonga is particularly useful for its ability to bring together the common health promotion themes adhered to by Maori both in the past and the present. Its strength is within its multi-dimensional nature and its recognition of both healthy

lifestyles and the wider determinants of health as being both a central focus and practice of health promotion activity.

Table 12: Te Pae Mahutonga - A model for Maori health promotion

Theme	Key Components
Mauri Ora - access to te ao Maori	<ul style="list-style-type: none">* access to Maori language* access to Maori culture and cultural institutions such as Marae* access to Maori economic resources such as whanau, Maori services, networks* access to societal domains where being Maori is facilitated not hindered
Waiora - environmental protection	<ul style="list-style-type: none">* water free from pollutants* clean air* earth abundant in vegetation* healthy noise levels* opportunities to experience the natural environment
Toiora - Healthy lifestyles	<ul style="list-style-type: none">* harm minimisation* targeted interventions* risk management* cultural relevance* positive development
Te Oranga - Participation	<ul style="list-style-type: none">* participation in the economy* participation in education* participation in employment* participation in the knowledge society* participation in decision making
Nga Manukura - Leadership	<ul style="list-style-type: none">* community leadership* health leadership* tribal leadership* communication* alliances between leaders and groups

Autonomy - Te Mana Whakahaere	<ul style="list-style-type: none"> * control * recognition of group aspirations * relevant processes * sensible measures and indicators * the capacity for self governance
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MODERN HEALTH PROMOTION DEVELOPMENTS

Labonte (1999), Raeburn et al (1998), Seedhouse (1997), agree the most significant development to the modern tradition of health promotion was the 1974 *Lalonde report* "A new perspective of the public health of Canadians". This report is significant because it was the first time that a major government publicly acknowledged that medicine and personal services only played a small part in determining health status. Furthermore, the 1974 *Lalonde report* recommended health promotion as a key strategy for addressing health, recognising that health was determined by "an interplay of human biology, health care organisations, environment and lifestyle. (Health Canada/Sante Canada, 1998.8)."

Raeburn (1998) attributes the rise to prominence of health promotion to *the Lalonde report*, "Central to the Lalonde report, and subsequent governmental initiatives in Canada, the United States, New Zealand, Australia, the United kingdom, some Scandinavian countries and the Netherlands was, the neglected importance of lifestyle as a determinant of health...Enlightened health promotion practitioners and writers continued to develop a more robust concept of lifestyle with intellectual and research roots in anthropology and sociology (Raeburn et al, 1998.vii)."

After the *Lalonde report*, health promotion gained momentum as an important approach in addressing negative health issues, using interventions aimed at modifying lifestyle.

Reasons for modern Health promotion gaining prominence

There are at least two reasons for the rapid development and increasing prominence of health promotion post 1970 as an effective approach for dealing with issues associated with poor health outcomes:

1. The increased awareness and rise to prominence of the impact of lifestyles on health outcomes, and eventual increase in awareness of structural conditions and their impact on health status.
2. The effectiveness of preventative strategies in gaining positive health outcomes Vs the ineffective performance of traditional (treatment based) approaches in the prevention of the prevalence of negative health.

Increased awareness of lifestyle in determining Health status

One of the predominant reasons for the modern development of health promotion is the increased awareness of the importance of lifestyle and other wider determinants to health. (Kemm et al., 1995. Raeburn, 1998. Labonte, 1999). The 1974 *Lalonde report* subsequently sparked life into the process for progressing and modernising health promotion. The essence of this report was focused on how health could be positively or negatively influenced by lifestyle. Subsequently in terms of the development of health promotion two further important outcomes resulted. First, lifestyle could be positively effected by the individual and second, supportive social structures in the community could be developed to support individuals thus having a significant impact on lifestyle (Raeburn, 1998).

By the mid 1980's the realisation that poor health was also the result of structural inequalities was advanced. "It was argued that the health of people living in relatively disadvantaged circumstances was also determined by structural conditions, such as poverty unemployment, discrimination, powerlessness, poor housing and pollution to name just a few. It was the contention that personal

lifestyles were not freely determined by individual choice, but rather existed in social and cultural structures that conditioned and constrained behaviour (Health Canada/Sante Canada. 1998.8)".

The following Canadian example presented by Labonte (1999) shows the impact structural inequalities has on health outcomes.

"Canadian data for example find that if the poorest 20% of the population had the same health status as the wealthiest 40%, they would enjoy 13 more years of disability free life. (On the other hand) If all disease and death from heart disease and cancer were eliminated for the poorest 20% they would experience only 2 - 5 years of disability free life. (Therefore) rather than cancer, heart disease and lifestyles being considered the most important contributors, we might consider structural inequalities the leading cause of death of which different diseases are partial expression and different lifestyles partial vectors (Labonte, 1999. 9)."

Health promotion has also gained prominence, because it is seen as being effective in prevention of negative health states and at times more cost effective to provide, when compared with traditional medical alternatives.

Prevention focus

The importance of prevention is often illustrated with the following analogy 'refocusing upstream' which effectively emphasises the wider determinants of health.

"Someone was standing up stream when they saw a man in the river shouting for help and on the verge of drowning. The person on the bridge immediately jumped into the river and after a great battle against the current reached the drowning man. The rescuer pulled him to the shore, gave him mouth to mouth resuscitation and eventually revived him. No sooner had the first man recovered then the

rescuer heard another cry for help and was horrified to see another person floundering in the river. The rescuer was very tired but leaped in again and rescued the second victim. No sooner had this been done they saw a third and fourth person were seen in the river and then more and more. At great risk to themselves they spent the rest of the day fishing people out of the river and resuscitating them. Furthermore, despite their superhuman efforts more could not be rescued and drowned (Kemmm et al, 1995.8).

The point of the above analogy is the fact that no one took the time to look up river to determine what was causing people to fall in and whether the falls could be prevented. Instead they continued to react to the resulting catastrophes, using all their personal resources and placing themselves at great risk. If someone took the time to look upstream the falls might have been easily prevented by appropriate signals, fences and safety measures.

Health promotion has gained prominence because of its readiness to look upstream and to advocate the implementation of interventions that will prevent negative health events. This highlights the growing realisation that by using health promotion strategies many poor health outcomes can be prevented (Broughton, 1999. Kemmm, 1995).

At the same time it needs to be acknowledged that preventative measures must be evidenced based. It is misleading to maintain for example that health promotional activities can prevent schizophrenia, or Alzheimer's disease, or even depression, when the causes are not clearly established nor the benefits of broad health promotional efforts proven. But if these disorders cannot be prevented, health promotion has a role to play in their management and their acceptance within the community.

Low Cost of health promotion

Coupled with the ability of health promotion to prevent poor health outcomes is its relatively low cost in relation to the provision of traditional medical services. The cost effectiveness of health promotion in turn appeals to politicians, Kemm et al (1995) provides a pertinent example of this issue:

"Some politicians have enthusiastically adopted health promotion on the grounds that prevention is cheaper than cure. It costs hundreds of thousands of pounds to care for a child severely damaged by congenital rubella. Immunisation with measles, mumps, rubella vaccine (MMR) costs only a few pounds and will protect a woman from ever having children with this disease (Kemm et al, 1995. 9)."

Another example of the cost effectiveness of health promotion strategies is provided by Te Hotu Manawa Maori (Maori programme within the Heart Foundation) in their training of health workers on the East Coast in 1996. The Te Hotu Manawa Maori trainer stated that in terms of rheumatic fever, the incidence on the East Coast (which has been traditionally high) could be totally abolished for the cost of one heart transplant (i.e. the type of surgical intervention required by someone who has advanced stages of rheumatic fever).

However, Cohen et al (1994) suggests that while health promotion can be seen to be attractive for its ability to save resources, it should not be pursued for this reason alone. The benefits of health promotion should be the main motivation. Furthermore, the calculations in terms of the cost of health promotion interventions are complex and should not be over rated. In the long run costs may be higher, given that people will live longer lives. Therefore, in terms of the issue of prevention being discussed here Cohen argues it should be progressed because it is better for people, and not because it is cheaper.

Summary

Health promotion has gained prominence for two main reasons. Initially, as a way of addressing the health impacts of lifestyle and adversity and then as a strong reaction to the inadequacies of treatment as an effective method to address rising poor health statistics. Health promotion was seen as a way of preventing poor health, in ways that are often significantly less costly than personal health care.

DEFINING HEALTH PROMOTION

Defining health promotion is problematic. Labonte (1999), Ratima (1999) surmise that because health promotion means all things to all people it can mean very little to anyone. This section examines some of the most common approaches to health promotion in an attempt to, identify common health promotion themes and to present a clear picture of the intent of health promotion.

Prevailing issues surrounding the definition of health promotion.

Before discussing approaches to the definition of health promotion it is important to consider some key issues surrounding the task.

The following key issues are discussed:

1. the prejudicial nature of health promotion
2. the need for health promotion to develop a theoretical base of its own
3. the need for objective definition of key terms.
4. outputs vs outcomes

The prejudicial nature of health promotion

Seedhouse (1997) views health promotion as being prejudiced in that it is based upon what certain people think is good health, according to their own values, beliefs and political perspectives. To highlight this issue he uses the example of health promotion attempting to prevent people from smoking because of its strong association with different illnesses, in comparison, to the fact that health promoters

do not attempt to stop people playing rugby despite rugby being responsible for many injuries each year.

The real issue being raised here has to do with whether health promotion imposes the values and beliefs of one upon another. Taken to its logical conclusion this issue is about who should determine what being healthy is all about, or whether being healthy is an issue that requires attention. The implication for health promotion therefore is in terms of whose values and beliefs are most important, the balance between health promotion practitioners and community priorities. Other factors also surround the issues of values in health promotion, for example:

1. in a decent society is it ethical to let people suffer from health disparities
2. with the rising cost of health care, should we not be attempting to prevent negative health statistics.
3. should societies resources be spent on positive health developments instead of negative health maintenance.

The need for a health promotion theoretical base

Seedhouse (1997) argues that health promotion does not have a theoretical base of its own. Instead it is eclectic in nature and takes from other theories, models and frameworks what it requires to operate. For this reason Seedhouse describes health promotion as a 'magpie profession' He labels health promotion is this way because there is a strategic advantage in being vague, in that keeping health promotion 'fuzzy', allows it to suggest many different things to many different people thus gaining wide-spread support, from a variety of sectors.

Seedhouse (1997) argues health promotion needs to develop its own theory for the following four reasons:

1. the goals of health promotion are always prejudiced and therefore require justification

2. health promotion interventions are often progressed without recipient permission, and therefore at the very least need to be theoretically sound (tested and proven).
3. in order to mature as a profession, health promotion must make itself explicit, and open itself to informed debate.
4. health promotion workers require clear guidance to remove the potential for implementing strategies, which are based on noise rather than evidence.

Does health promotion require a more robust theory that will provide its workforce with clear and practical guidelines and also provides academic validity? Or is the eclectic nature of health promotion one of its strengths? And should providing a theoretical base be the main task of health promotion, or should health status be the focus of its energies? Or both?

The need for objective definition of key health promotion terms.

There remains confusion and debate about the exercise of health promotion. If health promotion is about promoting health, what is it promoting? If community development is about developing communities, what is it developing?

Seedhouse (1997) is sceptical about most of the commonly used definitions of key health promotion terms, as he does not believe they make any sense. He is particularly critical of those definitions progressed by the World Health Organisation. He describes such terms as health and community being defined too subjectively and calls for the more objective definition of key health promotion terms.

The important issue is that if those practising health promotion are not clear about key health promotion terms and key health promotion terms are not objectively defined, then there is room for misapplication of a potentially valuable approach to health and counter productive results.

Tangible Outcomes

Another issue that requires some discussion and that encompasses all prior issues is how the performance of health promotion should be measured. What is the intent of health promotion? And furthermore, what is it that should be evaluated to determine whether health promotion has been successful. Is it the health promotion process? Is it the goals of health promotion? These questions are particularly relevant in the context of this thesis.

There are three questions particularly relevant to the performance of health promotion.

1. Who decides the goals of health promotion?
2. Is process more important than outcome?
3. How is performance to be measured?

These three questions raise two particularly important issues in the context of this thesis. (1) What health promotion activities are purchased by the government and subsequently what is measured to determine the success of these activities? (2) How should health promotion be measured and against what performance indicators should it be measured?

The intangible nature of Health Promotion.

One ongoing criticism of health promotion is that its outcomes are not tangible or easy to measure. Furthermore it is difficult to determine what outcomes can be attributed in part or in full to effective health promotion activities. The broad focus of health promotion interventions compounds the complexities associated with measuring the success of health promotion projects. There are continued questions being raised about whether health promotion actually makes a difference, and whether health resources would better be spent on attaining more tangible outcomes.

For some observers the issue with health promotion is that it is difficult to measure, it does not produce health outcomes, and is therefore not necessarily cost effective. Dunt et al (1995) describes the three most common objections to health promotion: whether it actually does save resources, the issue that no one actually demands health promotion services, and finally treatment services are in greater demand. (Dunt, 1995.326)

Table 13: An outcome model for health promotion

Outcome category	Measure	Explanation
Health and Social outcomes	Quality of Life, functional independence, equity	The focus of outcomes in this category are centred at the end point i.e. what is being strived for.
	mortality, morbidity, disability	
Intermediate Health outcomes	Healthy Lifestyles	The focus of measures in this category are focused on the degree of control people have over such issues as the determinants of health
	Effective health services	
	Healthy environments	
Health promotion outcomes	Health literacy	the focus of measures in this category are centred at the degree measurers have been put in place to enable people greater control over determinants of health
	Social influence and actions	
	Health public policy and organisational practice	
Health promotion actions	Education	The final component of this framework is more to do with what is required to achieve the above outcomes.
	Advocacy	
	Facilitation	

(Source: Nutbeam, 1998. 30)

Nutbeam (1998) has attempted to solve or at least provide some structure to the measuring of health promotion activities, by making a distinction between health and social outcomes, intermediate health outcomes and health promotion outcomes (see table 13).

The Nutbeam framework provides one possible approach to the evaluation of health promotion activities using a structured conceptual approach. The framework is also useful in its provision of clarity around how health promotion can be purchased, both in terms of health outputs, and health outcomes.

Outputs vs Outcomes

While the importance of health outcomes to health promotion will be covered in the following chapters, it is perhaps beneficial to at this stage to touch on the debate centred on health promotion and its ability to generate health outcomes.

In 1997, a steering group set up to oversee the implementation of the coalition health agreement recommended that "Services should always be focused on outcomes, although it is also important to acknowledge that health status is influenced by factors beyond health sector control (Ministry of Health, 1997.7)."

Kingi (1999) reports that there are at least three levels of outcomes that can be targeted by the strategic intervention of departments; population, service, and consumer outcomes.

"Population outcome measures are concerned with macro-data sets that give an indication of major shifts in health statistics (e.g. morbidity rates, life expectancies). Service outcome measures the performance of a particular service in terms of efficiencies and effectiveness. Consumer outcomes are about individual gains (or losses) in health as a result of an intervention (Kingi, 1999.12). "

While there is an on going debate about the ability of health promotion to achieve any of the above outcomes, it is important to note a number of key issues surrounding this argument in New Zealand. First, Health promotion outputs are purchased in New Zealand. Services delivering health promotion activities are required to deliver against a set of pre-agreed performance indicators or outputs. Outputs can be defined as contributing factors to an outcome. Second, it would be very difficult to argue health promotion is able or unable to produce outcomes, because when it is evaluated in New Zealand it is evaluated in terms of whether it has achieved the predetermined performance indicators. Very little effort is put into evaluating outcomes across the public sector, that is how a particular intervention contributed to a desired outcome. Finally, health promotion strategies are long term, because they are at times attempting to change attitudes embedded within a societies culture can sometimes take a generation to effect. A good example is that advanced by Pomare in his attempts to outlaw certain cultural practices that he saw as being detrimental to the health of Maori.

Summary

Labonte (1999) believes health promotion is faced with 5 core tensions. These core tensions perhaps best summarise the issues facing the task of understanding health promotion.

1. Disease prevention or the focus on individual health behaviours vs health promotion or the efforts to create healthier living and working conditions.
2. Outcomes expressed as decline in mortality and morbidity rates vs outcomes expressed as well being or quality of life
3. Community based programs where groups are urged to buy into issues defined by health institutions vs community development approaches, where groups are supported to define their own issues and actions.

4. Professional expertise and knowledge often coded in the epistemology of objective scientific fact vs community wisdom often regarded as subjective lay opinion.
5. Health promotion as accountable to those institutions that fund its practice vs health promotion as accountable to those individuals and groups in communities with whom practitioners work.

Finally for a variety of reasons it would be unfair to suggest that health promotion does not contribute to health outcomes. One particular reason, using New Zealand as an example is that health promotion is not evaluated against its ability to produce health outcomes. This point will be expanded later.

DEFINING HEALTH

An important step towards understanding health promotion is to define health, because unless there is clarity in terms of what health means, it is impossible to define health promotion. Health is not an easy term to define. In health promotion circles there has been a tendency to see health more in terms of well being. Health promotion experts have attempted to define health as a positive concept, but acknowledge that its precise meaning is difficult to explain (Kemmer et al., 1995. Raeburn, 1998. Seedhouse, 1997. Labonte, 1999).

Labonte (1999) does not believe that the conceptualisation of health is easily resolved, because health unlike disease has a plurality of meanings that are shaped and prioritised in importance against such contexts as changing cultures, class, age, gender, language and location. For Labonte health is best defined in terms of people's experiences and is best understood under the following broad categories.

1. feeling vital and full of energy
2. having a sense of purpose in life.
3. experiencing a connectedness to the community
4. being able to do things one enjoys
5. having good social relationships
6. experiencing a sense of control over ones life and ones living conditions

Thus Labonte chooses to see health in the guise of well being. Labonte also supports the notion that health status is determined by structural inequalities, that is differences in wealth, poverty, living conditions. These determinants he describes as 'risk conditions'.

Raeburn (1998) argues that defining health as a positive concept is difficult in so far as health is often seen in terms of prevention, that is prevention of disease, illness even death. Instead he sees health as a subjective matter and as a component of a Quality of Life framework that consists of:

1. becoming - physical growth, leisure, practical
2. being - physical, psychological, spiritual
3. belonging - social, community, ecological

Each component can either be negative or positive in nature pending on its condition. Within this framework health exists, but is only a part of the total concept. Health outcomes can be measured against physical, psychological and social well being. These outcomes are shaped by both macro and micro determinants such as politics, environment, supports, skill resources, life events. The aim of health promotion is to progress good health within this quality of life framework (Raeburn, 1998.60 -62)

Seedhouse (1997) expends much effort undermining the WHO definition of health,

which he describes as a statement of 'Limitless meaning'. For Seedhouse the concept of health is seen in terms of individuals optimum health status.

'A person's optimum status of health is equivalent to the state of the set conditions, which fulfil or enable a person to work to fulfil his or her realistic chosen and biological potentials. Some of these conditions are of the highest importance for all people. Other are variant dependent on individual abilities and circumstances (Seedhouse, 1997. 136)."

Seedhouse therefore sees health as a state towards which people are able to work, within their 'realistic and biological potential'. This definition takes into consideration that people are different and faced with different conditions (internal and external).

Kemm et al (1995) see health as best understood in terms of a multi dimensional health matrix (see table 14). Kemms' definition postulates health in terms of lifestyle, and would exclude those people with disabilities from ever being able to experience health.

Table 14: Health matrix

Health fields	Absence of Disease	Absence of ill health	presence of positive health (well-being)
Physical Health	long life No physical disease Low risk of disease Low risk lifestyle	no physical symptoms no physical disabilities	Fitness Health promoting lifestyle
Mental Health	No psychiatric disease	No mental distress No mental disability	Self esteem Mental ability Resilience
Social Health	No social/family breakdowns	No social/family friction	Role in society social support sense of belonging

(Source: Kemm et al, 1995. 23)

The WHO defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (1946).” Again health is seen as a positive concept. WHO maintain that the essential preconditions for health are “peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (1986).”

Seedhouse (1997) argues that a close look at the WHO definition of health would suggest it is unattainable, because it does not take into consideration people are different (physically and mentally), and can not hope to achieve the WHO definition of health.

However, while the WHO definition has its many critics, its significance is more to do with the view that health is multi-dimensional. Green et al (1998) argues that the WHO definition is significant not for its obvious shortcomings in terms of suggesting that health the fulfilment of a state of completeness, but because it raises the notion that “Health includes more than physical aspects, and more than just the absence of disease...health is a multidimensional, holistic phenomenon, with multiple determinants and its positively defined by its positive well being rather than its negative aspects (1998. 153).

Common themes in defining health

There have been some common themes in terms of defining health. They are:

1. health means many different things and is not easily defined
2. health is multi - dimensional and is more than just a persons physical well being
3. health is a positive concept and not just about illness
4. positive health can also be understood as well being

5. health status is determined among other things by lifestyle and social / structural inequalities.

Table 15: Traditional Maori perspectives of health vs Health promotion perspectives of health

Theme	Maori examples	Health promotion examples
Health has many meanings	Te Wheke Te Whare Tapa Wha Nga Pou Mana	All above accounts have suggested different yet similar views of what health means.
Health is multi-dimensional	Traditional and contemporary models of Maori health see health as being more than just physical well-being. Health includes, physical, social, mental and spiritual well being	Above accounts of health have suggested health is more than just the absence of illness and disease. i.e. health includes, physical, social, mental and spiritual well being
Health is positive	Traditional models of Maori health stress the importance of lifestyle, kinship, ancestry, knowledge, skills. Little mention is made of health as illness or disease.	All above accounts have attempted to define health as a positive concept or as well being.
Health determinants	Traditional models of Maori health all stress the importance of various external and internal concepts to health, e.g. supportive family structures, land and environment,	All above accounts see health being determined by both internal individual conditions and external factors, e.g. social, economic and cultural determinants of health

Maori Health perspectives and Health promotion perspectives of Health

A discussion of Maori perspectives of health was included in a previous chapter. What is most interesting, however, is that traditional Maori perspectives of health have also generated similar themes to those presented in the health promotion

debate. (See table 15).

Table 15 makes important linkages between traditional Maori perspectives of health and the health promotion perspective of health that has evolved over the past three decades. These linkages are significant because they show that health promotion has a scope that encompasses the widely accepted Maori health perspectives, and is wide enough to address the complex Maori health issues.

Summary

While attempts to define health have not shed very much new light, they have raised some important issues. First, there are common themes that run through the health promotion perspective of health. Second, these themes are consistent with the traditional Maori view of health, and therefore have a scope wide enough to address the Maori health issues.

DEFINING HEALTH PROMOTION

The main issues that this section attempts to address are: what is health promotion? What are its intentions? How does health promotion function? How does it achieve these functions? For most health promoters the core function of health promotion is to stimulate action against the root causes of ill health in communities. (Dean, 1996. 19).

Labonte (1999) presents a Community Development perspective of health promotion. For Labonte health promotion is a 'situated practice' rather than a universal theory that attempts to explain how the world and its inhabitants act. Health promotion is therefore situated in certain organisations and is practised by a range of people, particularly health promoters.

Labonte (1999) argues the aim of health promotion is to change the relationship between the state, civil society and market economies. For example improving the

ability of groups marginalised by socio-economic conditions to voice concerns and influence political decision making in their favour. For Labonte, given the overwhelming presence of 'risk conditions' in some communities, the main focus of health promotion is to change the relationship between civil society, the state and market economies, thus working to eliminate the presence of 'risk conditions' in those communities that are most at risk. However, this task should be approached with the community rather than for the community

Raeburn defines health promotion as "an enterprise involving the development over individuals and communities, of basic conditions for physical mental social and spiritual health. The control of and resources for this enterprise need to be primarily in the hands of the people themselves, but with the back up and support of professionals, policy makers, and the overall political system (1998, 11).

For Raeburn health promotion has the following key components:

1. creates healthiness and happiness
2. advocates a holistic focus
3. a multidimensional view of health
4. focuses on the long-term living environment of people
5. should attempt to change the balance of power in human and health domains.

Central to Raeburn's view of health promotion is the notion of development (personal and community) and empowerment. What makes PCHP different is that it starts with the subjective views of people first as opposed to objective scientific fact, based on data and other evidence. .

Seedhouse (1997) defines health promotion more in terms of the health promoters and their task to enable people to fulfil their health potential, thus recognising

people have different abilities and limitations. He sees health promotion more about working for health

"Work for health is essentially enabling. It is a question of providing the appropriate foundations to enable the achievement of personal and group potential. Health in its different degrees is created by removing obstacles and by providing the basic means by which biological and chosen goals can be achieved. (Seedhouse., 1997. 136)."

Kemm et al (1995) define health promotion as:

"Those activities which are intended to prevent disease and ill health and to increase well-being in the community (1995. 3)."

Perhaps the most accepted definition of health promotion and its primary functions is that progressed by the WHO, in the Ottawa Charter. Nutbeam (a WHO representative) defines health promotion as "the process of enabling people to increase control over and to improve their health (1998. 351).

The WHO (1996) states that health promotion "represents a comprehensive social and political process: it not only embraces actions directed at strengthening skills and capabilities of individuals, but also action directed towards changing social, environment and economic conditions so as to alleviate their impact on the public and individual health (as cited in Nutbeam, 1998. 351) ".

While the WHO approach to health promotion has received wide ranging criticism (Capland, 1993. Tesh, 1998. Seedhouse, 1997), it nevertheless remains the cornerstone of health promotion in most societies where health promotion is practised (Ratima, 1999).

The WHO identifies three basic strategies for health promotion, namely advocacy (as above), enabling (all people to fulfil their health potential) and mediating (between the different interests in society in the pursuit of health. These strategies need to be seen in terms of five priority areas: building healthy public policy, creating supportive environments for health, strengthening community action for health, develop personal skills and re-orientate health services.

Building healthy public policy

This article acknowledges and recognises the importance of public policy, social policy and legislation. It also states the importance of health being on the agenda of policy makers, and that health is more than just about health care.

Creating supportive environments for health

This article of the Ottawa Charter acknowledges that health is the product of the environment. Both at home, at work, at school and son on. Thus environments must be health focused and developed to either maintain or improve health status.

Strengthening community action for health

The community is seen as an important part of community action. Communities must be involved in decision making and set their own priorities for better health experiences. They therefore must be empowered to work in their own best interests.

Develop personal skills

Central to health promotion is education of individuals, groups and communities, education that will pass on knowledge required to enable people to fulfil their potential health status. Education increases options and choices. Increased skills empower people to deal with a variety of situations.

Re-orientate health services

For peoples health to improve the health sector must modify its approach. It must involve communities in decision making, it must have more of a preventative focus and it must implement methods that ensure ongoing continuous improvements. Importantly it must shift resources from the secondary levels of care to primary levels.

The Ottawa Charter is important to health promotion for several reasons:

1. it defines health as being multidimensional
2. it outlines the main functions of health promotion
3. it prescribes the main tasks of health promoters
4. it sets key priorities, which are multidimensional in nature.
5. it is generally accepted by the bulk of the health promotion workforce

The Ottawa Charter and the Treaty of Waitangi.

At the health promotion Forum conference of New Zealand in 1997 the following remit was received:

“that the Health Promotion Forum reaffirm their role as leader of health promotion in Aotearoa by committing to facilitate the development of a framework document based on Te Tiriti o Waitangi to guide health in Aotearoa. The Ottawa charter should be used within the wider Tiriti based framework”

The Health Promotion Forum responded to the remit, by instigating four consultation hui in 1998, around New Zealand to discuss the remit with the wider health promotion workforce. In relation to the remit the findings from all four hui were fairly conclusive. The report of the consultation process entitled ‘E Rua’ make two particularly pertinent recommendations.

1. Te Tiriti o Waitangi be actively promoted as the basis for health promotion upon which all health promotion action should be based in New Zealand; and:
2. A framework document be developed as a tool for health promotion practice in Aotearoa - New Zealand and that the framework document acknowledge Te Tiriti o Waitangi as having 'paramount status'
3. Where relevant the Ottawa Charter be utilised as a useful guiding model for the progression of health promotion practice.

Put simply it was the view of the health promotion workforce that the Treaty of Waitangi was paramount to the practice of health promotion in New Zealand beyond any other document including the Ottawa Charter.

The health promotion workforce went on to recommend that any resulting framework document should also be both practical and meaningful in that it should:

1. be Treaty based and specific to Aotearoa - New Zealand, in its reflection of relevant values and issues.
2. protect the rights of iwi and hapu to express and manage their own treaty interests
3. have international relevance, although provide leadership by role modeling local experience and process.
4. represent a progressive developmental step from the Ottawa Charter and demonstrate the development of health promotion in Aotearoa - New Zealand.
5. advocate effective methods of evaluation.

(Source: TUHANZ Memorandum of Understanding, 1999. 2-3)

While still being developed, the Health Promotion Forum released the TUHANZ

Memorandum of Understanding, 1999, at its recent conference held in Napier, New Zealand, which is the first draft of the framework document. This document attempts to apply the articles and essence of Te Tiriti o Waitangi as specific goals for which health promoters can identify achievable objectives and strategies. Its main purpose being to support treaty based health promotion in Aotearoa-New Zealand

The TUHANZ memorandum states that: "The Tiriti o Waitangi is the basis on which all health promotion action should be based in Aotearoa - New Zealand (HPF, 1999. 4)." While still being progressed the TUHANZ framework identifies three goals for health promotion in direct relationship to the treaty principles and provisions (see table 16).

The next step in the development of this document will be the development of objectives, strategies and performance indicators for each goal. It is hoped this will be achieved in the near future. The first draft of the TUHANZ document suggests that its most significant contribution is likely to be:

1. proactive attempts to give the Treaty more detailed relevance to health promotion.
2. confirmation of the Treaty as the basis of all health promotion in New Zealand
3. the connection of health promotion practice with the key components of positive Maori development.

The document is also intended to be useful in the sense that it has been developed in adherence with principles of simplicity, practicality and the need to be meaningful in the Aotearoa - New Zealand context. However, what is most significant about the document is that it represents a practical reflection of the health promotion workforce commitment to the Treaty of Waitangi and a desire to

have the Treaty principles firmly grounded as the basis of health promotion practice in New Zealand.

Table 16: TUHANZ memorandum goals for health promotion

Article	Principle	Provision	Goal for health promotion
One	Participation	Governance	Achieve meaningful Maori involvement in prioritising, planning, implementing and evaluating health promotion services
Two	Partnership	Tino Rangatiratanga	Actively support the ongoing development of Maori health, purchasers, providers and workforce.
Three	Active Protection	Equality	Prioritise Maori health and health promotion to ensure that Maori have the same opportunity to enjoy at least the same level of health as non-Maori.

(Source: Health Promotion Forum, 1999)

The Jarkata Declaration

The Jakarta Declaration which builds upon the thrust of the Ottawa charter, provides some direction for health promotion into the 21st Century. The Jakarta Declaration affirms the approach of the Ottawa Charter and states five further priority areas for health promotion in the future.

1. promote social responsibility for health
2. increase investments for health developments
3. expand partnerships for Health promotion
4. increase community capacity and empower the individual
5. secure an infrastructure for health promotion

While the Jarkata Declaration has relevance to health promotion, it is yet to gain prominence in New Zealand. Most health promoters remain within the broader

gambit of the Ottawa Charter (Martin, 1998. 5)

The politics of health promotion

Health promotion is political. It is about changing relationships between people and the means of production. It is about a fairer sharing of resources. Health promotion works towards improving disparities between people. It has a vision of social justice. This notion of health promotion is gaining support (Signal, 1998. Labonte, 1999. Bunton et al., 1992). Underlying it is the view that for there to be poverty, there needs to be wealth, for there to be poor health there needs to be good health. The political aspects of health promotion challenge these polarities and proactively set out to make changes by attempting to address the disparities through strategies targeted at shifts in power.

Signal (1998) perhaps best sums up this view when she writes: "Health promotion is an inherently political enterprise. Not only is it largely funded by government, but the very nature of its activities suggests shift in power...social justice and equity (1998.257)."

Summary

It is clear that while variation exists in defining health promotion there are two constants. First, health promotion is about addressing the inequalities that exist in society in order to improve the opportunities for better health. It attempts to do this using strategies that are linked as much to social justice as to health narrowly defined. Second, the Ottawa Charter remains the most commonly accepted cornerstone of health promotion in New Zealand and the world. An interesting development in New Zealand has been the development of health promotion guidelines for practice which recognise Treaty of Waitangi, as well as the Ottawa Charter

PRACTICAL APPROACHES TO APPLYING HEALTH PROMOTION

There are at least two major approaches to practising health promotion community development and community based approaches. It is important to differentiate between them. This distinction is important to the wider context of this thesis in that each approach generates different outcomes with different levels of effectiveness in addressing Maori health outcomes.

Community Development vs Community Based Approaches.

For Labonte (1999) setting goals in health promotion is the task of the communities with health promoters and not the task of the health promoters alone. Labonte claims that health promotion should be applied adhering to the principle that health promotion works best when,

“The concerns or issues around which mobilisation occurs are defined and negotiated with community residents rather than being imposed by the health authority (Labonte, 1999.5)”

For this reason he does not believe health promotion is solely to do with disease prevention. Instead health promotion is about working with communities using the principles of community development as guidelines for practice, as opposed to principles informing the community based approach to health promotion (see table 17)

Labonte (1999) defines Community development as “...those intentional efforts on part of government or non-government institutions to improve the capacity of less powerful groups to address their social, economic and political needs, many of which play a role in determining health status (Labonte, 1999. 5).”

According to Freudenburg (1997) who has case studied 135 ‘Community Based’ approaches to health promotion, the following disadvantages were common:

1. does not reach those communities most disadvantaged
2. only addresses lifestyle issues and not wider social health determinants.
3. lacked theoretical underpinnings informing approaches.
4. ignored wider social determinants of health

Labonte states that politically community based programmes can also disempower already disadvantaged groups by:

1. trying to progress issues not relevant to the community
2. being non-responsive and judgmental
3. complicate lives of people already struggling
4. focusing on individual gains, rather than collective needs

Labonte (1999) argues that health promotion is most effective when using the guiding principles of community development. The community development approach allows communities to determine issues, not agencies. Power is therefore maintained by the community thus, ownership and buy in by the community becomes more likely, which leads to a greater opportunity for success. The health promoter also has power, particularly in terms of knowledge. Therefore the task of the health promoter is to share this knowledge without disempowering the community and to reframe community identified issues to ensure participation by the wider community and accountability to the funder of health services. (see table 18).

Labonte (1999) describes five key strategies, not necessarily as a prescription for community development, but definitely as issues that require consideration. These five key strategies are personal care, supporting group development, community organisation, coalition building and advocacy and political action and should be

applied in accordance with the situation at hand. (see table 19).

Table 17: Community Development vs Community Based approaches to health promotion.

Concept	Community Development Approach	Community Based Approach
Setting Goals	Defined by the Community	Set by the agency, usually contractual
Accountability	Accountable to the community first	Accountable to the agency, or funder
Practice perspective	Bottom up	Top down
Prevention of disease	Only important if an issue for the community	Usually the measure of performance as per funder contracts
Power	Maintained by the community	Held by the agency
Main focus	Addressing Health determinants	Making Lifestyle changes
Ottawa Charter	works in principle with this key health promotion document	Sometimes contradicts this document.

(Source: Labonte, 1999)

Table 18: Tasks of the community development health promoter

Task	Description
Must choose groups	Health promoter must choose which groups to work with based on, their own abilities. Selection should consider the factors, an overlap in interests, the need for a group, which is democratic and has the ability to become autonomous.
Sharing power	To allow communities to make decisions, set goals etc., and to be empowered by sharing knowledge
Reframing goals	This is important both in terms of reframing issue to gain support at the community level and at a funding level.
Supporting	Supporting communities to find solutions, rather than presenting

communities	remedies
Address determinants	Should be aiming to address determinants of health rather than just lifestyle issue
Mobilisation	Should be aiming to mobilise communities

Raeburn (1998) also supports the community development approach, because it values the subjective realities of the individual.

Raeburn (1998) believe that health promotion has evolved through two distinct stages, the life styles phase (thrust forward by the 1974 Lalonde report) and then the social determinants phase which was a response in part to the lifestyle model being used to heap blame on the individual for their poor health choices. The social determinants era according to Raeburn recognised that health choices were more than personally determined, and in fact were associated to social class issues. This was perhaps best outlined in the documentation associated to the Ottawa Charter. The move of health promotion to see the wider social issues as the predominant cause of poor health and not the individual, was sound in its reasoning, but also resulted in playing down the importance of the individual to health promotion.

“ ... along with throwing out the lifestyle concept, was a playing down of the role of the individual as an agent in his or her health promotion(Raeburn, 1998. 7).”

Table 19: Labontes' community development strategies

Strategic Sphere	Characteristics
Personal Care	basic support, empathy and affirming trust individual advocacy counselling, education and crisis intervention referral to other agencies and/or community support groups

support Group development	improving social support and increasing social networks overcoming learned helplessness building support for personal changes building support for social action groups on risk conditions
Community organisation	outreach to the under represented critical community / professional dialogue developing local actions on community defined health issues leadership development, evaluation and community building
Coalition building and advocacy	organising and supporting social action coalitions participating in and supporting issue based coalitions advocacy and lobbying for healthier public policies moving from advocacy for to advocacy with
Political action	intensifying participatory politics linking local issues with nation/global policies aligning with social movement struggles creating democratic partnerships between state and civil society

Raeburn (1998) defines community as the “every day setting , the nexus where people choose live out their lives from moment to moment, for most of us involves the mundane issues of the house we live in, family, relationships, neighbourhood, workplace, school church, interest groups, clubs, community services, politics, and so on (1998.19).”

Central to Raeburn et al (1998) views of people centred health promotion is allowing the community to take control of its endeavours. Resources should be directed into the community for the community to fulfil its self determined goals. Again the role of the health promoter is as a resource person and facilitator, not the director of affairs (see table 20).

Table 20: Key essentials of people centred health promotion.

Concept	Feature	Practical Application
People Centred	Every day Experience	Valuing qualitative information i.e. the views of 'just plain folks' (jpf's)
	Community perspective	Valuing perception of a situation as opposed to the objective reality.
	Facilitatory role for Health professionals	Being a resource person for the community
Empowerment	Control - community, group and personal	recognising the importance of the community, group and person having control
	Strength building	Supporting people to gain control, by developing strengths and assets of people
	Resources based approach	Support communities to do, not do it for them.
Organisational and Community development	Organisational development	Implementing strategies that will encourage people to learn and fosters commitment.
	Community development	Allowing the community to make decisions
Participation	Involvement of as many peoples possible	Being inclusive as opposed to exclusive
	Representativeness	Encouraging those least likely to participate, but most in need
	Popular activities hat motivate, meet needs and strengthen	Implementing activities that attract not detract participation. I.e. people must be able to relate to them.
	Unity	Generating cohesiveness

Life Quality	Ultimate goal of PCHP	Strategies must impact positively on the 'Quality of Life'
	Positivity	Focusing on issues beyond illness e.g. fitness, well-being, healthiness, skill development and so on.
	Spirituality and spiritual health	Recognising importance to Health
Evaluation	Outcome evaluation	Evaluating success of projects in terms of whether goals have been met.
	Process evaluation	Systematic evaluation of progress
	Accountability	being clear about requirements to demonstrate accountability to both community and agency.
	Power of Data	Collecting relevant data as a tool for progression
	Cybernetic and self criticism	ongoing systems for continuous improvements.

While the community based approach to health promotion is not totally discarded, there is some consensus that health promotion achieves results best when it is applied in association with principles of community development. The main difference between the two models being the notion that the community should decide what the goals of health promotion practice are as opposed to the health agency. Thus, the performance of health promotion should be evaluated according to the achievement of community identified goals and not necessarily mortality and/or morbidity rates.

SUMMARY

The recognition that lifestyles and then wider social conditions play a greater part in determining health status than medical intervention, is central to the rise in

prominence of health promotion.

Health promotion is not a new concept, examples exist across many cultures, including traditional Maori society, where a customary health system protected communities from disease and illness and promoted well-being by adhering to conservation principles. There is evidence to suggest that Dr Pomare the first Medical Officer to Maori advanced public health methods to prevent disease and protect Maori from illness. Significant to Dr Pomare's work is his realisation that social, cultural and economic factors play a part in determining health. The approach of Dr Pomare to health and the traditional approaches of Maori align themselves closely with what has come to be termed health promotion.

Health is seen within health promotion as a multidimensional concept. It involves more than just physical well-being and includes well-being in the mental, social, and spiritual spheres. Furthermore, it is generally accepted that health is predominantly socially determined by such issues as poverty, housing, social belonging and income. All play a part in determining health status. This concept of health is closely aligned to the traditional and contemporary Maori perceptions of health, which are also multi-dimensional in nature.

Finally, while there is much debate about health promotion, there is general agreement that health promotion is "about the process of enabling people to increase control over and to improve their health". This is best articulated in accordance with the Ottawa Charter, which provides clarity and guidance to most health promotion activity. A final point is that it is becoming more accepted that health promotion is most effective within a community development framework.

Health promotion as a tool for addressing Maori health issues

Before concluding this chapter it is important to explore the potential of health promotion to align with Maori development aspirations and secondly to be able to

address Maori health in a broad sense.

What can clearly be concluded from the alignment of Maori development aspirations to the aims and functions of health promotion, is that:

1. health promotion clearly has strong similarities with Maori perceptions of health
2. health promotion clearly provides a useful framework to advance Maori health outcomes
3. the underlying philosophies of health promotion clearly support and compliment the principles and provisions guiding Maori development and the process for better health outcomes.

These observations would suggest that health promotion can be provide an effective model of practice at the service delivery level, and an effective framework at a policy level to advance Maori health outcomes. The question that remains is whether health promotion can make a positive difference to Maori standards of health within the publicly funded New Zealand health system.

An analysis of the New Zealand health system with regard to the application of health promotion and a progression of the debate surrounding outputs and outcomes will follow in continuing chapters.

CHAPTER SIX

UNIVERSAL THEORIES THAT SHAPE SOCIAL POLICY IN NEW ZEALAND

INTRODUCTION

In order to understand the radical health reforms experienced in New Zealand in the 1990's it is important to have an understanding of those theoretical perspectives that have played a part in shaping social policy in New Zealand and the world. This chapter provides an overview of the dominant political perspectives represented in New Zealand politics (Marxist, neo Marxist, Social Democratic, Liberal and neo Liberal) as a precursor to an examination of the health reformation started in 1984 by the fourth Labour Government and progressed through the 1990's by the 1990 National Government and 1996 National led Coalition Government.

The purpose of this chapter in the context of this thesis is to provide a theoretical framework that can be used to understand the rationale for the health reforms, what the reforms are expected to achieve (in particular Maori and their growing health needs) and what alternative approaches exist. This chapter focuses on the universal theories and their implication for social policy in terms of:

- health service delivery
- nature of services to be delivered
- who delivers services
- who is responsible for meeting the cost of health care.

FACT AND THEORY

Why look at how theory shapes practice/policy? Fundamental to understanding the reforms is an analysis of those theories which predominantly inform decision-makers in their quest to develop and shape social policy. These policies then have the practical function of operationalising a governments approach to welfare and

health provision. From this understanding it is possible to first, realise the underlying philosophies of social policy and, second, identify both the proposed and likely outcome of social policy. An understanding of universal theories that shape approaches to welfare provision also enables a consideration of other alternatives (Cheyne et al, 1997).

" Social policy is not however, simply a matter of looking at the facts and rationally selecting a strategy for dealing with the problems of poverty, poor housing, or unemployment. Policy directions are inevitably based on a series of assumptions about the relationship between the state, individuals and various groups within society. These assumptions are often tied explicitly or implicitly to one or other of a number of theoretical perspectives. Being able to locate the various arguments used in policy debates within particular theories helps us to understand the origins of these arguments and allows us to consider other alternatives, based on other perspectives (Cheyne, 1997.67)."

It is with this notion in mind that an analysis of those theoretical perspectives most dominant in the shaping of social policy in New Zealand is made.

AN OVERVIEW OF UNIVERSAL THEORIES THAT INFORM SOCIAL POLICY

This section provides an analysis of the following 'universal theories' with particular regard to their implication for social policy.

- Marxism and Neo Marxist
- Social Democracy
- Liberalism and Neo Liberalism

The following analysis has been structured to show how each of the above universal theories have fundamental implications in both prescription and outcome to social policy and the provision of health and welfare with particular reference

to:

- the role and responsibility of the 'State'
- the role and responsibilities of the 'Individual'
- the role and responsibility of 'Society'
- the role and responsibility of the 'Free market'

Liberalism

Many approaches to social policy have been developed in reaction to liberalism. It is argued that liberalism provided the impetus for the development of the necessary framework for social policy through its practical association with democratic government and market economies. Defining this approach however is difficult as there is no single person whose work provides the source of key ideas (Cheyne, 1997. Pierson, 1991. Spoonley et al, 1990).

However, while definition is a challenge, fundamental to liberalism are four key features; (1) the importance of Individual freedom and choice, (2) the unhindered operations of the free market, (3) the laissez-faire approach to state intervention, and (4) the acceptance of deprivation and inequality resulting from the unhindered operations of the free market. For the sake of simplifying the analysis of this approach, this section is structured against the above four key components of liberal thought.

The Individual

Central to the liberal approach are the individual and the right of the individual to act as rational and autonomous human beings. That is the individual has the right to own property, to trade freely, the right to constitutional government and to individual civil rights. (Cheyne, 1997)

Put simply society is seen as a collective of rational and autonomous human beings who given the opportunity will act as such. Thus, individuals must be

allowed to make choices and more importantly have freedom of choice. Choice should not be made for the individual by the State. The choice about where to live, where to work, what schools to attend, which doctor to see should be in all instances individually determined. The only restrictions come when the individual choice of one negatively (with regards the judicial system) impacts on the rights of another. The practical application of choice in liberal society means also that individuals are free to make choices but must meet the cost of making a particular choice.

In terms of health and welfare coupled with freedom of choice is the responsibility for maintaining ones own welfare (meeting the cost) except in extreme cases of misfortune, disability and poverty. For example, one is free to choose and utilise the best possible coronary heart surgeon available as long as one has the ability to sustain the market cost of such a service. Only in exceptional circumstances is the individual to be rescued by the state. It is thought that reluctant state intervention ensures the individual is motivated to maintain and excel their individual well being

The laissez-faire approach to State intervention

From a liberal perspective the state has three main functions. First to maintain justice (in terms of a judicial system) and protect the individual, second to promote individualism, thus allowing the individual to act in their own self-interest and third to provide a residual welfare safety net. Underlying these functions is the principle of laissez-faire or minimal and reluctant state intervention.

Simply stated the State is present to act in the interest of the individual by providing a judicial system that maintains justice through conviction of those who contradict it. The state also encourages individualism and reluctantly provides basic welfare to those most in need. Hayek (1992) sees the role of the state as:

"The duty of the public authority is not to pursue its own ends but rather to provide the framework within which 'catallaxy' may develop. Those functions for which the state may ... raise taxation are (1) ... provision of collective security... (2) preservation ... to the impartial application of general rules of property, and contract and tort, (3) provision for (though not necessarily the administration of) those collective public goods which the market cannot efficiently provide, e.g. Internal violence, building and maintenance of roads (4) provision of a minimum income for everyone, more precisely ... the sick, the old and mentally defective. (Hayek as cited in Pierson, 1991. 43)."

The liberal state therefore has a minimal role to play in the provision of welfare and adopts what is termed a residual approach. Excessive intervention by the state is thought to create dependency, remove choice and deter the opportunity for individual self-actualisation. Individuals in a laissez-faire state are charged with the task of self-help, and are motivated by the doom of dependency on a reluctant provider of welfare.

However an important distinction to make between the classical liberal perspective and the neo liberal perspective is that while intervention by the state is reluctant it nevertheless is deemed necessary for the state to intervene. Albeit that the State is seen by libertarians in a negative vein at best. Any intervention should be minimal in nature.

The Free Market

As with the neo liberal approach or the new right perspective the answer to societies problems is seen to lie in the unhindered operations of the free market.

At the market of which individuals interact as buyers and sellers - both of services and products. The free market is believed to create meaningful competition that stimulates people to self-actualisation. The forces of the market drive people to create their own opportunities. Thus, if one can provide what the others in the

market demand, then one is likely to prosper. If demands cannot be met, the service or product is simply not available.

Within the free market therefore, there are winners and losers, both of which are deservedly placed according to liberal thought. Thus inequality is an accepted reality in liberal society, accepted because the free market is seen as being able to operate without bias. Thus any outcomes of the market are natural as the market has no bias.

Deprivation and Inequality

The existence of inequality and deprivation in a liberal society is an accepted evil, the result of the market. Given that the market operates without bias its outcomes are not intentional and therefore should be accepted. Such is the nature of competition. For competition in the market to work someone must always have what someone else cannot provide. If the product is desirable, this in turn creates demand. Welfare is not an option according to liberals as it takes away peoples freedom, creates dependency and minimises the desire to fulfil their potential.

Libertarians therefore accept deprivation and inequality because it is created without bias and inequality is an important component in the fuelling of competition.

Neo liberalism and the New Right

Neo liberalism or the New Right approach is a return to liberalism with one fundamental difference - the rejection of the necessary role of the state. Within this approach there are four key features which both encompass and expand those features put forward in earlier discussions about liberalism. For the purposes of providing a basic definition of Neo Liberalism, the Neo Liberalism approach can be seen in terms of the following four key features: (1) sovereign consumer, (2) a non interventionist state, (3) free market justice and (4) equality of opportunity and

treatment. These features draw on direct parallels with those described in the liberal approach

The Sovereign Consumer

Neo liberalism encompasses the liberal perception of the consumer, only it is taken it even further by deeming the individual the all-sovereign power in society as opposed to the state. It adheres to the concept of self-ownership in that every person owns his/her body and has the right to determine what they do with it. Any advantages that result from these decisions belong to the individual. It is thought that individuals know what is best for themselves. They are rational and intelligent. In the eyes of neo liberals, individuals are and should be responsible for their destiny (Cheyne, 1997).

Hence the Neo Liberal view of the 'sovereign consumer'. Ultimately, if the free market operates unhindered than individuals have the power to make decisions, as it is through individual choice that changes, desires, markets are driven. This view of the individual is even better understood in the context of the free market.

Free Market Justice

Justice, welfare and well-being are best determined by the unhindered operation of the free market. Any intervention by the state is deemed coercive, not useful and unnatural.

"... it is through the operations of the market that the freely acting individual will be best able to pursue his/her self-interest. It is in the market that the individual can exercise choice. Through buyers expression of choice the seller learns whether the goods and services provided are wanted, if the seller ignores the preferences of the buyers the seller tends to go out of business...The expression of individual self interest through the market leads to the most desirable social outcomes in which social well-being is necessarily advanced by the pursuit of the individuals self interest. (Cheyne et al, 1997.80)"

The neo liberal approach then relies heavily on the free market as it is seen as an unbiased mechanism that has the ability to produce well being. Of course the fuel that drives the free market is competition, that is the urge to do better than another in order to survive in neo liberal society. Thus, an emphasis is placed on being the best in the first instance in the second instance. Providing services/products, efficiently (so to be able to price competitively) and ensuring provision is effective, accessible and competent are all goals of those competing in the free market, for it is these goals that makes one competitive.

Libertarian right theory asserts the supremacy of the market to provide goods and services as opposed to the public sector, a preference for individual rather than collective action and an emphasis on the free individual acting in competition with other individuals. (Spoonley et al, 125. 1991)." Deprivation and inequality in terms of outcome is accepted as everyone is accorded equality of opportunity and treatment. The state must refrain from intervention and allow individuals freedom of choice.

The Non-Intervening Government

Neo liberals reject any state intervention outside the bounds of providing a justice system that allows for individualism and free market operations and protection of internal and external harm. The state is seen as being negative in nature. The state should not intervene. Intervention is seen as the removal of the individuals right to make choices and to determine their own destiny. Taxation of individual income is sometimes seen as theft, as it is the compulsory removing of money from an individual and using it in some instances to improve the well being of others. This type of intervention by the state is seen as harmful and nonsensical.

" The objective of government must be limited. Its major function must be to protect our freedom, both from the enemies outside our gates and from our fellow

citizens; to preserve law and order, to enforce private contracts, to foster competitive markets (Freidman as cited in Pierson, 1991.42)."

In simple terms the role of the government is protection of the individual, promotion of individualism and the fostering of competitive markets. The neo liberal community (Jesson et al. 1988) scorns upon any intervention outside these parameters.

Equality of opportunity and Treatment

Central to the neo liberal approach are the concepts of equality of equal opportunity and treatment. Every one is treated the same and has the right to the same opportunities presented by the market as any other individual. This premise based upon freedom of choice and individual self-determination has one implication already discussed with regards to liberalism. In a neo liberal economy there are winners and losers. This is an accepted reality as are the notions of inequality, deprivation and disparities. In other words personal welfare is the responsibility of the individual and as long as the individual is protected and has the same opportunities and treatment as other individuals, such issues become motivators for that individual to better their circumstances.

According to the neo liberals, the cause of deprivation is by and large derived from the choices made by individuals. Whatever the case there is no external cause of need: it is very much a matter of individual choice ... disparities of income and wealth can serve to provide incentives for those who are less well off to better themselves (Cheyne et al, 1997. 88)."

Implication of the liberal approach for health services

There are three distinct features of welfare provision driven by the liberal / neo liberal user pays, private service providers and minimal support by the state in the provision of health or welfare services (see Table 21). One positive factor however, is low taxation rates and freedom of choice.

A critique of the Liberal/Neo Liberal perspective

Most critical of the Liberal approach are the Marxist and Neo Marxists camps. Their criticisms in particular centres around class relations, capitalism and the acceptance of inequality.

Table 21: Liberal/neo liberal approach to health provision

Issue	Liberal	Neo Liberal
State Intervention	Minimal Welfare provided. Residual in nature.	Reluctant residual welfare provided. Last resort only.
Individual Responsibility	Individuals are responsible for their own health. They are free to choose who and what services they require	
User Pays	All services are to be paid for by those who use them. Some services in special circumstances may be subsidised by the state but only to provide for those most in need.	All services are to be paid for by those who use them. The voluntary sector is relied on to provide services to those most in need who can not provide for themselves.
Free Market	The free market will ensure that all services are provided and affordable. This is based on the premise that services must be priced right in order to survive.	
Taxation	While the consumer pays for services, very low taxes are taken by the state.	Low taxes, only required for funding of necessary government operations. e.g. law and order, security.
Service Providers	Service providers are independent and free from the state, must compete for funds to provide services	Private companies all of whom compete vigorously to obtain funds provide services. Profit driven.

The role of the State

Marxists share a similar view with Liberals in terms of the state. Neither perspective, trust, respects or has much time for the state. Although, for quite different reasons. From a Marxists perspective however, the liberal state works to oppress the working class in favour of maintaining exploitative class relations and the dominance of the capitalist class.

For neo Marxists and social democrats, the minimal approach to intervention by the state is inhumane and prolongs and intensifies hardship and poverty. The liberal approach to the state is therefore strongly opposed by neo Marxists and social democrats. Albeit, that from a neo Marxist perspective, ultimately the state operates to serve capitalist interests.

Acceptance of Inequality and Deprivation

The acceptance by liberals of inequality is again a contentious issue for Marxists, neo Marxists and social democrats, of whom strive for equality of outcome. The acceptance of inequality and deprivation in society by liberals and use of these experiences to motivate competition in the capitalist society confirms for Marxists, neo Marxists and social democrats the inhumane nature of the liberal approach, all of whom see inequality and the acceptance of as unnecessary.

Capitalism

The operations of the free market to generate an unbiased well being in a capitalist economy is again a contentious issue for Marxists, neo Marxists and social democrats. For Marxists and neo Marxists, capitalism is the ultimate in all evil as this mode of production, oppresses the working class, polarises the predominant classes in society and creates inequality and deprivation.

For social democrats however, capitalism is seen as a necessary evil. However, the free market in a capitalist society should not be allowed to function

independently of the state. It needs to be regulated and maintained in order to provide for greater well being and to produce equal outcomes for all.

The Individual

The liberal obsession with promoting individualism is again not seen as favourable by Marxists, neo Marxists and social democrats All of whom prefer to view the collective well-being and equality of outcome across the board as paramount. Furthermore, no individual deserves to be considerable worse off than another.

Social Democracy

The social democratic tradition is thought to have stemmed from concern about the ability of capitalist economies to deal with and prevent such events as the great depression of the 1930's (Cheyne et al., 1997. Spoonley et al., 1991. Pierson, 1991).

The social democratic consensus was largely a reaction to the failure of neo classical economics to either explain the Great depression or provide governments with effective policy responses to it (Spoonley et al.1990.120). The social democratic approach is characteristic of New Zealand society post 1930 for fifty or so years (Spoonley et al.,1990, Bedggood, 1998. Williams, 1995).

The social democratic approach asserts three fundamental propositions. (1) the continuation of the capitalist economy but with a human face (2) the necessary intervention of government in both the regulation of the economy and the provision of welfare, in response to the inability of capitalism to both prevent and address significant deprivation as experienced during the great depression of the 1930's. (3) in comparison to Marxism the social democratic approach is described as being evolutionary in nature as opposed to revolutionary.

Pierson (1991) writes social democracy is a twofold strategy "... built upon active government intervention through the macro management of the economy to

ensure economic growth under conditions of full employment and a range of social policies dealing with the redistribution of the fruits of economic growth, the management of its human effects and the compensation of those who suffer from them. (Pierson, 1991. 28)."

Using Capitalism to Meet Social Needs

In a sense this approach uses capitalism to meet social needs. Unemployment and poverty are seen as evils that should be combated by the state through the application of regulated economic policy. From a social democratic viewpoint it is thought that capitalism can be advanced through state regulation and control to minimise hardship and prevent a reoccurrence of such events as the great depression (1930). Social democracy in a sense attempts to give capitalism a human face by effecting alongside the regulated capitalist economy a comprehensive approach to welfare, which has the simultaneous effect of also driving demand. Thus despite obvious differences in the application of the capitalist model, social democrats choose to see it as the most effective form of economic organisation (Cheyne et al, 1997).

At the centre of the social democratic approach is Keynes economics i.e. demand side economics as opposed to supply side economics adhered to by the liberal camp. The demand side economics approach is central to the proposition of advancing capitalism through positively creating demand, while simultaneously meeting social needs.

The theories of John Maynard Keynes were to justify the development of a programme of greater state intervention in the economy as a means to promote full employment , minimise inflation, "...curb the volatility of private investment using an active fiscal policy(government spending and taxation policies) and monetary management policy (Spoonley et al., 1990. 120)."

Put simply, regulated capitalist economies can be used by the state to create employment, improve life opportunities while simultaneously advancing the intervention of the state in the comprehensive provision of welfare. For example, the state will regulate the economy by applying tariffs to incoming trade from overseas. This has the result of making local products cheaper, thus ensuring demand by the consumer for local goods and in the long-term jobs for people that can be maintained. Second the value of the dollar may be frozen by the state when it has a low off shore value. This strategy in turn creates offshore demand for local products given the comparative strength of overseas currency. Again given the resulting demand jobs are created to meet demands of those off shore. Third again to stimulate the local economy, the state will endeavour to manufacture low interest rates. This makes money cheaper to buy, as a result more spending is encouraged, which again increases demand and again jobs are created. Alongside the regulation of the economy the government will endeavour to provide a responsive welfare state. For example if there is a housing shortage the government will build houses and rent or sell them cheaply. The mass building of houses again creates jobs across a range of suppliers and services. The mass creation of jobs then minimises unemployment, and generates spending. In essence the state attempts to create demand for goods and services through regulation of the economy and the injection of taxation revenue in a multitude of ventures, as opposed to allowing market forces to act independently.

The down side to this approach is the likelihood of rapid inflationary growth. If a growing child that been injected full of steroids to increase growth rates, eventually the child will want more than the body can provide. Furthermore, with provision of extra resource the cost becomes higher and higher because the body can't cope with demand and eventually burns out or bursts. Ultimately the costs become so high the body can not afford it. In real terms in a demand driven economy, inflation and prices are hard to maintain, taxes become very high and the value of money on the international market is low.

The Social Democratic State - Necessary Government Intervention

Cheyne (1997) perhaps best sums up the role of the state in a social democratic society:

"To abolish avoidable ills... to be reactive rather than promotional: it is problem centred. State intervention is required out of necessity, not a matter of principle. The task for the state is to ensure that the economic system of capitalism is given stability through the state thereby enabling capitalism to operate most effectively. Cheyne, 1997. 76)."

Under the social democratic regime individuals in society are seen as deserving of welfare, and the provision of welfare is seen as a citizens rights, the view being that without such an egalitarian approach by the state to society, some of its members would not have a voice and would continually be disadvantaged, for example the mentally ill and the elderly.

However, this well being is funded through taxation and based on the state and what it believes to be best for individuals. A component of which is greatly criticised by neo liberals or those ascribing to the new right.

Nevertheless state intervention in the management of capitalist modes of production and the provision of welfare are seen as essential and necessary from a social democratic view point.

Evolution vs Revolution

The final central component of social democracy is that unlike the traditional Marxist view (which will be expanded later in this chapter) social democrats view political and ideological change being achievable through evolutionary means as opposed to the total upheaval of society by way of social revolution. (Bedggood,

1988. Pierson, 1991. Williams, 1989). Changes can be achieved through controlling the state so that the capitalist mode of production can be used to advance or benefit the working class.

Keynes insisted that:

"It is not the ownership of the instruments of production, which it is important for the state to assume. If the state is able to determine the aggregate amount of resources devoted to augmenting the instruments and the basic rate of reward to those who own them, it will have accomplished all that is necessary (Keynes, 1973. 378)."

Table 22: Social democratic approach to health provision

Issue	Social Democracy
State Intervention	Absolutely necessary, both in terms of regulating the economy and providing welfare services. The aim for the State is to create 'full employment'
Individual Rights	Everyone in society has the right to experience good health. Achieving this notion is a function of the State..
User pays	Services would in the main be provided free by the State
Taxation	Taxation is high, in order to fund the comprehensive state provided Welfare and public works program.
Free Market	Capitalism would still be the preferred mode of production, but would be regulated and controlled for the benefit of all.
Service Providers	The state would ultimately control the provision of health services. There would be little need for private providers.

Implication of the Social Democratic Approach for Health Service Provision

Table 22 presents some of the key features of welfare and service provision in a social democratic society. Particularly relevant to their approach is that while welfare is comprehensive and free, this can lead to high taxes and an economy characterised by the rapid growth of inflation.

A critique of Social Democratic perspective

Strong criticism exists from both the liberal / neo liberal and Marxist / neo Marxist camp with regards the eclectic approach of the social democrat.

State Intervention and Regulation

From a Liberal / Neo Liberal perspective any intervention by the state outside the provision of a judicial system is scorned upon. Liberals believe that intervention by the state – such as regulating the economy, universal provision of welfare - creates dependency and leads to the generation of what they term 'unnatural' outcomes. Which are considered to be unfair and of little positive consequence for society in the long run. Natural and unbiased outcomes for a liberal / neo Liberals can only be achieved by the unhindered operations of the free market.

From a Marxist perspective state intervention is seen as only delaying the inevitable (i.e. social revolution) and rather than being positive is negative because it makes hardship and oppression of the working class bearable, thus minimising the opportunity for social revolution.

The Welfare State

Neo Marxists would support the universal provision of welfare by the state. However, for the liberal / neo liberals the welfare state adhered to by social democrats creates a number of issues. First the welfare state is uneconomic; it creates dependency and discourages people to work for a living. Second it creates a huge public bureaucracy, minimises private development and results inflation.

Third it creates a monopoly in welfare service provision by the State, which leads to inefficiencies and non-responsive services. Fourth the welfare state has proven to be ineffective in addressing poverty, by creating dependence, so a cycle of poverty is created. Fifth it is despotic; it grows bureaucracy and controls the social outcomes of people in society. Finally, it denies individual freedom and for people to make choices of their own (Pierson, 1991).

Marxists as already stated would not support the social democratic welfare state. The Marxist rejection of the social democratic welfare state is based upon two premises. First its softening of the wider issues effecting the working class thus maintaining continued oppression and second through taxation of the working class and redistribution of taxes to subsidise capital (in that much resource is required to fund the welfare state and subsidise services). Bedggood (1988) states that:

"The Social Democratic Welfare state ... represents the most advanced form of Bourgeois domination of the working class ... We find the taxation of working class is the only source of state income paying not only for the welfare system (much of which goes back to the working class) but paying also state subsidies to capital (Bedggood, 1988. 33)."

The Social Democratic Approach to Capitalism

Liberals, neo liberals, Marxists and neo Marxists all reject the social democratic approach to capitalism although from different perspectives

From a Marxist and neo Marxist perspective any acceptance of capitalism would be rejected because it maintains structural inequalities regardless of regulation.

From liberals and neo liberal perspectives it is rejected because regulation of the economy is seen as hindering the free market and the opportunity for unbiased and natural outcomes.

Marxism

Karl Marx argued that the free market did not lead to greater social wealth but to greater poverty and exploitation of the working class. Marx saw capitalism as the evil that created much inequality and hardship in society. For Marx the capitalist society maintained class relations by developing structural inequalities. Central to Marxism are three specific features. (1) exploitative nature of the capitalist economy (class society) (2) the state as a tool of the bourgeoisie (3) the need for revolution to effect change.

The Exploitative Nature of Capitalism (Class Society)

For Marx the capitalism economy is exploitative in nature. He believed that within a capitalist society two classes predominantly exist. the bourgeoisie (capitalists, characterised by the ownership of the means of production) and proletariat (working class - characterised by their need to sell their labour on the market). Marx also believed that society to a degree had two further much smaller classes, the lumpen proletariat (Those who could not fend for themselves and were poor) and the petty bourgeoisie (self-employed).

Marx believed that capitalists exploited the working class. He demonstrated this by showing how the working class was not paid the true worth of their labour but only a proportion of it. Capitalists would retain any surplus value (profit), such was the nature of the exploitative relationship that existed between the two classes.

Marx claimed that:

"Capitalism is a dynamic system in which the competitive search for profit and responses to the long-term tendency for the rate of profit to fall lead to the intensification of exploitation and the heightening of class conflict (Pierson.1991.10)".

An example of how Marx perceived the exploitative nature that existed between

the working class and capitalist class is illustrated by Bedggood (1988).

Table 23: Division of working day into necessary and surplus labour time.

B Value of Labour Power	C New Value	A Surplus Value

Table23 represents the structure of a working persons day in a capitalist economy. With regards to earning (salary/wages) the day is broken into three parts. Part B is the part of the day that represents the amount of work per individual to achieve what they are paid. Part A represents the work that is being done by an individual but is not paid, and Part C is the potential for the value of the workers' day in money terms to be increased, that the surplus value that could be distributed by the Capitalist (Bedggood, 1988).

Marx believed that if the capitalist society were not overthrown the capitalist and working class would continue to be polarised. The gap between rich and poor would continue to grow. According to Marx the only way forward to a fairer society (what he described as an egalitarian utopia) was social revolution (Giddens, 1990).

The State as a Tool of the Bourgeoisie

For Marxists the state is a tool of the capitalist class, that is used by the bourgeoisie to maintain class relations and to continue the oppression of the working class. Marx also described religion as the agent of oppression. He described religion as a drug – '*the opium of the people*', because it blurs reality and makes people believe that hardship and poverty was the divine will of God. Such tests would be rewarded in life after death, thereby passively forcing people to accept in some cases their undesirable circumstances.

The Marxist perception of the state was that it could:

"...not intervene in such a way as to undermine the logic of the capitalist market economy or act against the long term interests of the capitalist class. Whatever institutional forms the state under capitalists might take .. It remained in essence a capitalist state (Pierson, 1991. P.11)."

Marx was not convinced in the power of the state, even in terms of the democratic voting process and the working class electing its representatives to government that could advance their needs. For Marx the welfare state while positive in nature, was merely a nicely painted human mask (painted by capitalists) to cover up the greedy and uncaring beast (capitalist economy) that lay below. Marx believed the welfare state created conditions that would discourage social revolution either through managed fragmentation or religion, and that the provision of welfare by the state fell short of addressing the real issues.

The Need for Social Revolution to Effect Change

Marx saw the development of society in stages. Each stage could only move forward after a social revolution, such as the French revolution or the industrial revolution. He believed that capitalism would be replaced by socialism. Socialism would in turn bring a new communist state where all were equal.

"Capitalism was not the last phase in the historical process. The capitalist world would soon be replaced by Socialism, (which would then transform society into a truly communist state). With its exploitation and massive and increasing gulf between the capitalist bourgeoisie and the proletariat, capitalism was doomed as feudalism had been before it (Cheyne et al., 1997. 93)."

Marxists are against inequality derived from free market forces and do not believe there is a need for market driven deprivation and disparity. Marx believed that instead people should live in an egalitarian utopia, where all men / women were equal, and the function of society was the advancement of the collective good as

opposed to the progression of individualism. In short equal outcomes and results are achieved for all. Therefore Marxism is targeted predominantly at the destruction of capitalism and the implementation of socialism with the ultimate aim being the advancement of Communism.

Neo Marxism

Perhaps the fundamental modification in thought that exists between Marxism and neo Marxism is with regards the perception of the state. In contrast to Marxists, neo Marxists see opportunity in utilising the state. Thus there are two key features that characterise their approach in contrast to classical Marxism (1) the state as a useful tool and (2) elimination of inequality.

The Usefulness of the State.

For neo Marxists the state is seen as useful, even though it will always adhere to the advancing of the capitalist class. It can still be used to develop a more egalitarian society.

" Early Marxists believed the state to be a tool of the Bourgeoisie of which would be used to serve their own self interests including the systematic oppression of the Proletariat (working class). However, neo Marxists have modified this view (Gramsci) and see greater potential in the usefulness of the state in progressing the socialist worldview. In that, the State can in fact be used as a tool to advance through co-operation ones worldview, although in the last instance the worldview of the Bourgeoisie will be favoured (Armstrong as cited in Spoonley, 1991).

Elimination of Inequality.

Like Marxism neo Marxism is concerned with ridding society of inequalities that exist as a result of capitalism. However, for neo Marxists society is just when peoples needs are met, and when inequality and exploitation in economic and social relations are eliminated. Put simply both approaches focused on advancing

the position of the worker in society. Thus for neo Marxists the development of a benevolent welfare state is advantageous as it ensures basic health and welfare outcomes are achievable by all. Comprehensive welfare and benevolent intervention by the state in terms of the redistribution of societies resources to the working class are central to the neo Marxist approach.

Implication of the Neo Marxist / Socialist Approach for Health Service Provision

While the Neo Marxist and Marxist perspective are similar, there is one distinguishing feature, the greater acceptance of the state and its ability to work in favour of the working class by the Neo Marxists. The Marxist perspective has been presented from a socialist view point, which has been described as practical Marxism (Chenye et al., 1997) or the transition phase from capitalism to pure communism (see table 24).

A Critique of Neo Marxism / Marxism

The main criticism of Marxists approaches stems from the liberal camp. They are perhaps best describes in terms of a number of opposites.

Individual Vs Collectivism

Liberals reject the Marxist obsession with the collective good and working towards the collective good at the expense of promoting individualism. For the liberal, promoting the collective is unfair on the individual and prevents the opportunity for all individuals to self-actualise.

Inequality Vs Equality

Liberals also reject the Marxist desire for equality, again they see this as controlling natural outcomes. Liberals argue that maintaining standards or manufacturing equal outcomes, removes freedom of choice and can only be achieved at the expense of others. Inequality for liberals is healthy because it

drives people to fulfil their potential and strive to be all they can be, in the knowledge that if they are the sole determinant of their own destiny (be it good or bad).

Competition Vs Co-operation

From a Liberal perspective the notion of co-operation in terms of manufacturing equal outcomes is scorned upon. The most reliable method of achieving the best and most natural outcomes according to liberals is through competition generated by the free market.

Table 24: The Neo Marxist and Socialist approach to the provision of health.

Feature	Neo Marxist	Socialist
State Intervention	Is accepted, the state can be used to better the conditions of the working class. Thus comprehensive welfare services would be provided by the state. However, the state is always seen as an agent of the Bourgeoisie	Is not accepted as the state is seen as an agent of the Bourgeoisie. The main role of the state would be to dismantle itself, so that a fairer form of governance (Communist society) that represented all people can replace it. During the transition to this new society (communist State), however comprehensive welfare services would be provided.
Individual Rights	All individuals have the right to equality of positive health outcomes. The state can be used to achieve this.	All individuals have the right to equality of positive health outcomes. This could only be achieved in a truly communist society.
User Pays	All services are provided free by the state.	In communist society all services would be provided free, they would be comprehensive in nature and

		very responsive.
Free Market	Capitalism is seen as the cause of poverty and oppression. The economy would be regulated to achieve the equal outcomes for all.	The capitalist state would be replaced by the Communist state that has the function of ensuring equal outcomes for all.
Taxation	High taxes to pay for the comprehensive provision of services	High taxes to pay for the comprehensive provision of services
Service Providers	All services are provided by the State	Services to be universally provided by the new communist state

Rights Vs Needs

Again for liberals individuals have rights to freedom of choice, but not to equality of outcome. In terms of service provision only those who are so disadvantaged that they can not provide for themselves should receive services from the state. The manufacturing of outcomes is to be determined by need not right. Right to equality of outcome is of course a central and guiding feature.

UNIVERSAL THEORIES AND MAORI

An important question requiring some discussion is what the impact of government policy resulting from each of the universal theories is likely to be for Maori. This is a difficult question to address, as regardless of the theoretical and philosophical perspective underlying any governments approach what is important is the overall policy regarding Maori development, across all sectors. For example while under the social democratic governments predating the term of the Fourth Labour Government, a comprehensive welfare system was provided in New Zealand and full employment was achieved for a period during the 1960's yet Maori still dominated all negative health statistics in new Zealand. The more pertinent issue therefore pertaining to Maori and social policy, is what is the incumbent governments attitude to Maori development. Because while the universal theories

are important in determining the type of welfare and economic program a government may adhere to, any positive health care system is quickly undermined if decision makers have no time for Treaty obligations, and the positive notion of Maori development discussed in Chapter three. In short, the theoretical positions do not readily address Crown obligations under the Treaty of Waitangi. However, the Treaty can be accommodated in most of them, provided the individual – collective balance is recognised. Liberal views for example, while seeing a reduced role for the state, allow for tribes to exercise greater autonomy and control. Marxists and neo Marxists on the other hand may discourage Maori autonomy in favour of universal approaches for all New Zealanders.

Interestingly under the current neo liberal approach to government, a key focus of the Government within health circles has been Maori provider development, This is an example of the governments interpretation of the tino rangatiratanga (self-determination) provision of the Treaty. Since the inception of the Regional Health Authorities the resource spent on Maori providers has increased from \$500,000 pa to \$21 million pa in 1999 (HFA, 1999).

Ongoing disparities however, give cause for serious concerns. How should Maori measure the effectiveness of the health and other government sectors in achieving positive health outcomes for Maori. While it is early days in terms of Maori provider development, it is important to recognise two important issues. Should Maori provider development be the health outcome sought for Maori by government or should the improvement of Maori health statistics be the health outcome sought for Maori by government. Or should the outcomes sought be a combination of both. Statistical analysis would suggest that the two are not necessarily the mirror image of each other. An increase in Maori providers has not necessarily resulted in better health outcomes for Maori.

This thesis is primarily concerned with the effectiveness of the current approach

of the health sector to effect positive changes in Maori health statistical outcomes. It is attempt to assess the effectiveness of Government policy to effecting positive health outcomes for Maori using health promotion as an example. Is the Government setting the right goals for Maori health? How is the Government measuring the performance of the health sector? What likelihood is there for improvements in positive Maori health outcomes? The answers to these questions are to be progressed as matter of priority within this thesis.

SUMMARY

Universal theories are useful in determining the basis of any political parties approach to social policy, the intended outcomes, the likely outcomes and what alternatives also exist. Most significant in terms of the political perspectives presented in this chapter is that they provide a useful background and starting point in terms of trying to understand the intent and outcomes of 1990's health reforms in New Zealand.

CHAPTER SEVEN

HEALTH REFORMS AND THE HEALTH SECTOR

INTRODUCTION

This chapter has three functions. First, to provide an overview of significant events that preceded the 1991 Health Reforms (initially presented in Green and White paper prepared by Upton, 1991). Second, to outline the key management and economic theories that along with neo liberal theory have shaped the current approach to public sector management. Third, to overview the structure of the health sector (1993 – 1999) and the functions of key agencies - Ministry of Health, Health Funding Authority and National Health Committee.

Within the overview of the health sector (1991 – 1999) the 'demise' of the Public Health Commission in 1995 is also discussed.

REPORTS PRECEDING THE 1991 HEALTH REFORMS.

A series of significant documentation preceded the 1991 health reforms in New Zealand. Perhaps the three most significant documents were: the Green and White paper prepared by the Minister of Health in 1991 (Simon Upton) entitled '*Your health and the public health*'. The *task force report on the health sector* in 1987 prepared by Alan Gibbs, and the *Treasury report* in 1984 to the Crown – outlining the Treasury's recommended approach to future public sector management.

Three trends were widely regarded as the reasons for 1991 health reforms:

- 1 the growing cost of health in monetary terms, required some mechanism for setting limits
2. the management of health care in New Zealand was no longer adequate, nor were information and management systems capable of meeting the needs of the sector

3. a change in the underlying dominant hegemonic political philosophy from social democracy to free market orientations came to involve social policy areas and the delivery of social services

Kelsey (1997) suggests the direction of 1991 health reforms was not a new one. A system of regional health authorities similar to those being proposed in 1991 had been discussed earlier in a white paper in 1974.

In 1984 the Treasury (in briefing papers to the incoming government) argued that major deficiencies existed in the provision of health by the public sector because, (1) government increases in health expenditure were not proportionate to gains in health status, (2) the system did not provide enough incentives for individuals to adjust their lifestyle to reduce the risk of illness and preventable accidents, and the belief that (3) the funding and provision of health care by the State significantly reduced the scope for efficiency gains, compared to situations where these two roles have been separated (Cheyne, 1991.166-167).

On that basis Treasury recommended:

1. charges should be introduced to users of public health to encourage individuals to do more to safeguard their health
2. there should be separation of funder and provider (ideally through corporatisation of health service delivery.)
3. there should be competition between providers to create the necessary environment for greater efficiency.
4. there should be more emphasis on community health care which was expected to lead to greater responsiveness by suppliers or providers of health care to consumer needs
5. there should be greater targeting of services towards those most in need.

Treasury was suggesting that comprehensive health care should no longer be

considered a right of all people, but a responsibility for all people. These views were again advanced by a 1987 task force investigating 'Hospital and Related Health Services' established under the direction of Alan Gibbs (a member of the new Zealand business round table), by the Minister of Health. The main aim of the task force was:

"To ensure that the hospital and related services contribute to the governments broad health goals and in particular assist in the achievement of improved health status for all New Zealanders (The Task force Report, 1998)."

The Task force findings made similar conclusions to the Treasury in 1984. *The Gibbs Report* stated that the main problem in New Zealand hospitals was poor management, which they described as shackling the ability of hospitals to perform in all areas, especially in fiscal terms. The *Gibbs Report* referred to the inefficient management style as a 'triumvirate' system consisting of a doctor, a nurse, and an administrator. It was a common feature of all hospitals. McKay (1995) perhaps best summarises the direction of the report in relation to perceived ineffective management systems:

"It was criticised on the grounds of, firstly, the few groups it represented, it stifled leadership, diluted accountability, made for poor management relationships at lower levels of the organisation and was generally inefficient and ineffective in terms of staffing, management of information, cost consciousness, lack of productivity and monitoring (Mackay, 1995. 50)."

The *Gibbs Report* recommended a new structure for the health sector. It was to comprise of six Regional Health Authorities responsible for purchasing health services, a Ministry of Health that would develop health legislation and high level policy direction, independent providers (public or private) that would compete to provide services and a National Health Commission that would oversee the

system and have a monitoring function aimed at assessing the performance of the health sector in terms of its contribution to health (Gibbs Report, 1998).

The recommendations for change was however, halted by the Fourth Labour Government who choose instead to progress the concept of Area Health Boards, by making what had been optional in 1983, mandatory in 1989 through the Area Health Boards Act. Fourteen Area Health Boards were created each responsible for the effective co-ordination and delivery of health services within their regions. One reason for the Area Health Boards structure was to create an avenue for community health programmes and to encourage stronger links between the primary and secondary health care systems.

Under the National Government a health task force was established in 1990 to Identify and investigate options for defining the role of the government, the private sector and individuals, with regard the funding, provision and regulation of the health services (Bolger et al 1990, as cited in Goodwin, 1997, 63). The taskforce findings were reflected within the Green and White paper entitled '*Your health and the public health*', (Upton,1991). The report reflected the ideas that had been presented by *the Gibbs Report* (1988). Significantly this report would later provide the basis for the 1993 Health and Disability Services Act. Ashton (1999. 135) states that the Green and White paper had nine key objectives:

- improve access of all New Zealanders to a health system that is effective, fair and affordable
- encourage efficiency, flexibility and innovation in service delivery
- reduce waiting times
- wider consumer choices
- enhance the working environment for health professionals
- recognise the importance of the public health effort in preventing illness, and injury and in promoting health

- increase the sensitivity of the health system to the changing needs of the population.

The changes were to be achieved by:

1. separating the role of the purchaser and the provider, by creating Regional Health Authorities
2. separating public from personal health with the introduction of the Public Health Commission and Public Health Agency
3. development of a new approach/structure to health service delivery that would encourage competition and ultimately lead to greater efficiency gains.

The 1993 Health and Disability Act saw the introductions of four Regional Health Authorities, responsible for purchasing services, the Public Health Commission which was established mostly according to plan, (although the Public Health Agencies were not established). The Ministry of Health was introduced as the legislative and policy arm of the health sector, responsible to the Minister of Health, and the appointment of a National Advisory Committee on core services was implemented in 1992. Finally, twenty three Crown Health Enterprises were implemented as the primary providers of hospital and health services.

A separation of purchaser and provider and an initial separation of public health from personal health services sought to enhance efficiency gains - but also in the case of public health - protect the sector from erosion in the face of more urgent demands.

THE CURRENT STRUCTURE OF THE HEALTH SECTOR

Since the 1993 Health and Disability Act there have been a number of subsequent amendments. Some of these changes have been:

1. the change from four Regional Health Authorities to a single Health Funding Authorities
2. the change from four purchasers to a single funder
3. the Minister of Health to be responsible for the entire health sector
4. the replacement of Crown Health Enterprises with not for profit Hospital and Health services.
5. a shift from competitive contract processes to longer term contracts
6. an increase in health funding, and a move to reduce waiting times
7. free health services for children under six
8. the removal of income and asset testing for some members of the population
9. the removal of some part charges
10. increased emphasis on Maori health, child health and mental health.

The changes have seen the consolidation of three major policy organisations within the health sector, the Ministry of Health, the Health Funding Authority and the National Health Committee. All are responsible to the Minister of Health. One significant organisation not continued was the Public Health Commission, disestablished in 1995.

The Public Health Commission

There were a number of reasons for the development of the Public Health Commission, including the need to address the poor health status of the population particularly Maori, and the recognition that Area Health Boards (whose core business was mainly the operations of hospital services) were not proactive in their endeavours to promote long term population based health strategies, due to pressure of day to day demands for effective hospital care (Kriebles, 1996. Goodwin, 1997). The Public Health Commission was officially established as a reflection of the practical commitment of Government to separating 'Public' from

'Personal' health services. As highlighted by the Green and White paper there are at least three reasons for the separation of public from personal health;

1. to centralise Public health services
2. to make Public health services more transparent and operate more efficiently
3. to implement an effective means of preventing disease and illness.

Upton (1991) stated that:

"...much lip service is paid to the importance of public health activities, but this is not always matched by the provision of resources necessary to carry out effective programmes...with health funding on a tight reign, boards are often unwilling to venture into less visible activities, the benefits of which are not immediately obvious. Urgent health needs to easily take priority over spending on longer term programmes. The government believes that resources for Public Health activities must be explicitly identified and decisions about spending on these longer term investments made at a national level with direct accountability to the Minister of Health (Upton, 1991. 11)."

All three issues were closely linked to the Governments desire to implement preventative strategies that would reduce the cost of treatment and reduce the wider burden of illness. This notion was based on the rational that the separation of the purchasing of public health from the provision of personal health care would ensure providers of public health services could apply themselves to the task of prevention in a dedicated and confident manner. .

However when the Public Health Commission was finally established in 1993, there were two significant changes to what had been planned in the Green and White paper. First, the Public Health Commission would be an independent Crown

entity that reported directly to the Minister of Health and not an independent unit within the Ministry of Health, and second, the establishment of primary public health providers (i.e. public health agencies) within the regions would not occur. Kriebles (1996) reports that after consultation with Area Health Boards, the Public Health Commission Implementation Group decided that the agency approach was sub-optimal because:

- agency regional officers would have both provider and purchaser roles
- there was a serious shortage of contracting expertise at a local level
- the proposed regional offices would not be sufficiently 'localised'
- the existence of an agency would force a cleavage between personal and public health that was not desirable at a local level.

What resulted in 1993 was a Public Health Commission with three central functions, set out in the Health and Disability Act, 1993.

- to monitor the state of the public health and to identify public health needs
- to advise the Minister on health matters relating to public health -
 - (i) personal health matters relating to public health; and
 - (ii) regulatory matters relating to public health
- to purchase, or arrange for the purchase of public health services

(Source: Goodwin, 1997. 33)

The three primary focus areas of the Public Health Commission were to be Health Protection, Health Promotion and Disease prevention (Upton. 1991): By 1995 The Public Health Commission had identified six national public health goals for both Maori and the general population. For each goal a set of outcome focused targets were established (see table 25).

Goodwin (1997) states that the perception of the public health workforce was that the Public Health Commission in its short term before being decommissioned had

several practical successes:

"Results indicated that the Public Health Commission had successfully raised awareness of public health issues and gave public health a focus, on a national level, that was strategic in direction. The strengths identified of the Public Health Commission policy advice was that their advice was independent, they consulted widely, and produced high quality publications, and that advice was accessible to the public. The PHC's purchasing function was identified as its weaknesses, due to one yearly contracting rounds which were a protracted process, and required a large amount of paper work. ...a strength of the Public Health Commission's purchasing arrangements was that it provided clear guidelines of what services were required (Goodwin, 1997. ii)."

Table 25: Public Health Commission goals for public health

General Population	Maori
to provide a social environment which improves and protects the public health	to provide a social environment which improves and protects whanau public health
to improve Maori health status so that in the future Maori will have the opportunity to enjoy at least the same level of health as non- Maori	to improve Maori health status so that in the future Maori will have the opportunity to enjoy at least the same level of health as non-Maori
to improve and protect the health of children	to improve and protect the health of tamariki
to improve and protect the health of young people	to improve and protect the health of rangatahi
to improve and protect the health of adults	to improve and protect the health of pakeke/matua
to improve and protect the health of older people	to improve and protect the health of kaumatua

(Source: Public Health Commission, 1995)

The way the Public Health Commission was structured and its approach to the public health had at least five advantages for the promotion of public health:

1. its independence and legislative independent assessment function allowed for decision making that was less likely to be influenced by other members of the public sector or private sector;
2. its independence from personal health ensured the primary focus and advocacy for public health could be maintained;
3. its operation at a policy level meant it could develop a clear national strategic focus for public health, and have the ability to purchase services to meet public health goals;
4. it had the ability to use competition as a motivator for more effective and concerted regional public health efforts than had been experienced in the past;
5. as a single central public health service it ensured that advantages from economy of scales could be realised

One significant contribution of the Public Health Commission was its setting of outcome targets. The setting of clear and concise outcomes targets allowed for more careful and focused strategic planning which made explicit the intentions of the Public Health Commission for a particular health population. Where Maori were concerned the Public Health Commission set a number of outcome targets, for example to increase the immunisation rate of Maori children to 85% by 1997 and then to 95% or more by the year 2000.

With the decommissioning of the Public Health Commission, the positive thrust has not been maintained. While outcome targets have been set and are monitored by the Ministry of Health, no agency or service has been directly tasked with their achievement. Outside the Minister of Health, no one is accountable for achieving set outcome targets.

“..strategies must typically be used in combination to achieve the desired public health outcomes, and they involve working with many sectors and across a range of settings. Improving the health of new Zealanders is not solely the responsibility of public health workers. Individuals, families, communities and the public and private sectors can all contribute to health gain (Ministry of Health, 1998.1).”

While there is a reluctance to take responsibility for outcomes, the task of monitoring outcomes is worsened by an apparent inability of the Ministry of Health to effectively monitor outcome targets effectively (as previously discussed in chapter three).

Reasons for the decommissioning of the Public Health Commission

in December 1994, the Minister of Health publicly announced the Governments decision to terminate the Public Health Commission in July of 1995, on the grounds that disestablishment would lead to;

- better co-ordination between public and personal health issues
- better co-ordination between the Ministry of Health's regulatory role and other public health services
- more effective and efficient delivery of public health services
- reduced compliance and transaction costs.

The decision was greeted by members of the Public Health Commission Board resigning en masse, suggesting that there was more to the decision than simply an overlapping of roles with the Ministry of Health. There had been mounting concern that the Public Health Commission advice in respect of alcohol and tobacco was likely to result in a conflict between the Government and the captains of industry (Ashton, 1999. Goodwin, 1997. Beaglehole and Bonita, 1997. Kriebles, 1996). Kriebles (1996) adds strength to the conjecture when suggesting that many of the official reasons for the decommission of the Public Health

Commission had been obvious before the Commission was established. According to Hutt and Howden Chapman (1998), the Public Health Commission ran foul of the Government by advocating a population based reduction of per capita alcohol consumption approach, rather than supporting a harm minimisation policy - the Governments preferred approach (Hutt, Howden - Chapman, 1998).

The functions of the Public Health Commission have subsequently been transferred to the Ministry of Health (policy advice), the Health Funding Authority (purchasing) and National Health Committee (policy advice in terms of mix and quality of service to be provided by the health sector).

Summary

The Public Health Commission was established primarily to provide direction and resource for effective population based strategies, based upon independent assessment. Many issues surround the rationale for its demise and there is some debate about whether the function has been diminished by re-integration of public health back into the Ministry of Health. But as an independent Commission, the Public Health Commission had demonstrated a capacity to communicate a public health approach which might have borne fruit.

The Minister of Health

According to the Health and Disability Act 1993 the responsibilities of the Minister of Health include:

- notifying the Health Funding Authority of the objectives of the Crown. This can be considered the first stage of the purchasing process and its associated accountability cycle
- negotiating and entering into a funding agreement with the Health Funding Authority and monitoring the performance of the Health Funding Authority.
- appointing persons to investigate or inquire into the purchase and provision of health and disability services

While under constitutional convention the Minister of Health is directly accountable to Parliament, the Minister of Health virtually has total power over the public health sector, and over those who work within it. Within the public Finance Act, 1989, the Minister has the responsibility for the achievement outcomes set by Government.

The Ministry of Health

The Ministry of Health (see Appendix one – structure) is the Governments principal advisor on Health and Disability in New Zealand In performing its role the Ministry carries out activities which include:

- providing strategic policy advice about outcomes and strategies for advancing the health status of New Zealanders and reducing disparities in health status for Maori and other groups
- developing and maintaining a framework of regularity health interventions
- establishing and promoting links with other sectors which influence health status and dependence
- providing advice on the protection and improvement of New Zealands biosecurity, and the health impact of measures to control biosecurity

- monitoring Health Funding Authority performance against the objectives agreed with the government and monitoring ownership interests in the Health Funding Authority (i.e. how effectively and efficiently the Health Funding Authority is managing itself, as opposed to carrying out its funding functions).

- providing services to Ministers
- providing informed independent advice to ministers about sector performance
- establishing links with health agencies with other countries for bench

marking the performance of New Zealand's health sector and for disease prevention and control.

(Source: Ministry of Health Strategic Business Plan for 1997 - 2002)

The Ministry of Health is responsible for providing effective advice to Government on matters of policy direction and the implication of policy. It acts as the Minister of Health's agent for administering public funding to the sector, negotiating funding agreements with the Health Funding Authority and monitoring their performance. (Ministry of Health, 1999. 3).

The Health Funding Authority

The Health Funding Authority (see Appendix two – structure) replaced the four Regional Health Authorities established by the 1993 Health and Disability Act as the single funder of health services in New Zealand. However, the four Regional Health Authority offices were maintained as regional health funding authority offices. Some 200 positions were disestablished in the restructuring process (Health Funding Authority, 1998.2).

The main function of the Health Funding Authority is to:

“develop an implementation and purchase plan for the delivery of health services in response to government strategy (Health Funding Authority, 1999.14).”

More precisely the statutory functions of the Health Funding Authority under the 1993 Health and Disability Act are to:

- monitor the need for health services and disability services of the people who are described for this purpose in the funding agreement
- purchase health services and disability services for those people: by means of purchase agreements or otherwise:

- monitor the performance of purchase agreements or other agreements be persons with whom it has entered into such agreements or arrangements, and
- such other functions as it is for the time being -
 - (I) Given by or under any enactment; or
 - (ii) Authorised to perform by the Minister, by written notice to the authority after consultation with the authority.

The statutory objectives of the Health Funding Authority are to

- promote the personal health of people
- promote the care and support of those in need of personal health services or disability services
- promote the independence of people with disabilities
- improve promote and protect public health, and
- meet the Crowns objectives specified under section 8 of the Health and Disability Act 1993.

(Source: Ministry of Health, 1999. 5)

The Health Funding Authority is tasked with purchasing health services in New Zealand that will meet the Crowns objectives including those for Maori. In order to achieve this the Health Funding Authority must prioritise what it buys.

The National Health Committee.

While operating a budget significantly less than other key departments of the health sector, the National Health Committee is also a key to the Health and Disability Act 1993, its purpose being to advise the Minister of Health on:

The kinds and relative priorities of public health services, personal health services, and disability services that should in the committees opinion be publicly funded; and other matters relating to public health including (i) personal health matters

relating to public health; and (ii) regulatory matters relating to public health; and such other matters the minister specifies by notice to the committee (National Health Committee, 1999. 2).

The key task of the Committee is to provide independent assessment for the Minister of Health on the quality and mix of services that should in the Committee's opinion be publicly funded. The membership to the committee is appointed by the Minister. The Committee has a particular role in assessing Health Funding Authority priorities and in developing evidence based advice for achieving outcomes.

.Summary

While the agencies discussed above are not the only key players within the health sector at a policy level, they are the most significant. Their functions are summarised in table 26. Ultimately, they have the combined responsibility, within the health sector to ensure that the health goals of the Government, including those for Maori are being achieved. It should be noted however, that the Minister has the sole responsibility for health outcomes, while those agencies mentioned above are required to make a meaningful contributions to these outcomes, in the form of outputs (see table 26).

THE CHANGE IN POLITICAL PHILOSOPHY

It is important to recognise that the reforms reflected a shift in dominant political philosophy from the centre left to the centre right (Kelsey, 1997; Jesson, 1988; Ashton, 1988). This change in dominant theoretical perspectives began with the Fourth Labour government during the 1980's and then the National Government (and coalition government) during the 1990's

While neo liberalism provided the overall thrust behind public sector reforms three further theoretical perspectives make a useful contribution toward a fuller understanding of the reforms (Boston et al., 1999. Shaw, 1999. Person, 1991):

1. public choice theory
2. agency theory
3. managerialism

These theories are particularly useful in describing the neo liberal perspective of the public sector how it should be managed and its performance measured.

Table 26: Functions of health sector agencies

Legislative Body	Key Functions
Ministry of Health	<ul style="list-style-type: none"> • providing effective advice to Government on matters of policy direction and the implication of policy, • acting as the Minister of Health's agent for administering public funding to the sector • negotiating funding agreements with the HA and monitoring their performance. • Protecting, promoting and improving the public health • Reporting annually on the state of the public health, monitoring the performance of the health sector, • Administering health sector legislation and regulations • Collecting and disseminating national health information
Health Funding Authority	<ul style="list-style-type: none"> • Monitor the need for health services and disability services • Purchase health services and disability services • Monitor the performance of purchase agreements • other functions given by or under any enactment or authorised to perform by the Minister
National Health Committee	<p>To advise the Minister of Health on:</p> <ul style="list-style-type: none"> • the kinds and relative priorities of public health services, personal health services, and disability

	<p>services that should in the committees opinion be publicly funded; .</p> <ul style="list-style-type: none"> • other matters relating to public health including: <ul style="list-style-type: none"> (i) personal health matters relating to public health; and (ii) regulatory matters relating to public health; and such other matters the minister specifies . • on the quality and mix of services that should be purchased
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Public Choice Theory

Public Choice Theory (PCT) applies economic models to the analysis of conduct and practices of voters, politicians and bureaucrats. It describes the political domain as a market, made up of government departments and agencies (politicians, public servant sand voters). The fuel that perpetuates the relationship between key players is self interest and the maximisation of profit (the need to feather ones own nest). Absent from the relationship is any desire or need for collective action to promote collective well being. Instead all individuals are said to operate in their own self interest (Self, 1993. Pierson, 1991. Shaw,1999).

Within the public sector, public servants are described as being interested only in their own advancement - greater enumeration, more power, greater status and control. Such things can be considered relative to the size of a departments budget. Each key player is thought to conspire to gain more funds for their respective service / sector. This notion of self interest is described by Shaw (1999) when stating that;

“Because ... greater enumeration, more power, greater status and control, are a function of the size of a departments budget, senior bureaucrats constantly pursue an ever increasing share of government revenue (in much the same way as the private sector seek increased market share) by seeking to convince ministers of

the wisdom of publicly funding the goods and services provided by their particular department. (Shaw, 1999. 3)."

Public Choice Theory contends that the results of the drive for more resource by bureaucrats is usually successful, given the absence of alternative providers, systematic bias by Ministers of the Crown and the existence of traditional monopolies in some service areas, such as health, welfare and telecommunications (prior to 1990). This is further complicated by the grouping together of a wide range of functions in the one department, for example policy advice, service delivery and evaluation of services, essentially creating an environment where self interest by bureaucrats is easily maintained (Shaw, 1999).

In accordance with this perspective, Public Choice theorists suggest that the provision of welfare services by the State leads to more costly outcomes, inefficient service provision and the tendency for accountability to be non-existent. Public Choice theorists therefore advocate reforms where functions, such as purchasing and provision of services are separated. Competition is then used as the motor to ensure the efficient and effective production of desired outcomes.

Agency Theory

Agency theory essentially sees all human relationships in society as contractual and those parties entering into a relationship as best categorised by either being a 'principals' or 'agent'. An example of such a relationship would be a Chief Executive Officer (the principal) and a consultant (the agent). The latter performs agreed upon tasks on behalf of the principal. The relationship is entered into because the agent is thought to have skills and knowledge required to do the task most effectively; more so than the principal (Kriebles, 1996. Shaw, 1999).

Agency theory advocates that, the most efficient relationships are those when the agent meets the desired outcomes of the principal. The relationship however, is

again based on self-interest; that is agents will only do as much as they have to and if possible will do nothing at all if the opportunity arises, or will achieve the desired outputs, within the most limited amount of effort necessary (Shaw, 1999).

Agency theorists, therefore suggest that if any principal/agent relationship is to be effective, contractual relationships must be explicit about:

1. the task required by the agent
2. the incentives available to the agent on successful completion of tasks
3. the sanctions that will result for either party if tasks are not completed.

Kriebles(1996) states that for the Crown:

"The critical point about agency theory is ensuring that the agent acts in the principals interests, including the public interest, however defined. The key lies in first defining the Crowns interests or objectives. The Crown must then decide on whether to use an agent or Crown entity, considering the degree of contractibility, outputs specificity, the impact of independents and the quality of information from decision making. The costs and benefits of organising with core departments or with an agent can then be compared (Kriebles, 1998. 10)".

Thus, for Agency theorists, the public sector if it is to function effectively, must be well informed about the overall desired outcomes of Government, the tasks they are expected to undertake to contribute to these outcomes, and the resource they have available to operationalise tasks.

Managerialism

The growing tradition of Managerialism has also played a part in shaping the approach of the public sector in the 1980's and 1990's. Underlying this tradition is the notion that:

"Management is an inherently scientific activity with objective, neutral and universally applicable rules and principles which can be applied to all human endeavours (Pollit, as cited in Shaw, 1999. 5)."

The management approach attempts to take the subjectivity out of decision making and to free government departments from partisan political considerations, or considerations of self-interest. Management is aimed at the optimal use of resources to achieve desired and specific objectives. Management is considered by some, the most effective way to operationalise scarce resources toward the progression of certain targets.

The following key considerations are central to the focus advocated by Managerialism (Shaw, 1999: 6-7);

1. the efficient use of inputs (such as staff, computer hardware and software, premises and so on). in the production of outputs(goods and services).
2. the devolution of management control and the associated development of improved reporting, monitoring and accountability regimes in departments
3. a preference for monetary rather than non-monetary performance incentives for staff.
4. an emphasis on cost cutting, increased efficiency and cutback management.

The managerialism approach to service provision is that effectiveness is best measured in terms of using minimal resources to produce maximum outputs.

Fiscal Accountability

The new right approach to public sector management is reflected throughout the health sector reforms of the 1990's. While in part financial issues have been

associated with the need to address the rising costs of health care in New Zealand, Kelsey (1997) suggests this rationale to be unconvincing as:

"Real public spending on primary health care had increased by 42% between 1980 and 1991, but overall health spending had risen by less than 9%. Most of the increase had occurred in the mid 1980's. Per capita government spending on health had declined by 7% since 1989 ... Funding from public sources as a proportion of public health spending had fallen from 88% in 1980 to 81.7% in 1991(Kelsey,1998. 214). "

The reforms must therefore be seen as a vote of no confidence in the capacity of the state - or its agencies- to deliver cost effective services at least not in comparison to the private sector. As a result clear contractual obligations and better financial management have been made central to the expectation of the performance and operations of the health sector. This is reflected in the (1997 - 2000) nine strategic result areas developed by Government for the public sector. These expectations are an example of both a greater emphasis on clear contracted obligations and the desire for greater financial efficiency gains.

Strategic result area seven directly relates to the health sector. It states:

'Improve the overall health status of New Zealanders through health disability service and injury prevention regimes that:

- maximise health gains in a cost effective way:
- are accessible, responsive to changing public need and flexible enough to enable resources to go to areas of highest priority:
- encourage co-operation and collaboration between service providers
- encourage individuals, business and communities to avoid and prevent behaviours that contribute to illness and injury'

The emphasis on financial considerations is further reflected within the Governments performance expectations of the Health Funding Authority, which under the heading 'Financial management and financial performance', that the Health Funding Authority must:

'operate and be able to assure the Government of this, a financially sound and sustainable business, within appropriate funding levels, this includes an immediate emphasis on reducing and optimising operating costs (NZ Gazzette, 1998. 14)."

Summary

The health reforms of the 1990's can in part be seen as a combination of the growing cost of health in monetary terms, a growing dissatisfaction with the management of health care in New Zealand, and most significantly a move from the centre left to the centre right, from social democracy to the new right. The new right approach to health provision is underpinned by such theoretical perspectives as, Public Choice Theory, Agency theory and the Managerialism perspective.

The theories combined suggest that for services within the public sector to be effective they must have clear contractual responsibilities, be financially focused and have clear lines of accountability (Jesson, 1988). Furthermore; .

- if key functions of the public sector are not separated senior bureaucrats will act in their own self interests
- the relationship between the Crown and its agents must be clearly defined and outcome focused, otherwise the agent will again act in their own best interests
- the public sector must be measured in performance against such factors as efficiency gains particular in the financial area, to avoid unnecessary spending and provide motivation for services at all levels to become more

effective.

SUMMARY

In summary a number of significant reports preceded the health reforms of the 1990's: Treasury report to the new Labour Government in 1984, the Gibbs Report in 1988 and the Green and White paper, entitled 'Your health and the public health' in 1991. Each of these reports suggested that the health sector was managed inefficiently and lacked the ability in its current form to produce health gains proportionate with the Governments investment.

As a result the Government implemented a new health system based on accountability and responsibility. The changes have been underpinned by an adherence to new right philosophies, that advocate, a health sector operating within free market principles, that supposedly increase the opportunity to result in better quality of services likely to lead to better health outcomes.

The Public Health Commission was an important feature of the health reforms. While in existence (1993 - 1995) it functioned in most cases very effectively. What can not be measured however because of its short lifespan, is its effectiveness in purchasing services that had a positive impact on health outcomes. One important factor however, was its attempt to have an outcome focus.

Whether the health reforms have made a difference particularly with regard better health outcomes for Maori is the central focus of the next chapter.

CHAPTER EIGHT

HEALTH SECTOR RESPONSIVENESS

INTRODUCTION

The purpose of this chapter is to overview the responsiveness strategies of the health sector to Maori. Its focus is predominantly at the policy / purchaser level. This chapter will provide a useful precursor to chapter nine which examines the degree to which the high level strategies developed by government and communicated by the Ministry of Health for Maori are reflected at the provider level.

THE GOVERNMENTS OBJECTIVES FOR MAORI HEALTH

In 1992 the Government clearly stated its objectives for Maori health in '*Whaia te ora mo te Iwi*'. The policy direction outlined in *Whaia te ora mo te iwi*, has remained the basis of the Governments responsiveness approach to Maori for seven years. Its principal objective is that:

"The Crown will seek to improve Maori health status so that in the future Maori will have the same opportunity To enjoy at least the same level of health as non-Maori (Ministry of Health, 1992. 11)."

According to the Crown this objective should be considered in conjunction with:

1. the overall purpose and objectives of the RHA's as outlined in the Health and Disability Services Act;
2. the need to recognise Maori aspirations and structures such as those based around, whanau, hapu, Iwi and the desire of Maori to take responsibility for their own health care;
3. the need to purchase health services and encourage initiatives which promote positive health for Maori; and
4. the need to encourage the greater participation of Maori in order to develop health solutions which are effective, affordable, accessible and culturally

appropriate (Ministry of Health, 1992. 13)

The key Maori policy direction, is to develop strategies that will ensure:

1. greater participation of Maori at all levels of the health sector
2. resource allocation priorities which take account of Maori health needs and perspectives (including Maori provider development); and:
3. the development of culturally appropriate practices and procedures as integral requirements in the purchase and provision of health services.

(Department of Health, 1993. 14).

Since the release of Whaia te ora mo te iwi (1992), the above policy guidelines for Maori have been reaffirmed in the publications entitled 'Policy Guidelines for Maori health', in 1994/95, 1995/96 and by the Honourable Jenny Shipley in 1996/97 in 'Nga Aratohu Kaupapahere Hauora Maori'. This document reaffirmed Maori health as a health gain priority area, and stated that:

"For Maori health, the focus is on achieving health gains for Maori by addressing the significant disparities in health between Maori and non-Maori (Ministry of Health, 1996. 17)."

in 1997 the Crown notified the Health Funding Authority of its objectives for health for the 1998/99 financial year. The performance expectation was clearly stated under the heading 'Maori health' to the Health Funding Authority:

"contract for services which are responsive and sensitive to the ethical and social beliefs, values and practices of iwi, hapu and Maori so that they have the opportunity to enjoy the same level of health as non-Maori - this is to include the immediate emphasis on provider development (Minister of Health, 1997. 3)."

The assumption Made by Government

The Governments approach to Maori health gains makes the assumption that if there is increased participation of Maori at all levels of the health sector, and if

health services are enhanced to be more appropriate to Maori that the disparity experienced by Maori in health will be addressed.

Summary

The Governments responsiveness approach to Maori is aimed at the reduction in disparity of health experienced by Maori when compared to non-Maori. This is to be achieved using three main strategies:

1. increasing Maori participation in the health sector at all levels
2. developing the number and quality of Maori providers in the health sector
3. ensuring health service provision to Maori is appropriate

HOW THE HEALTH SECTOR OPERATES

The health sector is structured in accordance with what is termed a 'supply side competitive purchase model' (Gill, 1998. 8). This structure has as a key feature, a purchaser who has the responsibility for purchasing services from a range of health services who in theory compete for services. The purchaser is monitored by another government department which also provides policy advice to government.

Within the New Zealand health sector, the Ministry of Health has the policy function and provides advice to government, the Health Funding Authority is the principal purchaser of health services, and hospitals and other health providers are providers of specific health services purchased by the Health Funding Authority. The activities of the Health Funding Authority are monitored by the Ministry of health.

The supply side competitive purchase model is based on the assumption that health outcomes will be achieved efficiently, by providers who compete for funding, as the desire of providers to maintain preferred provider status(or market dominance) will depend on their ability to fulfil contracted obligations efficiently and effectively.

However, within the New Zealand example, contracts with providers are output focused, that is providers are required to fulfil a number of detailed tasks that theoretically have a positive link to desired outcomes. Actual outcomes are the responsibility of the Crown, through Ministers. The link between contracted outputs and desired outcomes can only be determined by outcome focused evaluation. The practice adhered to in New Zealand is guided by the Public Finance Act, 1989, which is;

“based on the principle that ministers are accountable for outcomes , while departments are accountable for the production of outputs. The distinction in responsibilities for outputs and outcomes allows clear guidelines of accountability - which can be written into contracts - between each department and their minister (State Services Commission, 1999. 8).”

The State Services Commission (1999) has noted that the linkage between outputs and desired outcomes is difficult to establish. This difficulty is amplified by a reluctance to evaluate the contribution of outputs to outcomes within the public sector.

“On a day to day basis broad outcomes seem to be even less evident as the driving force behind or *raison d’etre* for policy proposals, and policy advice outputs. Departments appear to be able to identify the potential ‘winners and losers’ in a policy proposal, but are less able or willing to cite the potential impact on strategic outcomes. Even more worrying is that very few departments actually monitor, review or evaluate the extent to which the policy outputs they purchase contribute to Government strategic priorities. (State Services Commission, 1999. 3).”

RESPONSIVENESS AT THE POLICY / PURCHASER LEVEL

The overview provided within this section focuses on the Ministry of Health and Health Funding Authority, and is predominantly centred around two issues:

1. what strategies have been implemented internally to enhance organisational responsiveness to Maori;

2. what strategies have been implemented to advance the responsiveness of external agencies, to Maori with particular reference to the Governments objective for Maori health?

The Ministry of Health

The core roles/functions of the Ministry of Health are policy advice to the Minister of health, monitoring and evaluating the performance of the Health Funding Authority and Ministerial servicing (Ministry of Health, 1997, 10). Part of the Ministry of Health's function is to communicate the desired policy direction of the Government to the health sector, particularly the Health Funding Authority. It must then monitor the sector to ensure progress is being made. The success of any strategies depends largely on how well the Ministry of Health can communicate the Governments objectives to the Health Funding Authority. This is usually done in the form of clear and explicit 'key result areas' (KRA's)

Internal Responsiveness strategies

In 1993 a review of the Department of Health's Maori policy was undertaken by Prof. Mason Durie and Hekia Parata, in order to determine:

- 1 the ability of the Department of Health to achieve the Governments objective for Maori health
2. to outline what the Department of Health needed to do in order to achieve the Governments objective for Maori health.

The findings and recommendations were reported in 1993. The report made several recommendations, all of which related to three common themes:

1. increased Maori participation in the Health sector, especially the Department of Health
2. the establishment of a specific Maori policy advisory section within the Ministry of Health
3. the development of more clearly stated objectives for Maori at all levels of the Department of Health.

The Ministry of Health has attempted to implement responsiveness strategies that are consistent with these three themes, and which relate directly to the Governments Maori policy strategies (see table 27).

Table 27: The responsiveness approach of the Ministry of Health

Strategy	Documented Examples
Improving Organisational Responsiveness to Maori	Te Tatai Urupare ki te Maori o te Manatu Hauora, Te Urupare rangapu, 1988 Te Ara Tohu, 1994/99
Increasing Maori participation within the Ministry of Health and encouraging greater participation through out the health sector.	Whaia te ora mo te Iwi, 1992 Public Sector objectives, 1997/01 Policy guidelines for Maori health , 1996/97
Maori provider development	Ministry of Health performance expectation of the Health Funding Authority 1998 Policy guidelines for Maori health , 1996/97

In 1994 the Ministry of Health released its strategic management plan for Maori health - ‘*Te Ara Tohu*’, which heralded the conception of a Maori health policy unit, Te Kete Hauora (see Appendix three – structure). The primary focus of Te Kete Hauora was to:

” lead and influence the strategic direction of Maori health by providing informed policy advice to government, and ensuring that the Ministry of Health meets its obligations to Maori as embodied in the Treaty of Waitangi, in order to improve Maori health (Ministry of Health, 1994. 10).”

The main purpose of Te Kete Hauora is to provide expert policy advice on the improvement of Maori health and to assist the Ministry of Health to improve its responsiveness. The key functions of Te Kete Hauora are best described in terms

of its seven identified strategic goals (see table 28).

Central to the role of Te Kete Hauora is the development of effective health policy for the strategic direction of Maori health. More specific Maori focused policy is one example of the Ministry of Health's' approach to improve its responsiveness to Maori.

Another internal development of the Ministry of Health has been its attempt to make the Ministry itself more responsive to Maori. '*Te Tatai Urupare ki te Maori o te Manatu Hauora*' provides staff with guidance on how to improve the responsiveness in their respective work areas.

The assumption made by Ministry in terms of its internal responsiveness approach to Maori, is that a Maori specific policy unit and expert direction to staff will enable the MOH to advance strategies within the health sector that will positively contribute to the Governments goal for Maori health

The most recent internal development by the Ministry, however, has been the appointment of Dr Tony Ruakere as the chief medical adviser in Maori health. A position developed specifically to overview Maori public health issues and to positively boost guidance and direction in this area.

External Developments

The Ministry of Health has progressed a number of strategies to advance responsiveness to Maori within the health sector. The most significant developments are Maori provider development and ensuring services within the health sector are appropriate to Maori. Two specific strategies employed by the Ministry of Health have been:

1. the development of a document for measuring the effectiveness of health services for Maori entitled - '*He Taura Tieke*' and
2. the development of specific performance expectations for the Health Funding Authority in this area.

Table 28: The seven strategic goals of Te Kete Hauora, 1994 - 1999.

Goal	Outline
1	An agreed understanding between the Crown and tangata whenua of the place of the Treaty of Waitangi that forms the basis for the improvement of Maori health
2	A model of Maori health is adopted as a framework for the development of policy, purchasing decisions and service delivery to Maori
3	Health funding is allocated in a manner that provides opportunities for the effective purchase of health services for Maori
4	To increase the opportunity for providers of culturally appropriate services to enter the market/sector
5	The Ministry of Health and purchasers have the capacity to target and measure the effectiveness of service delivery to Maori
6	The Ministry of Health produces quality Maori policy advice as integral to its core business
7	To implement effective and efficient operational management systems to support the business activities of the Te Kete Hauora.

(Source: Ministry of Health, 1994)

He Taura Tieke outlines what the Ministry of Health considers there to be three key elements which underpins effective service provision to Maori. These are:

1. technical or clinical competence including safety and monitoring
2. structural and systematic responsiveness such as Maori workforce development and preferred providers; and
3. consumer satisfaction including access, information, trust and respect.

In terms of Maori provider development the Ministry of Health as part of its monitoring and policy direction function has issued the Health Funding Authority with the following performance expectation, on behalf of the Minister of Health:

“contract for services which are responsive and sensitive to the ethical and social

beliefs, values and practices of iwi, hapu and Maori so that they have the opportunity to enjoy the same level of health as non-Maori - this is to include the immediate emphasis on provider development (Minister of Health, 1997. 3)"

Summary

The Ministry of Health has attempted to take a lead role in encouraging the health sector to demonstrate greater responsiveness to Maori. It has implemented a responsiveness program, which has three key components related to the Crown's overall policy. The approach of the Ministry of Health has been to implement systems to improve its own level of responsiveness to Maori, and to proactively monitor and advance the Government's performance expectation of the Health Funding Authority.

The Health Funding Authority

The Health Funding Authority is tasked with purchasing health services that meet the Crown's objectives including those for Maori. In order to achieve this the Health Funding Authority must prioritise what it buys. Its progress in terms of contractual obligations is directly monitored by the Ministry of Health and the National Health Committee (which has an additional monitoring role linked to the quality and mix of services purchased).

The Responsiveness approach of the Health Funding Authority to Maori

The responsiveness approach of the Health Funding Authority to Maori is informed both by the Government's objectives for Maori and the Government's guidelines for working with Maori. It has been required to adopt a multi levelled responsiveness approach to Maori and like the Ministry of Health has both internal and external responsiveness strategies (that shape the wider sector).

Internally, there has been a two pronged approach, reflected by the development of the National Maori Health Group and their development of a Health Funding Authority Treaty of Waitangi based Maori policy.

The Maori Health Group has three main functions. First, the purchase of some

services for Maori, second, developing Maori service strategies for the Health Funding Authority and third, ensuring specifications relating to Maori are in all Health Funding Authority provider contracts. Ultimately a requirement of all groups is that all contracts must have a Maori contract specification, this is monitored by the Maori group, who have the ability to decline the progression of any contract if not up to a certain standard (Andrews. 1999)

The external responsiveness strategies of the Health Funding Authority are best illustrated in accordance with three themes, all which directly reflect the Governments objectives:

1. Maori provider development including workforce development
2. greater Maori participation at all levels of the health sector
3. mainstream sector advancement.

Table 29: Key features of the Health Funding Authority Maori policy

Key Feature	Strategy
Strategic Business Planning	to ensure all plans of the Health Funding Authority detail strategies for Maori health gains
Financial Accountability (funding allocation)	Funding for Maori is clearly identifiable, and other funds are made available to address issues of equity and need
Personal Accountability	to ensure all staff implement the Health Funding Authority Maori policy including consultants
Collective Accountability	All executive decisions are applied with due diligence for the Maori health policy
Maori Workforce Development	to ensure Maori have the opportunity to participate as staff of the Health Funding Authority and have the opportunity for personal development while working with the Health Funding Authority
Indigenous Matrix management	to ensure Maori staff are strategically placed within the

system	wider Health Funding Authority organisation
Relationships with Maori	to ensure relationships with Maori are developed, that will ensure their involvement in developing principles and practices aimed at improving Maori health status
Maori provider development	Maori providers have an opportunity to make a meaningful contribution.
Maori provider revenue	Ongoing funding of approved Maori providers
Maori provider development fund	Ensure funds are made available to support Maori provider development.
Contract clauses	All Health Funding Authority contracts have a clause that clearly outlines the Health Funding Authority's position on Maori health and associated expectation
Strategic Dialogue	to talk with Hospital shareholders to ensure boards are clear about the Health Funding Authority Maori policy and make Maori appointments to Hospital boards
Monitoring mechanisms	Performance accountabilities are defined for all Health Funding Authority contracts with regards to Maori and a clause that allows for monitoring, evaluation and contract redefinition to achieve Maori health gains is in all provider contracts

(Source: Health Funding Authority, 1998)

The responsiveness approach (both internal and external) of the Health Funding Authority is most effectively reflected with its Maori policy (see Table 29). The purpose of this policy:

“is to identify and implement a proactive Health Funding Authority response to Maori health gain issues and development. This policy position is directly related to the role and function of the Health Funding Authority in the health sector (Health Funding Authority, 1998. 2)”.

The Health Funding Authority Maori policy aims to ensure the following key factors

when implementing its purchasing role;

1. the amount of resource to be spent on Maori is made explicit at all levels
2. all staff are aware of the Health Funding Authority Maori policy and are contracted to fulfil its obligations
3. all Health Funding Authority work groups are aware of the Health Funding Authority Maori policy and are contracted to fulfil its obligations
4. proactive recruitment and development of Maori staff
5. that Maori participation within the Health Funding Authority is strategically representative thought out its operations.
6. meaningful working relationships with Maori are developed
7. Maori providers are developed and adequately resourced
8. mainstream providers are contracted to operationalise the Health Funding Authority Maori policy and position on Maori health (i.e. they achieve a greater effectiveness among Maori consumers by creating an environment and a capacity to understand and ably meets the needs of Maori)
9. contract accountabilities for Maori are monitored, evaluated and adjusted in order to achieve Maori health gains.

Summary

The Maori policy of the Health Funding Authority explicitly outlines its commitment to Maori and Maori health issues. The policy helps to ensure that the Health Funding Authority adheres to several key issues when implementing its purchasing role, for example, the amount of spend on Maori health is explicit, strategies to increase Maori staff within the Health Funding Authority, Maori staff are developed and strategically placed, increased Maori providers, more effective mainstream services, more effective relationships with Maori, an emphasis on the monitoring and evaluation of providers and a commitment by all within the Health Funding Authority to its Maori policy.

Both the Health Funding Authority and Ministry of Health have advanced the

Governments responsiveness policy for Maori. However, the test of these strategies is to determine to what level they are mirrored throughout the health sector and to what degree they will achieve health gains for Maori.

SUMMARY

The Governments objective for Maori health is to address the disparity that Maori currently experience when compared to non-Maori. The key strategies advocated by Government to achieve this objective are: to increase Maori participation in the health sector at all levels, develop the number and quality of Maori providers in the health sector, to ensure health service provision to Maori is appropriate.

The Governments strategies are clearly reflected in the key documentation and to some degree the practical operations of the Ministry of Health and Health Funding Authority. The test of the Governments strategies, however, are to what degree they are reflected at the provider level and to what degree they actually address the health disparities experienced by Maori. These questions provide the focus of chapter nine.

CHAPTER NINE

PUBLIC HEALTH DELIVERY

INTRODUCTION

This chapter is an examination of how health promotion service delivery in New Zealand, in terms of how it is purchased and provided. The purpose of this section is to determine to what degree the Governments objective for Maori health is being achieved, and to what degree health promotion creates the opportunity for better Maori health outcomes. To achieve this task three mainstream public health service providers have been studied.

SETTING GOALS FOR HEALTH PROMOTION AT THE POLICY / PURCHASER LEVEL

in 1997 the Government made clear its expectations of the health sector pertaining to public health. It directed the sector to place particular emphasis on;

“achieving improvements in health outcomes for priority groups, particularly for children significantly at risk of poor health, by developing and implementing innovative health promotion and service delivery strategies (Strategic result areas for the public sector, 1997 - 2000).”

Health promotion is perceived as a key component of the Governments public health strategy. The Government through the Ministry of Health Public Health Group developed eight goals for public health in New Zealand, which have been adapted from those goals set by the Public Health Commission in 1993. The public health goals for New Zealand are:

- to ensure a social and physical environment which improves, promotes and protects public health and whanau public health
- to improve promote and protect Maori health status so in the future Maori will have the opportunity to enjoy at least the same level of health as non-Maori
- to improve promote and protect the health of;

- to improve promote and protect the health of children / tamariki
- to improve promote and protect the health of pacific people
- to improve promote and protect the health of young people / rangatahi
- to improve promote and protect the health of adults/pakeke/matua
- to improve promote and protect the health of older people / kaumatua

(Ministry of Health, 1997. 12)

A number of outcome targets have also been set, but no agency has been accorded the responsibility to achieve them. The Ministry of Health attempts to monitor these outcome targets, but have had limited success to date.

The Health Funding Authority in particular has a key role to play in the implementation of the Governments public health goals as, it is charged with the development of purchasing strategies that will positively contribute to their achievement. The policy direction for both Maori health and public health is clearly communicated to the Health Funding Authority by the Ministry of Health on behalf of Government. A memorandum of understanding is drafted between the Health Funding Authority and Ministry of Health. The Health Funding Authority then undertakes a work program that through its purchasing function attempts to achieve the desired goals, for public health including Maori.

Public health resource allocation

In 1998/99 the Government allocated \$84, 177, 000 for the purchase of public health services in New Zealand. This is expected to increase to \$90,457, 000 in 1999/00. This allocation is ring fenced and must be spent on public health. The level of public health designated funding is less than 3% of the vote health dollar.

PURCHASING HEALTH PROMOTION

The Health Funding Authority Public Health Group is responsible for purchasing public health services. Public health services consist of three types of service, health protection, health promotion, and health protection and health promotion

combined. In most instances these services are purchased from mainstream public health units, all of which are attached to Hospital and Health services Hospital and Health Services (HHS's) were created under the Health and Disability Services Act 1993 as Crown health enterprises to provide health and/or disability services. Their names were changed in a 1998 amendment to the Act. There are 23 HHS's based on previous area health board hospitals.

The Health Funding Authority has four regional offices. For the purposes of this thesis the focus is primarily on the 1998/99 funding approach of the Public Health Group within the central region of the Health Funding Authority (CPHG).

The vision of the CPHG is that they:

"...see New Zealand as a country in which Maori and non-Maori enjoy equitable health outcomes. Everyone lives longer in good health, disease is progressively reduced and people with disabilities are able to achieve independence. We see people empowered to realise their full potential through effective health public policy, supportive social, culturally and physical environments, strong communities, well developed personal skills and a health system focused on health gain. We see fully informed and resources people able to make healthy choices in the context of a healthy and sustainable environment (Health Funding Authority, 1998. 3)."

The CPHG sees Public Health Units as preferred providers of health promotion, as they:

- have a critical mass of public health practitioners in the local area
- gather a wealth of information and develop an understanding about the communities for whom they provide services and whose efforts they support and co-ordinate to improve public health status; and
- use their unique position within their communities to encourage and support effective co-ordination of public health action between sectors and generate greater competition and integration in the planning and delivery of Public Health services.

Within the central region a purchasing process (see table 30) is undertaken either annually or two yearly for the purchase of health promotion services

Table 30: Central Health Funding Authorities purchasing process 1998/99 of public health services.

Dates	Task	Responsibility
3/12/97	managers briefed on RFP outline and purchasing process for 1998/99	Health Funding Authority
16 January 1998	PHU's invited to submit District Strategy for Public Health Services within their CHE (now HHS) regions	Health Funding Authority
16 March 1988	PHU's submit revised district strategies	Public Health Units
9 April 1998	response to District Plans	Health Funding Authority
April - May 1998	negotiation of District Strategy and price	Joint
April - May 1998	amend District Strategy if required	Public Health Units
28 May 1998	contract signed	Joint

(Source: Health Funding Authority, 1998)

The central region had approximately, \$357,185, 000 in 1998/99 to spend on public health services including health promotion. This is expected to increase to \$405,628, 000 in 1999/00. The amount can be compared to \$ 1, 023, 827, 000 being allocated for personal health services in the central region for 1998/99, which is expected to increase to \$1,063,185, 000 in 1999/00.

The District Strategy: a contract for health promotion

The main task for Public health Units during the contracting process is the development of a district strategy. The district strategy has two roles:

"First, it is a strategic document which determines the priorities for public health action in a district, and allocated public health funding accordingly. Second, it is a detailed description of the public health services (including health promotion)

which the Public Health Unit has agreed to deliver. ...it is a proposal to provide specified public health services for a stated price...it is then a legally binding document (Health Funding Authority, 1998. 4)."

Once completed the district strategy becomes the provider contract with the Health Funding Authority. Like most contracts for service it clearly outlines expected outputs and the price per output or group of outputs.

District strategies are usually purchased for one or two years by the Health Funding Authority, which means most PHU's in the central region are required to review and redevelop if necessary the district strategy either every twelve or twenty four months. This has meant that much work each year goes into the district strategy development process, which takes place over a 4 - 6 month period.

How does the Health Funding Authority decide what to buy?

For the 1998/99 contracting round the Health Funding Authority decided to purchase public health programmes that would address:

- the Physical Environment
- Alcohol related harm
- Communicable disease
- Food safety and quality
- Tobacco control
- injury prevention and control
- Mental Health
- Non-Communicable Disease
- Nutrition and Physical exercise
- Sexual Health
- Well Child
- Public Health infrastructure

The Health Funding Authority determines what it purchases by using a prioritisation process called 'programme budgeting marginal analysis' (PBMA) in

association with a set of purchasing principles. The Health Funding Authority purchasing principles are, effectiveness, cost, equity, Maori health and acceptability (Health Funding Authority, 1999. 18).

The programme budgeting marginal analysis' has been designed around economic evaluation techniques, but has a process for considering priorities. It consists of two main phases a programme budgeting phase and a marginal analysis phase. The programme budgeting phase involves a process of considering, current health expenditure in terms of both services delivered (outputs) and actual improvements in health (outcomes).

The marginal analysis involves two phases. First, a process of determining additional services to be purchased if funding increases and services to be reduced or lost if funding decreases. Second, the costs and benefits associated with these changes are identified, in detail and with the primary focus being on outcomes (that is, length and quality of life). Decisions are then made in accordance with resource allocations and desired resource shifts (Ashton, Cumming, Devilo, 1999.16).

An example on how this might work is presented in the recently released draft Health Funding Authority public health purchasing handbook, currently under development to guide purchasing of public health services for 2000/2001 (see table 31).

Using the Health Funding Authority purchasing principles a weighting regime is undertaken for; each proposed service they may wish to purchase, may already purchase or may decide not to purchase. Services are then prioritised according to resource allocation and desired or necessary resource shifts.

Table 31: Weighting criteria for PBMA

EFFECTIVENESS (75%)	
Severity of Health Problem elevated	15%
impact of service on need when delivered by the prescribed provider	15%
proportion of regional population likely to benefit	15%
Strength of evidence	20%
Reduces the costs/ improves effectiveness of other services	10%
EQUITY (10%)	
Closes the gap in unacceptable health status disparity	10%
MAORI HEALTH (10%)	
proportion of population affected who are Maori	10%
COMMUNITY ACCEPTABILITY (5%)	
Service is acceptable to community	5%

(Source: Health Funding Authority, 1999. 19)

Responsiveness strategies of the Central Region Health Funding Authority

The responsiveness approach of the CPHG is guided by the wider Health Funding Authority Maori policy. When purchasing public health services, providers are required to identify the amount of resource spent directly on services for Maori, level of Maori staff, links with Maori and strategies to be used to service Maori. Most of these issues must be clearly stated within the district strategy. For the contracting round of 1998/99 each district strategy purchased by the Health Funding Authority was required to show the following information clearly;

“For 1998/99 you will be required to develop or demonstrate, or demonstrate that you have developed a written strategy which underpins how you ensure your public health services are consistent with the principles of the Treaty of Waitangi. It will describe how you will further the governments objective to improve Maori

health status so that in the future Maori will have the opportunity to enjoy at least the same level of health as non -Maori. District strategies are required to expressly:

- state how programme planning and delivery meets the special needs of Maori
- acknowledge and affirm the relationship between Maori as tangata whenua and CHE's as entities owned by the Crown
- consult with Maori about, or involved in the design and delivery of appropriate programmes
- involve local iwi and other Maori groups participate in the decision making and planning process of the public health unit
- develop an appropriate quantity and range of programmes are developed to specifically address Maori health issues
- ensure that an appropriate quantity and range of programmes are provide by Maori for Maori
- ensure that programmes are culturally appropriate to Maori (Health Funding Authority, 1998. 4)"

Public Health Units are required to identify a number of key issues pertaining to Maori.

Programme Plans

Health promotion programmes are a key component of the district strategy. Health Promotion Programmes are structured in line with a particular programme format (see table 32).

Whether or not programmes have been completed is largely determined in accordance with the completion of performance indicators. That is providers are expected to achieve the stated performance indicators, and it is the performance indicators that are reported on, and monitored by the Health Funding Authority (Health Funding Authority, 1998. 6).

HEALTH FUNDING AUTHORITY PERFORMANCE MONITORING METHODS

The CPHG monitors the performance of providers using three distinct methods. First, all providers are required to systematically report against district strategy performance indicators as per contractual agreement with the Health Funding Authority

Second, the implementation of various audits of Public Health units by the Health Funding Authority, including cultural audits and quality and compliance audits are used to determine if what has been reported is accurate.

Third, as part of the public health contract, Public Health units are required to purchase the external evaluation of a selected programme.

Table 32: Health promotion programme plan format

Headings	Description
Background	outlines demographic details and key issues pertaining to a public health issue. E.g. tobacco control
Rationale	identifies the problem with supporting data and the those groups most at risk. Who will be targeted.
Needs of population	describes the actual needs of the population with regard the issue, e.g. service gaps
Preventability	identification of methods that can be used to prevent adverse effects or ongoing negative health issues
Programme Goals	the targeted aim of the programme
Programme objectives	includes time frames and what will be achieved by the programme
Stakeholders/linkages	identifies who will be worked with to fulfil the objectives of the programme and who will have an interest in the programme.
Cultural Appropriateness	how will addressing the issue address disparities between Maori and non-Maori
The Programme Activity Table	using the five key components of the Ottawa charter, relevant components of the programme are identified under each heading.
Performance Indicators	Performance indicators are developed for each programme, and are used to measure the completion of each programme
Coverage	identifies who the programme will be provided to
Budget	identifies the necessary resource allocation and price. To complete the programme

Time frame	the length of time before the programme will be completed
Evaluation	describes the evaluation methodology for the programme

(Source: Health Funding Authority, 1998, 7)

Thus evaluation of programmes is mostly the responsibility of the Public Health Unit in question (see table 33). Quality and compliance audits are undertaken by the Health Funding Authority to determine the accuracy of Public Health unit reports against performance indicators. However, no quality or compliance audits have been undertaken within the central region in the past three years, although they are planned for 2000.

Table 33: PHU reporting requirements to the Health Funding Authority

Report type	Format
Annual Visit	* PHU programme presentations to Health Funding Authority
Quarterly Report	* emergent Issues * exception report on contracted volumes * surveillance data * compliments and Complaints
Six monthly Report	* community environment issues * progress against performance issues * services for Maori * implementation of quality plans * Successes and lessons to share
Annual Report	* executive summary * developments within the unit * summary of events * summary of trends * indication of future directions * annual surveillance data - resource management activities

(Source: HFA, 1998. Appendix 6)

The Health Funding Authority Cultural Audit

The Health Funding Authority approach to the cultural audit involved the development of a review team. Two members of the review team then visit the Public Health Unit site and speak to selected staff only, including the manager. Using the audit tool interviews are carried out. The objective of the audit process being:

- to describe and assess the range of Maori health approaches/strategies implemented by PHU's
- to describe and assess the culturally appropriateness and responsiveness of the PHU's in specific programme areas
- to identify any innovative approaches that HHS's PHU's are undertaking in respect to Maori health promotion and health protection service delivery
- to identify any gaps in service delivery
- to make recommendations to HHS's based on the review.

(HFA, 1998b. 8)

The audit tool attempts to measure an organisations responsiveness with regards to the following issues;

- quality initiative developed with and for Maori
- involvement of Maori within the unit, especially the development of the district strategy
- how the Treaty of Waitangi is reflected in service delivery,
- support for Maori providers
- participation of Maori at all levels of the Unit
- other responsiveness strategies of the unit

(HFA, 1998b. 14 - 28)

Limitations of Evaluation and Reporting Mechanisms.

it should be noted, that while the reporting and evaluation mechanisms employed by the Health Funding Authority have some uses, the focus of evaluation methods

and frequency of evaluations used by the Health Funding Authority are limited. They are limited because evaluations are infrequent as external evaluations occur only once a year for one selected programme area. Internal evaluations are of little consequence because they are administered by units themselves who may sugar coat negative feedback to the Health Funding Authority pertaining to performance. They are also limited because quality and compliance audits only focus on purchased contracted outputs. Whether these outputs have any linkage to actual outcomes can not be determined without evaluations that are outcome focused.

Outcome focused evaluations have not occurred for a number of reasons, including cost. However, the fact remains that effectiveness of service activity needs to be determine and its contribution to targeted outcomes established so that the level of positive or negative impact can be determined.

"The advice given to Ministers on policy, and the decision made by managers on how to implement policies and programmes, can be (and frequently are) based on pure priori reasoning or intuition. But a priori reasoning and intuition on their own, are not adequate. Having a process for systematically testing whether a policy or plans behave as predicted is likely to help us develop better policy and plans so that, net time around, performance is improved. This in a nutshell is well (outcome) evaluation is important. (State Services Commission, 1999. 5)."

PUBLIC HEALTH UNIT'S, HEALTH PROMOTION AND MAORI HEALTH

The following section focuses on the practices of three Public Health Unit's located within the Central Region Health Funding Authorities purchasing region. They will be referred to as U1 (unit one), U2 (unit two) and U3 (unit three).

The three units were selected to provide a range of public health service delivery in quite distinct populations. Several visits to each unit were conducted in order to interview key staff, examine statements of intent and other relevant documents, and to gage a since o direction. Interviews were relatively informal although a standard approach was taken so that issues could be compared across the three situations.

Public Health Unit's are located within Hospital and Health services. They are generally contracted to provide a range of services, including health promotion, health protection, well child nursing services, adolescent nursing services, sexual health clinics, school dental health services, hearing and vision testing and cervical screening. The common theme that runs through most public health contracts is commitment to either early identification or disease prevention. Public Health Unit's therefore tend to focus on wellness as opposed to illness and on prevention rather than treatment. There are twenty one Public Health Unit's in New Zealand.

One common issue facing most Public Health Unit's is their location, most PHU workers prefer to be based in the community away from Hospitals to avoid public misconception of their preventative and promotional role and to maintain a certain level of independence.

Background information

U1 services a population of around 60,000, 20% of which are Maori. It has a large rural sector with some very isolated rural localities. It has both urban and rural localities, with the majority of the population being urban based. U2 services a population of around 45, 000, with a higher Maori population of around 44%. It also has a large rural sector with some of its localities also being very isolated. It has both rural and urban localities. Of its rural population 85% are Maori. U3 on the other hand is situated in a large urban centre and services a population of 134.000 people, 13 % of which are Maori. It has only semi rural locations and is predominantly urban in nature.

For Public Health Unit's two types of activities were investigated;

1. the approach of the units to health promotion service delivery
2. the responsiveness approach of the Units to Maori.

Some common Issues

As part of discussions with Public Health Units, some time was spent outlining the obstacles that hampered the progression of successful health promotion service delivery. There were at least three common issues shared to some degree by the units:

- length of contracts
- a central funder
- resource allocation

For all providers the contract cycle of 12 or even 24 months was too short. Short term contracting meant that between 25 and 50 % of a contract term (depending on length of contracts) could be spent planning and preparing for the next contract, as the contracting process generally takes around 6 months. This also meant that planning longer term health promotion contracts was associated with some risk. Even though changes resulting from effective health promotion interventions requiring up to a life time, due to contract length units felt they were forced to focus more on short term strategies, which limited options in terms of health promotion activity.

The second common issue, was the disadvantage of a central funder. There were at least three issues with a central funder not based locally. First, practical difficulties associated with not being able to contact the funder. Second, contracting difficulties, associated with the funder not having local knowledge or buy in to local issues. Third, contact issues, such as infrequent contact with the funder. These issues are seen as obstacles, particularly when the funder is tasked with purchasing services for communities they have little or no contact with. A vital issue to health promotion, given Community buy in is as an essential ingredient for successful health promotion practice.

The third common issue was resource allocation. While resource allocation to Public Health Unit's has remained constant over the past three years and has not

decreased, nor however, has it increased. The need for more resources was an issue for all providers. While lack of resources is not necessarily the fault of the funder, there is no sound rationale that appears to unpin the amount of resource committed by the purchaser to health promotion.

Public Health Units Approach to Responsiveness

All three units expressed a strong commitment to working responsively to and with Maori, although there is some variation in terms of how strategies to maintain or improve responsiveness to Maori are applied. With regards the responsiveness strategies of each unit there are however some common themes. Responsiveness strategies at the provider level can be grouped into at least five common approaches(see table 34):

1. cultural performance evaluation (CPE)
2. Maori workforce development (MWFD)
3. working in partnership (WIP)
4. Maori participation within the organisation (MPO)
5. Maori health gains (MHG)

For the most part Unit's have implemented a number of strategies for each approach. These strategies revolve around two particular principles of the Treaty of Waitangi - participation and partnership, with little evidence of the principle of protection.

Cultural Performance Evaluation

All three Units had an internal auditing process based upon the Consolidative Holisitc Interactive Cultural Auditing Framework (CHI Model) developed for the Public Health Commission to measure and monitor provider responsiveness to Maori. The CHI model has three key features. It assumes that organisations (with regards Maori) will already have some positive strategies, these should be identified and consolidated.

Table 34: Themes associated with the responsiveness approach of PHU's

Themes	Unit one approach	Unit two approach	Unit three approach
CPE	<ul style="list-style-type: none"> * internal cultural audits * full staff participation * uses CHI model * annual audit cycle * responsiveness plan 	<ul style="list-style-type: none"> internal cultural audits * full staff participation * uses CHI model * responsiveness plan 	<ul style="list-style-type: none"> internal cultural audits * uses CHI model * responsiveness plan *Guidelines for getting feedback from Maori with regard effectiveness
WFD	<ul style="list-style-type: none"> * specific responsiveness training plan for all staff * equal Maori representation on selection panels *ToW statement in Job Descriptions *Responsiveness a part of the Performance Management process 	<ul style="list-style-type: none"> * Maori representation on selection panel * some responsiveness training 	<ul style="list-style-type: none"> * designated Maori positions *ToW statement in Job Descriptions *Responsiveness a part of the Performance Management process
WIP	<ul style="list-style-type: none"> * sharing resources * joint projects * memorandum of understanding * sharing information * consultation with Iwi 	<ul style="list-style-type: none"> * sharing resources * joint venture * memorandum of understanding *sharing information * consultation with Iwi 	<ul style="list-style-type: none"> sharing resources * joint projects * memorandum of understanding * sharing information * consultation with Iwi
MPO	<ul style="list-style-type: none"> * consultation * proactively working with Maori * supporting Maori initiatives * contracting Maori expertise 	<ul style="list-style-type: none"> * consultation * proactively working with Maori * supporting Maori initiatives * contracting Maori expertise 	<ul style="list-style-type: none"> * consultation * proactively working with Maori * supporting Maori initiatives * contracting Maori expertise
MHG	<ul style="list-style-type: none"> * consultation * involving Maori in planning * proactively working with Maori * supporting Maori initiatives * contracting Maori expertise * specific projects targeted at Maori 	<ul style="list-style-type: none"> * joint ventures 	<ul style="list-style-type: none"> * consultation * involving Maori in planning * proactively working with Maori * supporting Maori initiatives * Maori Health gain projects a priority

Furthermore, give the wider perspective of health adopted by Maori, providers are assessed and encouraged in terms of their holistic focus to health. Finally, it is also assumed that the most positive responsiveness developments will be made if there is interaction between the purchaser and the provider – with regard to the responsiveness strategy setting process. That is providers are encouraged to be proactive about achieving goals specific to:

1. maori development
2. health gains for Maori
3. maori cultural values and beliefs

Each of the above goals have specific themes and performance indicators that are used to gage the performance of a provider. Implicit to the CHI model approach to cultural auditing model is the position of Maori in New Zealand society, the functions of public health and the Governments objectives (PHC, 1993. 17).

The approach of unit one and two to cultural audit was very similar. Both units undertook an internal cultural audit process that gave all staff the opportunity for involvement from the outset (see table 35).

The U1 process for the internal audit was evaluated. The most notable findings were:

- all staff were involved in the planning process of the audit
- 85% participated within the staff survey component of the audit

According to the evaluation report of the audit process:

“92% of staff stated that they would be more willing to implement outcomes from the audit due to being involved in the process from the outset. (Smith, 1998. 5).”

This is a particularly significant finding in that it confirms in part the community development notion that people are more likely to participate fully in something if

they have been involved from the outset. As a result staff of U1 are more willing to participate post audit, in the implementation of recommendations

Table 35: The internal Cultural Audit process undertaken by U1 and U2.

Task	Whom/what	outcome
Noho Marae / Staff Meeting to discuss the cultural audit held, and facilitated by an independent.	All staff invited	1. audit process agreed to 2. audit tools developed 3. Independent researcher identified
Cultural Audit undertaken by Independent auditor using audit tools developed by staff	Staff Projects key documents	4. all staff sent surveys 5. Selected projects audited 6. Key documents audited
Audit Report written with recommendations	Independent auditor	7. Report benchmarking the responsiveness of the Unit 8. Recommendations made to address weaknesses and consolidate strengths
Responsiveness Plan developed	All staff	9. Responsiveness programme clearly identified
Re - Audit after 12 months	All staff	10. Progress determined

.Both U1 and U3 had developed responsiveness plans as a result of their individual audit process. The key strategic features of the responsiveness plans are highlighted in table 36. At the time this study was undertaken U2 was updating its earlier responsiveness plan.

All three units have employed internal cultural audits to some degree and internal audit process responsiveness plans have resulted. Interestingly, these plans are mainly focused on how the Units can become more appropriate to Maori in accordance with the Treaty, but none of the units explicitly stated or provided evidence to suggest that they are positively effecting Maori health outcomes.

Table 36: Key features of U1 and U3 responsiveness plans

Unit one	Unit three
Workforce Development	Workforce Development
Development of strategic partnerships	Development of a systematic consultation process
Development of a process for Maori participation at all levels of the unit	Development of a system for Maori input into all planning of the unit
Development of an ongoing cultural responsiveness monitoring mechanism	Development of a process to respond to effectively to feedback on the responsiveness of the unit

Workforce Development

Two of the Units in particular are progressing workforce development in different ways. U3 has developed a three pronged approach to workforce development, proactive recruitment of Maori staff, implementation of designated Maori positions and attempts to improve the confidence of its non-Maori staff to work in partnership with Maori.

The approach of U1 to workforce development, however, is different. U1 does not proactively recruit Maori staff, yet has a high number of Maori staff (30%).

The decision not to proactively recruit was based on two premises. First, Maori staff do not always provide more appropriate services to Maori than non-Maori. Second, it is believed that it would be more beneficial for Maori to employ the best person for the job, than the best Maori for the job.

However, U1 is proactive in ensuring Maori have equal representation on all its selection panels. Furthermore, all panel members also take part in the shortlisting process and have equal power in the selection process.

Integral to U1's approach to workforce development is the development of a

specific responsiveness training package. The package has been developed in accordance with the findings of the internal cultural audit and is specific for its public health workforce. Training on the Treaty for example is related to the specific roles and functions of U1 staff members.

Partnership

All three units see partnership with Maori as important. In most instances memoranda of understanding (see Appendix 4) have or are currently being developed with iwi and Maori providers. Perhaps the best example is the working partnerships developed by U2 with two local iwi, and iwi providers, in the form of two joint venture pilot schemes. Partnership is reflected at all levels of this relationship, at the management level in the form of project management team and at the operational level by co-operation and collaboration amongst the respective work force. It seems to demonstrate that if given the opportunity Maori and non-Maori providers can work effectively together.

Also common to the partnership approach of each unit is the sharing of resources and information. All three units to some degree share information and resources with iwi and Iwi providers, who are consulted as part of the district strategy planning process.

For all three units partnership operates at various levels. At a management level in the form of memorandum, consultation and strategic planning. At an operational level in the form of information and resource sharing and implementation of joint or complimentary initiatives.

Participation

Participation is also proactively encouraged by all Units. All three units attempted to consult with Maori and to have Maori representation in most functions and planning activities of the units, including business and strategic planning, staff recruitment, programme evaluations and service delivery.

There were however, three interesting observations. First, U2 often felt

uncomfortable with participation of iwi in certain business matters, given the competitive nature of the health sector. U2's reluctance to collaborate was however, with all its competitors, not Maori alone.

Second, U3 aimed to have Maori staff levels which reflected the Maori proportion of its service population. The assumption was that by increasing Maori participation at a staffing level the health disparity between Maori and non-Maori would be reduced. This view is clearly documented with U3's responsiveness plan.

U1 on the other hand while encouraging the participation of Maori at all levels of their operation did not proactively set out to recruit Maori staff or to have designated Maori positions. Emphasis is however, proactively placed on the make up of selection panels. Since its inception (two years previously), the Maori staff numbers have moved from 2 in 1997 to 8 in 1999, increasing in real terms by 400%. Maori staff now represent 30% of the total U1 workforce. Furthermore Maori staff have been employed on the basis they can do the job better than others who applied, not because they are Maori. One advantage with this approach is the inclusion of the Maori communities at the decision making level when staff are appointed.

Maori health gains

Another theme that can be identified in the approaches of all three Public Health Units are their attempt to improve health gains for Maori. Interestingly, however, programme effectiveness is determined by the level of 'buy-in' from Maori for programmes, consulting with Maori before implementing programmes and delivering programmes with Maori. Where programmes have positive Maori inclusion there is an assumption that these programmes are effective. If effective means producing positive health outcomes for Maori, there is no evidence to suggest that positive Maori participation in a programme will automatically achieve this. Although it could be argued that active Maori support in a strategic approach would provide greater opportunity for success than if Maori were negative toward

activities, the outcomes in terms of health gains are yet to be determined.

Summary

The responsiveness approach of the three public health units to Maori can be summarised according to five activities.;

1. cultural performance evaluation (CPE)
2. workforce development (MWFD)
3. working in partnership (WIP)
4. Maori participation within the organisation (MPO)
5. Maori health gains (MHG)

These themes relate to the Governments overall strategic policy direction for Maori in terms of mainstream sector enhancement. They aim to improve the responsiveness of mainstream health services to Maori, to improve the participation levels of Maori within the health sector workforce at all levels and to improve the quality and number of Maori providers within the health sector. It could be concluded that the responsiveness direction of the Government is positively reflected at all levels of the health sector and to some degree is being achieved. The question however, is whether or not the Government responsiveness strategies will actually make a positive difference to Maori health outcomes. This question will be further explored in chapter ten.

Health Promotion Service Delivery

Effective Health Promotion service delivery is a major function of all Public Health Units. Common to all three units case studied is the adherence to the Ottawa charter as the principal guiding framework for health promotion service delivery. This is in part due to the purchasing format of the Health Funding Authority. The Ottawa Charter has five key components. They are:

- building healthy public policy
- creating supportive environments

- strengthening community action
- re-orientating the health sector
- developing personal skills

There is a consistency amongst Units in terms of the way they operationalise each section of the Ottawa Charter (see table 37). These strategies have been implemented to protect peoples health, promote health and prevent illness.

Table 37: PHU's approach to health promotion using the Ottawa charter

Ottawa Charter component	Common PHU Strategies
Building Healthy Public policy	<p>Submissions to any proposed policy document , discussion paper or bill pertaining to a particular health issue</p> <p>Development of local / regional reference group / advisory board to influence policy and decision makers (at all levels)</p>
Creating supportive environments	<p>Working in partnership with at risk or selected target groups to achieve their health- related goals</p> <p>Increasing the awareness of agencies/ bodies who may or can have an impact on selected health issues to ensure they are supportive</p> <p>Encouraging client bases or decision makers to develop supportive structures and policies pertaining to a particular health issue / group.</p>
Strengthen community action	<p>Use the media to promote awareness and foster support of the wider community for a selected health issue group</p> <p>Provide expertise and support to potential projects that will address or have a positive impact on a particular health issue / group</p> <p>Provide expertise and support to projects that will</p>

	address or have a positive impact on a particular health issue / group
Re-orientating the health sector	<p>Develop programmes that will encourage / enable the professionals to have a greater preventative focus.</p> <p>Work towards developing more specific and effective services pertaining to a particular health issue / group</p>
Develop personal skills	<p>Training trainers with reference to a particular health issue/group</p> <p>Up skill the public health workforce to work more effectively in achieving / implementing the above strategies pertaining to a particular issue.</p> <p>Up skill members of the at risk / target group to work more effectively in achieving / implementing the above strategies pertaining to a particular issue.</p> <p>Up skill others to work more effectively in achieving / implementing the above strategies pertaining to a particular issue.</p>

Programmes are developed using a combination of the community agency and community development approach outlined in chapter five. That is while the Health Funding Authority sets the key programme groups that will be purchased, Unit's have the ability and flexibility to develop programmes with community groups.

An example of both the community agency and community development approach to health promotion might be the purchase of a smoke free project to reduce the uptake of smoking amongst 3rd form girls (community agency approach) by the Health Funding Authority. However the project may then be developed and implemented with a focus group consisting of third form girls and other interested parties (community development approach). This of course is not purely a community development perspective because in theory the health promoter should

not have preconceived ideas of what to progress with communities, these decisions are meant to the domain of the community. According to Labonte (1999), such approaches have less opportunity to succeed, and are reflective of the dual accountability tensions faced by health promoters - that is a simultaneous accountability to both purchaser and community.

Mental Health Promotion

This section considers the health promotion approach of U1 to mental health, focusing on health promotion techniques to promote mental health, prevent mental illness and disability, and to reduce stigma attached to people with mental health problems.

The goal of U1 to mental health promotion in 1998 was:

"To promote a social and physical environment which improves and protects the public health/whanau public health by promoting mental health for the people of U1's service region"

The health promotion objectives of U1 for its mental health programme were:

- to increase knowledge and awareness of mental health, including the promotion of destigmatisation of mental illness
- contribute to an environment which assists in the reduction of the incidence of attempted suicide and death through complete suicide, using strategies which address the contributing personal, community and national factors.
- to assist in the promotion of whanau/family well-being, skill development, and advocate for supportive environments for families, parents caregivers and their children.
- through networking and liaison, assist health professionals and allied community agencies to access appropriate mental health training, knowledge and resources.

Table 38: U1 programmes and programme objectives

Programme	Objectives
Mentally Healthy Schools	<p>To actively promote school policies and procedures which support mentally healthy school environments through:</p> <p>utilisation of local intersectoral input</p> <p>provision of inservice and ongoing support for adolescent and child health nurses</p> <p>acknowledgement that the adoption of a mentally healthy schools programme will operate differently in each unique education setting</p> <p>development and implementation of a plan of action with the resource people in the education and health sector</p>
Critical incidence response	<p>To address the current situation which comprises the ability of potential users and providers of critical incident response services as a consequence of lack of liaison between services, knowledge of when, how and who to contact within services. By encouraging policy and process development and implementation, through:</p> <p>the establishment of a network of critical incident response providers</p> <p>facilitating the provision of adequate information and support to those who are likely to be 'helpers' to a critical incident</p> <p>key resource people in the education and health sectors identified and consulted</p>
Mental health awareness / destigmatisation of mental illness	<p>Promoting mental health awareness, and the destigmatisation of mental illness, may be achieved through action which the wider community including media become more aware of mental health issues</p>

U1 has developed 3 programmes to achieve these objectives. These are, Mentally Healthy Schools, Critical incidence response and Mental health awareness / destigmatisation of mental illness. The objective of these programmes in relation to mental health are shown in table 38.

The aim of the Mentally Healthy Schools programme is to increase the awareness of key issues relevant to mental health in order to create a mentally healthy environment within schools.

The aim of the Critical incident response programme is to put in place a response system that is able to effectively respond to critical incidence, so the opportunity for emotional and mental stress that are a consequence of such occurrences is reduced.

The aim of the Mental health awareness / destigmatisation of mental illness programme is to increase the awareness of the general population and in doing so reduce the level of stigma associated with mental illness.

Measuring Success

The success of these programmes is measured in various ways including internal evaluation. However, the Health Funding Authority measures the success of these programmes by receiving reports from the unit against a series of previously agreed upon performance indicators such as those in table 39.

Smoke Free Health Promotion

This section considers the approach taken by U2 to promoting healthy lifestyles with an emphasis on preventing smoking related illness and to protect people who do not smoke.

Table 39: U1 and U2 performance indicators for mental health promotion.

U1		U2	
Programme Objective	Performance indicator	Objective	performance indicator
Community networking	Attendance at meetings noted in meetings Increased demands in mental health resources (e.g. posters) is evident	Anti discrimination strategies	all speaking requests are fulfilled Evidence of successful activities reported in local papers Evidence that the mental health reference group contributes to and support the anti discrimination programme
Mentally Healthy Schools	Health nurses are confident in and are promoting mental health matters in 60% of secondary schools		
Destigmatisation	80% of trainees report that training is useful, 50% of trainees are available to deliver workshops by Dec.		

The smoking related Health promotion objectives of U2 are:

- to reduce the uptake of smoking and promote the 'why start' strategies
- to promote the implementation of smokefree schools
- to promote the concept of smokefree homes, buildings, cars
- to provide healthcare workers with current information on passive smoke
- to work toward the improvement of the health of the people by a reduction in smoking levels
- to enforce the smokefree environments Act

The aim of U2's programme is to increase awareness amongst the at risk target groups, to improve the knowledge of health professionals working with at risk target groups, to create more smokefree environments, to reduce smoking levels and to enforce relevant legislation relating to smoking.

Again the success of this programme is measured in several ways, but for the Health Funding Authority reporting it is measured against a set of pre-agreed upon performance indicators and milestones. Table 40 compares some of the performance indicators used by the Health Funding Authority to measure the success of Smokefree health promotion programmes undertaken by U1 and U3.

Table 40: U1 and U3 performance indicators for smoking related health promotion.

U2		U1	
Programme Objective	Performance indicator	Programme Objective	performance indicator
to promote the implementation of smokefree schools	Number of smokefree schools in region	Promote 'Act Now' train the trainer course to relevant groups	two train the trainer sessions are delivered to relevant personnel
to provide healthcare workers with current information on passive smoke	Number of training sessions tobacco/asthma held	Develop links with Maori providers	one joint venture planned and developed
to promote the concept of smokefree homes, buildings, cars	Number of enquiries and complaints	Network with other workers with an interest in smokefree	Attendance at smokefree interest group meetings

While all three Units set out to improve health status, their results simply record process and output measures which may or may not be linked to positive

outcomes. The assumption is that if a group of clearly identified outputs are achieved, programme goals will be achieved also, thus contributing to the Governments objective for Maori health.

Summary

The approach of Public Health Units to health promotion is best seen in terms of the Ottawa Charter. Units develop strategies pertaining to a particular health issues that are aimed at preventing negative health, promoting good health and protecting the health of people. The specific health issues to be addressed are set out by the Health Funding Authority, however specific programmes can and are developed with selected community groups. Several mulit faceted strategies are implemented by Public Health Units to address a particular health issue. While programmes are set out to achieve specific goals - such as the reduction of the uptake of smoking, success is measured not by a particular outcome (e.g. number of twelve year olds who have not taken up smoking in 1998) but by a set of performance indicators that may contribute to this particular outcome (e.g. number of awareness sessions held with twelve year olds).

The real issue lies with the focus of evaluations. While Public Health Units may all be effectively achieving contracted outputs, it is not clear to what degree these outputs actually contribute to desired health outcomes. The evaluative focus of both Public Health Units and the Health Funding Authority is whether contracted outputs have been achieved and not on whether contracted outputs have contributed to health outcomes. Until this issue is advanced, we can only assume health promotion is making a positive contribution to health status or at the very least causing no harm.

SUMMARY

It is hard to determine whether the responsiveness strategies developed by Government and operationalised by providers are making a substantial difference - if disparities between Maori and non-Maori are any guide then there is room for doubt. On the other hand, insofar as health promotion is about strengthening

community capacities, and greater health awareness, then the significant expansion of the Maori health promotion workforce and the involvement of Maori in partnerships and decision making reflect a degree of success. Nevertheless, more work is needed to develop outcome measures that are appropriate to Maori and which can capture the key gains necessary for improved health status.

An important issue is that the Governments strategies are clearly reflected at all levels of the health sector. At a provider level a number of strategies are being implemented to progress the standard of Maori health, including progress towards identifying health gains for Maori. Some confusion exists amongst providers who assume that Maori health gains strategies will be effective when they are accepted and co-developed by representatives of the Maori community . The fact is that while Maori acceptance of a strategy is positive and an advantage to health promotion, one should not assume that the strategy in question will lead to better Maori health outcomes.

It is difficult to determine whether the health sector contributes to improvements in Maori health outcomes, using health promotion as an example. This is primarily due to the limited evaluative methods implemented by the Health Funding Authority. Current evaluation methods assess the degree to which health promotion programme outputs have been achieved. They do not evaluate the contribution of this activities to health outcomes. Thus, while the health sector at the provider level fulfils its contracted obligations, it can not be stated whether or not health promotion interventions contribute to improved Maori health outcomes.

CHAPTER TEN

DISCUSSION

INTRODUCTION

The purpose of this chapter is to amplify key points made in this thesis. The key points can be grouped into the following categories:

1. effective health promotion service delivery
2. responsiveness to Maori
3. Maori health outcomes
4. issues with central funding

CHAPTER SUMMARY

Chapter two concluded that Maori prefer a multidimensional perspective of health, in that health is seen as more than physical wellbeing. For Maori, health pertains to a combination of internal and external factors. From an internal perspective, these include, mental, spiritual, and physical wellbeing. These internal factors are influenced by external forces issues such as whanau/family support, knowledge of historical family linkages, a healthy physical environment and a positive cultural identity.

Chapter three showed the extent of support for the Maori perspective of health largely through approaches taken by the National Health Committee in advancing the notion that health is the product of social, cultural and economic determinants. This perspective affirmed the view that the health of an individual and therefore the community is the result of wider social and economic factors such as income, housing, education and cultural identity.

Chapter three also provided an assessment of Maori health status and wellbeing. It concluded that Maori health standards are poor and will remain so until the

performance of Maori in such areas as employment, income, education and housing improves. This chapter also concluded that strategies aimed at the improvement of Maori health outcomes will need to be multidimensional in nature and must aim to address the adverse social, cultural and economic determinants of health if they are to be successful.

Chapter four contended that Maori have both expectations for better health standards and rights to good health. The expectation of Maori (underpinned by Article three of the Treaty) is to experience at least the same level of health as non-Maori. While disparities in health between Maori and Non-Maori continue this expectation has not been realised. This chapter also showed that Maori have the right to good health in accordance with international treaties relating to human rights. A final point was that Government has an important role to play in advancing the present position of Maori health.

Chapter five provided an overview of health promotion. It concluded that health promotion provides an effective framework for addressing the multiple health issues associated with being Maori. It also concluded that health promotion is most effective when local knowledge is used by communities to determine priorities and to develop effective preventative programmes to address identified issues. The point was made that health promotion should lead to gains in health, but because performance is measured against outputs there is uncertainty about the effectiveness of health promotion programmes.

Chapter six provided an overview of theoretical paradigms that underpin social and economic policy. Political operations are not randomly determined, but are aligned with certain theoretical and philosophical assumptions. The importance of this chapter has been to provide background information to the health reforms and the presentation of information outlining different political alternatives.

Chapter seven contained background information on the health reforms of the 1990's and concluded that in part they were progressed so that the health sector would become more accountable, efficient and effective in its operations. The key point however, is that the health sectors performance is based more on its ability to create financial efficiency gains than to provide effective health outcomes for the population, including Maori. This is particularly reflected in the Governments performance expectations of the health sector. An important issue here is the need to have explicit outcome goals for health, which are not on focused on financial benefits alone.

Chapter eight, provided a description of the health sector in action using health promotion as an example. It focused on two main issues, first, the responsiveness approach of the health sector to Maori and second, the opportunities that the health sector creates for the advancement of Maori health. It concluded that the responsiveness approach directed by Government is reflected throughout the health sector, which suggests that there is merit in the health sectors organisational model at least to meet Government policy objectives. The question however, is whether the responsiveness approach of Government will actually produce better Maori health outcomes. This issue is further complicated by the inability of output based contracts used to measure positive changes in health outcomes.

Chapter nine described the experiences of three public health units and the accountability arrangements explicit in their contracts with the Health Funding Authority. All were able to demonstrate the establishment of sound relationships with Maori communities, and to some extent the inclusion of Maori aspirations, values and staff. But since their reporting requirements do not necessitate comment on outcomes, it cannot be concluded that they have contributed to positive health gains.

THE KEY FINDINGS

Effective health promotion service delivery

Health promotion provides a framework within which to progress Maori health outcomes. It is useful for this purpose because it has a preventative focus, it has a multidimensional perspective of health, it advocates strategies that aim to address the adverse effects of social, cultural and economic determinants of health, it attempts where appropriate to change lifestyle behaviours that can lead to poor health outcomes and it advocates multi levelled and multi faceted strategies such as those prescribed by the Ottawa charter (see table 41).

Table 41: Health promotion - key components and implications for practice

Component / focus	Health promotion practitioners	Decision makers at a policy level
Prevent poor health outcomes	practice is focused on programmes and strategies that prevent the prevalence of poor health	must develop policy which is well researched and does not contribute to poor health
Work to address adverse social, cultural and economic determinants	must develop programmes that contribute to positive changes in the social and economic circumstances of those most in need	high level health improvement strategies must contribute to shifts in power, control and resources to those most in need
Have a multidimensional view of health	health must be seen as more than just physical well - being	health policy must be integrated throughout the public sector and must be multi dimensional
Work with the Ottawa charter	health promotion strategies must be multi levelled, multifaceted and owned by the community	the entire public sector must be accountable to the community for better health outcomes
Where appropriate support lifestyle changes	work with the community to support lifestyle changes	create social conditions that allow for health lifestyle choices

Effect positive health outcomes	deliver programmes that positively contribute to positive health outcomes	develop and implement effective evaluative methods that can determine the contribution of interventions to health outcomes
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While there is still much debate over the worth of health promotion, it can be considered a useful approach for both practice at a service delivery level and as a framework for decision makers tasked with developing policy that will improve health outcomes. Health promotion strategies are most effective when communities using local knowledge both identify issues and develop solutions to these issues. Community participation in the development of programmes extends a greater opportunity for success. At present health promotion activity at a provider level is faced with dual accountability tensions, which limit its opportunities for success.

Responsiveness to Maori

There are several concerns with the current approach of the health sector to Maori health. First, the objective of Government for Maori health has a number of shortcomings. The reduction in disparity the Government hopes to achieve, could be achieved by lack of progress in non-Maori health, meaning that there is room for the Government to make little headway into improvements in Maori health but still achieve its goal. The goal for Maori health must therefore be the improvement of Maori health outcomes, not necessarily using non-Maori benchmarks.

Maori development and Maori health are important issues , however, the progression of Maori development should not be confused with the goal for Maori health. The goal for Maori health must be 'the improvement of Maori health outcomes'. The health sector should be measured in performance against this goal , rather than in more generic cultural or political terms. Maori organisations not infrequently see health services as an opportunity to practice autonomy - often regarded as a higher ideal than good health outcomes. And sometimes the rational

for contracting with the Health Funding Authority hinges on a 'by Maori for Maori' philosophy, with only passing regard for best health outcomes.

There is of course a link between the two, just as there is a link between improving Maori standards of health and reducing the disparities between Maori and non-Maori. It is clear that the Government to a degree has confused its strategies for improving Maori health with strategies for advancing Maori development. Its service policy direction and instruction to the Health Funding Authority suggest that health gains for Maori are to be achieved by:

1. increasing participation of Maori in the health sector
2. increasing the number of Maori providers in the health sector
3. mainstream sector enhancement, that is making sure health services are appropriate to Maori

It is difficult to determine whether these strategies will necessarily make any contribution to better health outcomes for Maori health. If however, Government has progressed the above three strategies for Maori health as preparation for a move toward a more outcome focused model of health, their approach could be assessed as reasonable.

Maori health outcomes

There are a number of issues with the Government's approach to health outcomes. First, in accordance with the principles of the Public Finance Act, 1989, outcomes are the responsibility of the Minister, while associated outputs are the responsibility of departments. In the case of health, using health promotion as the example it would be very hard to argue that the outputs purchased have contributed positively to better health outcomes for Maori, because of limitations with evaluation methods of the Health Funding Authority, none of which are outcome focused. This is not to say that health promotion activity is ineffective or that it has not

resulted in health gains, but without reflection and review focused on outcomes it is hard to determine the worth of health promotion or any activity is within the public sector.

Issues with central funding arrangements

The purchasing function is associated with priorities and practices which are not always explicit, nor rational in the sense of being transparent, based on clear principles, and committed to preventative strategies for whole populations. Of the many problematic areas, five are of particular relevance to this thesis:

1. resource for public health services including health promotion is only two percent of the total vote health dollar
2. timeframes for contracting for the delivery of health promotion are too short
3. purchasing health promotion outputs means there is no direct links to outcomes
4. limited evaluations
5. centralised purchasing of health promotion

Resource allocation

Health promotion is not necessarily a cheap option. The present health system currently measures performance against financial efficiency gains and not improved health outcomes. This attitude was reflected in the Green and White paper which supported the advancement of public health strategies not so much for their ability to produce better health outcomes, as for their ability to save money on the provision of treatment based health services(1991. 3). While some health promotion activities are relatively cost effective resources are nonetheless required At present illness and disease services are maintained by pouring 97% of vote health dollars into personal health care (Goodwin, 1997). Furthermore, if hospitals (which are by far the largest providers) are to increase their revenue allocation they must show an increase in volumes, thus enhancing the maintenance of illness

and disease and focusing their attentions away from prevention and promotion.

Contract length.

Another issue that requires attention if health promotion is to be given a greater opportunity to progress outcomes is the length of contracts. The Public Health Unit contracts for the provision of health promotion are either on a 12 or 24 month cycle. This has a number of limiting effects. First, the ability to plan ahead and develop projects of a lifespan of more than 1 - 2 years is extremely difficult. Second, emphasis on the short term restricts progression of health outcomes in that most health promotion outcomes cannot be achieved in such short time frames. Third, the amount of time and resource that goes into each contract cycle, as opposed to service delivery detracts from the services potential. The contracting process lasts for at least six months, meaning that at least 25 - 50 % of a year can be primarily focused on contract renewal. The funding authorities must be prepared to fund services for longer periods.

Evaluation, outcomes and outputs.

A point that has already been touched on is that health promotion is currently purchased and evaluated against a number of pre-agreed upon outputs. These outputs may actually make very little contribution to actual health outcomes, and the opportunity exists for providers across all sectors to make little difference to desired outcomes, but still be successful in terms of fulfilling contractual obligations. This issue highlights the need to move towards outcome based purchasing and evaluations. A move toward an outcome focus will result in a greater emphasis on the wider determinants of health, forcing programmes to be multidimensional and multi levelled in nature.

Centralised Purchasing

While centralised purchasing has a number of benefits, for example taking advantage of economies of scale and greater opportunities for maintaining

consistency, it also has a number of disadvantages, particularly where the effective delivery of health promotion is concerned. The first major disadvantage is that a central purchaser does not have what can be termed local knowledge. This type of knowledge is thought to be a major contributing factor to such successful programmes as Tu Tangata. The second issue, is that the central purchaser does not have the same level of buy-in to programmes as people living in an area where a programme is being delivered. Both these factors are critical to the success of any health promotion programme. Community buy-in, ownership, knowledge and participation are essential components for advancing successful health promotion activity. These factors raise the case for strengthened localised purchasing.

FUTURE DIRECTION

The question remains, what can be done to advance Maori health outcomes so that Maori will have a greater opportunity to live healthier and productive lives. There is no easy way forward. Any changes are complicated by a series of issues pertaining to control, responsibility, accountability and available resources. Arising from this thesis, however, the following suggestions might be advanced:

1. the use of health promotion as a model for practice at all levels to advance Maori health standards.
2. Strengthening localised community purchasing
3. development of more effective public sector research, monitoring and evaluation, with particular reference to the evaluation of outcomes.
4. a greater focus on health outcomes

Health Promotion

The usefulness of health promotion as a model to effect positive changes in Maori health standards has already been outlined. Health promotion provides a useful model for this task, because it has a preventative focus, advocates community

developed initiatives that are both multi levelled and multi faceted and attempts to address the adverse effects of the social, cultural and economic determinants of health. These are all important issues if Maori health standards are to improve.

Strengthening localised community purchasing

This is not a new concept, in fact it is being advanced by the Health Funding Authority in a number of localities. However, the local purchasing authority must have a community mandate. If specific for Maori this means it must be mandated by iwi or other accepted representative groups or might indeed be a Maori authority. From a health promotion perspective it is important that the community must be integral to the purchasing decision making process. This will in part ensure strategies purchased to improve health will have greater opportunity for local participation and will be purchased using local knowledge.

More effective research, monitoring, and evaluation

A greater level of commitment to the evaluation of outcomes is required within the public sector. The question remains that if that has not been a focus in the past, what have health policy decisions been based on? Some would argue overseas research and internal feedback loops, but neither approach effectively indicates how well the health sector strategies are achieving or contributing to outcomes in New Zealand localities. The public sector needs to advance research, monitoring and evaluation of outcomes and need to:

- develop new and effective approaches to the evaluation of outcomes in New Zealand
- implement outcome focused evaluations of the public sector including health
to advise the government on which strategies are most successful in preventing negative health

Ultimately, the goal is to determine how a policy or intervention has impacted on or contributed to the achievement of government objectives or overall outcomes.

This new approach will require a change in attitude by government and a longer term commitment to determining effective interventions, by placing a greater importance on outcomes and the evaluation of outcomes. Ministers must therefore be open to constructive criticism and long term solutions for improvements in health. (State Services Commission, 1999).

Contracting for Outcomes

A change in the way health contracts are developed requires review also. They must begin to have an outcome focus. This will become more realistic with the above emphasis on outcome evaluation. At present too much opportunity exists for services to provide little towards the advancement of Maori health outcomes. This is not intentional, as services will ultimately only do what they have been contracted to do. Thus, unless progress towards outcome based contracts are made explicit in contracts, services and departments at all levels will continue to output focused , which at the end of the day, may make little or no contribution to health outcomes. A practical example of an outcome focused contract is where services are contracted to provide a 5% reduction in the uptake of smoking by fourth form Maori girls, as opposed to being contracted to provide an awareness session for fourth form Maori girls on the adverse effects of smoking.

The movement toward an outcome focus for Maori health will also encourage high level strategies that address the adverse effects of social, cultural and economic conditions, which are considered to be most significant in determining health standards.

CONCLUSIONS

Despite the disestablishment of the PHC, public health activities appear to be more secure than they were before the 1991 health reforms. The extent to which those activities have advanced Maori health remain to be tested, but the issues are clearer and overall, Maori participation in the public health movement is high. Further, the Maori public health workforce has increased several fold and the principles of public health are more likely to be espoused in a variety of domains including marae, kohanga reo and Māori sports clubs.

Health cannot be separated from the many other endeavours which contribute to Maori advancement. Health promotional activities need to be cognisant of the realities, organisational arrangements, aspirations and capacities of Maori communities. There is a danger that the potential of health promotional activities will be undermined if they are not well integrated into the broader aspects of Maori development. In this respect many of the HHS health promotional programmes are peripheral to Maori community development insofar as they are decided according to HFA purchasing schedules and may not be perceived by local communities as high priorities. Yet a community development model is now widely regarded as more likely to produce positive health gains than the community agency model that seems to currently dominate public health strategies in New Zealand.

Participation by itself, however, is not a guarantee of success. A major theme in this thesis has been the need for measures, which are able to reflect actual health gains. The tendency appears to have been to focus on process issues such as the level of Maori participation with relatively little regard for the actual impact on Maori health. Reporting requirements to the HFA for example, seldom require attention to improvements in health status; rather they focus on process and output measures that have, at the most, marginal relevance to improved community health. Missing, is the employment of outcome measures. And although outcome

measures currently lack refinement in terms of a cause and effect, they are sufficiently robust to incorporate into reporting mechanisms. Only when an outcome focused approach has been adopted will it be possible to determine the effectiveness of health promotional activities.

Two implications for purchasing agencies arise from this thesis. First, a shift from output to outcome focused purchasing strategies will be necessary if evidenced-based standards are to be applied to health promotion. Second, if there is to be a shift towards a community development model for health promotion, as distinct from a community agency model, then local purchasing will assume greater importance than the somewhat blunt application of national purchasing priorities.

This thesis has applied a critical eye to health promotion. The arguments, however, have not discounted the potential of health promotion for the advancement of Maori health. Instead if there is a single conclusion to the thesis it is that the capacity of health promotion to advance Maori health has untapped potential. Not only does health promotion provide an integrated approach to health, consistent with Maori philosophies of interconnectedness but it presents the opportunity for Maori communities themselves to effect positive changes for health.

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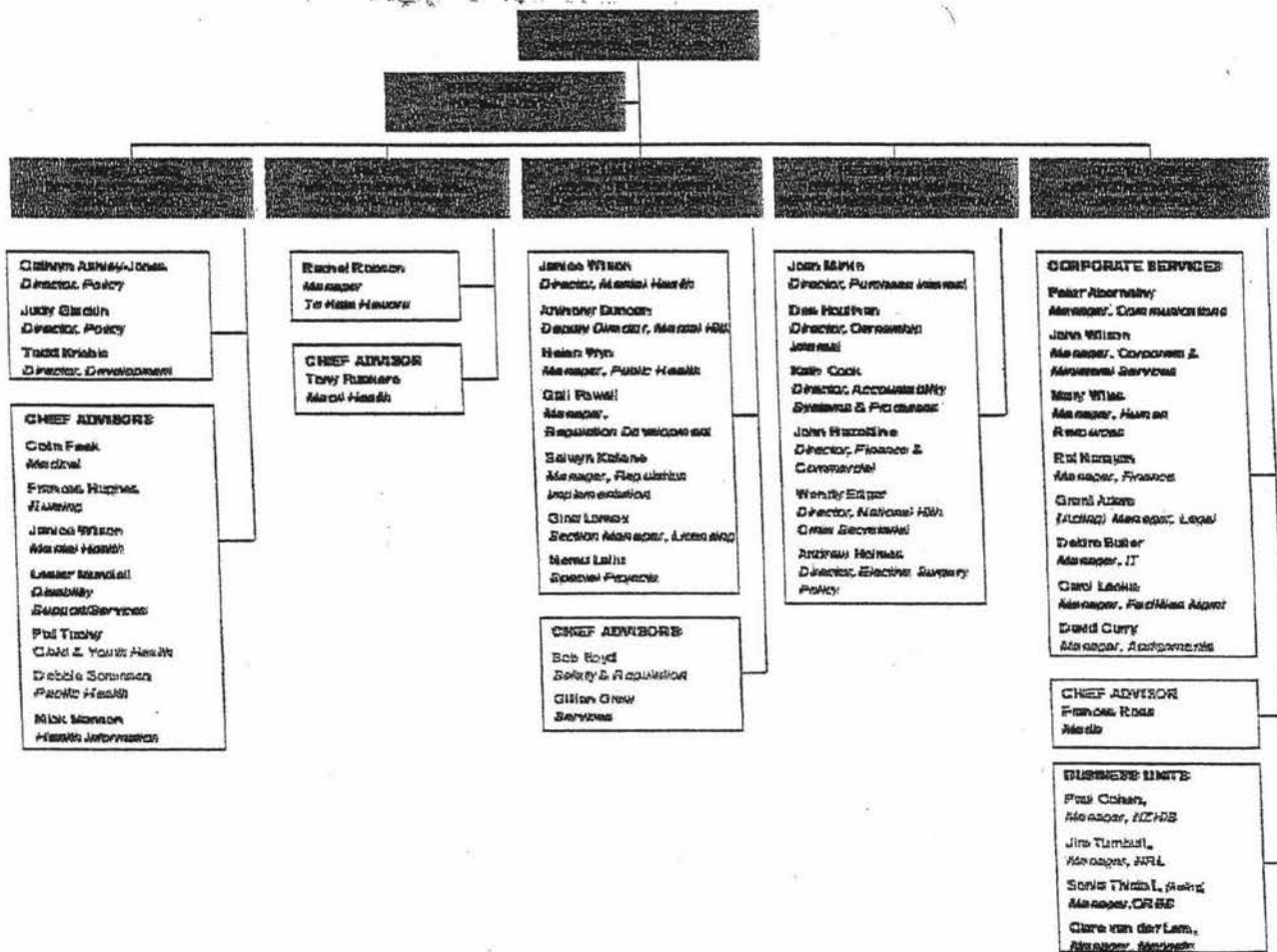
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APPENDIX ONE

MINISTRY OF HEALTH'S STRUCTURE

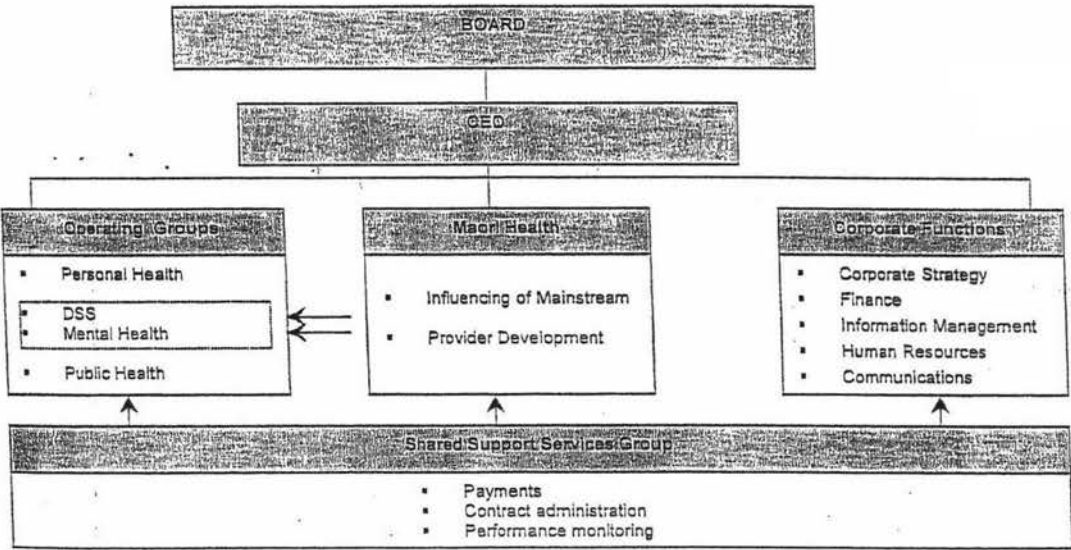


APPENDIX TWO

The Health Funding Authority

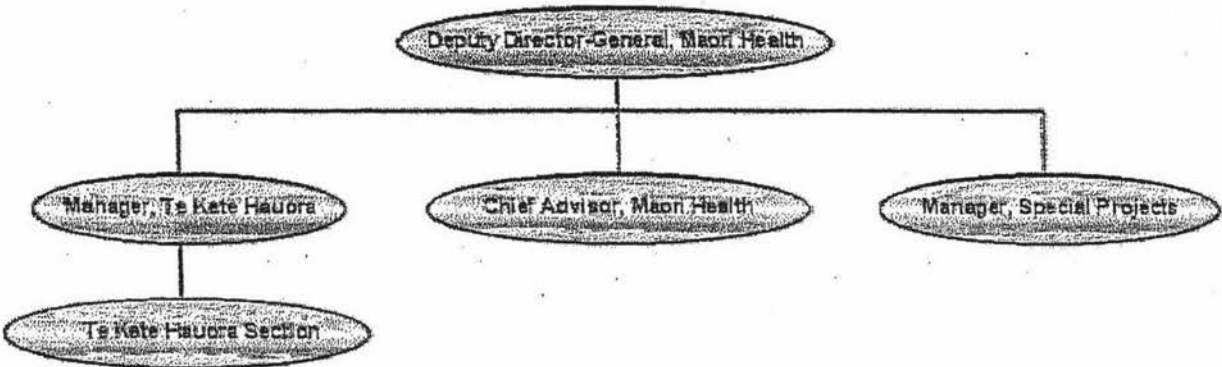
(simplified version)

Health Funding Authority Organisational Chart



APPENDIX THREE

Te Kete Hauora – Ministry of Health Maori Advisory Group



APPENDIX FOUR

PHU

LOGO

MEMORANDUM OF UNDERSTANDING

(To be renewed annually)

MAORI

LOGO

Mutual Agreement

Both parties agree to:

1. where possible work together toward common goals
2. identify and communicate opportunities for future joint ventures
3. consult and communicate with each other systematically (e.g. monthly at a management level) or as the need arises
4. share resources and training
5. work on the following projects jointly;
 - annual immunisation of Maori children
 - specific smoke free project for Maori

The PHU will always inform the Maori representative of:

1. any new initiatives
2. relevant recruitment issues
3. any changes to services
4. any relevant major concerns

Signed.....

On behalf of PHU

/ /

Signed.....

On behalf of Maori Organisation

/ /